IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 2802

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, JACQUI HAWKINS, Coroner having investigated the death of Lorraine Mary Bartolome

without holding an inquest:
find that the identity of the deceased was Lorraine Mary Bartolome
born on 27 August 1941
and the death occurred on 8 June 2015
at 44 Curlew Avenue, Altona, Victoria, 3018
from:

1 (a) EXSANGUINATION FROM RUPTURED VARICOSE VEIN RIGHT LOWER LEG

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Lorraine Bartolome was 73 years old at the time of her death. She lived with her husband Giuseppe Bartolome in Altona.

2. A brief was provided by Victoria Police to the Coroner, including statements obtained from Mr Bartolome, Mrs Bartolome's daughter's Michelle Pardy and Marisa O'Halloran, Mrs Bartolome's treating clinicians, attending paramedics, Ambulance Victoria (AV), the Emergency Services Telecommunications Authority (ESTA) and investigating officers. I have drawn on all of this material as to the factual matters in this finding.

3. Mrs Bartolome's known past medical history included hypertension, atrial fibrillation, restless legs syndrome, eczema, impaired glucose tolerance and depression. Cardiologist Dr Deepak Haikerwal reported he had been caring for Mrs Bartolome since November 2010 for atrial fibrillation. Mrs Bartolome was treated with cardioversion and due to a high stroke risk she was treated with anticoagulants, initially warfarin which was then changed to Pradaxa

(dabigatran)[1] in 2013. In January 2014, Mrs Bartolome was in chronic atrial fibrillation. She last saw Dr Haikerwal on 5 May 2015. Her Holter monitor showed she was in well controlled atrial fibrillation. An echocardiogram showed normal left ventricular systolic function with moderate pulmonary hypertension.

4. Mr Bartolome reported that Mrs Bartolome suffered from varicose veins. She made her own ointments and used them at night when she was worried about them. Sometime in early 2015, Mrs Bartolome injured a varicose vein on her right leg. As she was on anticoagulant medication, the vein bled a lot, however Mr Bartolome was able to stop the bleeding with a bandage. When Mrs Bartolome injured the varicose vein a second time, Mr Bartolome could not stop the bleeding and called emergency services for assistance. Ambulance Paramedics transported her to Frankston Hospital for further treatment after the bleeding was controlled. Mr Bartolome reported Mrs Bartolome injured the varicose vein a third time, approximately one month before her death. On this occasion, he was able to stop the bleeding with a sports bandage and applied pressure. On each occasion Mrs Bartolome injured her vein, it occurred shortly after she had showered.

Surrounding Circumstances

5. On 6 March 2015, Mr Bartolome travelled to their holiday home in Sawmill Settlement with his daughters and their families. Mrs Bartolome decided to stay home. She said she would be alright on her own; Mr Bartolome left some instructions for her just in case she had a problem.

6. On 8 March 2015 at approximately 1.22am, Mrs Bartolome called emergency services and reported that a scab on a vein on her leg was bleeding.

7. At 3.03am, Altona Ambulance AL224 was dispatched to Mrs Bartolome. Paramedics were instructed over the radio they were responding to a code 3 "*patient with minor haemorrhage in Altona*". AL224 arrived at 44 Curlew Avenue, Altona at 3.16am. They knocked on the front door however there was no answer. They asked via radio the last time someone had made contact and were informed there had been no contact since the original call. The paramedics contacted the AV Duty Manager for advice at 3.20am.

8. The AV Duty Manager did a 'call back' to the residence, however there was no answer. Paramedics were instructed "*you're welcome to clear unable to locate*," however they noticed a light on inside the house and went to investigate. At 3.25am, AL224 paramedics contacted the AV Duty Manager reporting they could see Mrs Bartolome through the window on the

[1] Dabigatran is an oral anticoagulant medicine used for the prevention of clots and emboli after major orthopaedic surgery and to prevent stroke and other systemic emboli in people with non-valvular atrial fibrillation (AF), a commonly occurring abnormal heart rhythm.

floor surrounded by blood and that they were going to attempt to force entry. At 3.30am AL224 paramedics contacted the ESTA dispatcher requesting police assistance to force entry, however at 3.34am they reported they had gained access and requested MICA paramedics respond on a code 1. At 3.35am, AL224 requested the attendance of a second MICA crew as Mrs Bartolome had suffered a cardiac arrest. The first MICA crew (MICA Response 3) arrived at 3.45am and the second MICA crew (MICA 23) arrived at 3.51am.

9. MICA Response 3 paramedic Robert Simpson reported that when he arrived on scene he found AL224 paramedics attempting to resuscitate Mrs Bartolome with the assistance of the Metropolitan Fire Brigade. A large amount of blood was on the floor surrounding Mrs Bartolome. There was a small wound above her right knee that appeared to be a varicose vein that had bled. No other significant injuries were immediately apparent. Mr Simpson immediately assisted by administering intravenous fluids and adrenaline. MICA 23 crew assisted on their arrival by securing her airway. Despite extensive resuscitative efforts, Mrs Bartolome could not be revived and she was declared deceased.

CORONIAL INVESTIGATION

10. Police conducted an investigation on my behalf into the circumstances of Mrs Bartolome's death. AL224 paramedics informed police they broke the front window of the property to gain access after locating Mrs Bartolome unresponsive. The investigation did not identify any suspicious circumstances or evidence of third party involvement.

11. On 12 June 2015, Dr Michael Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM) performed an autopsy on the body of Mrs Bartolome, reviewed the post mortem computed tomography (CT) scan and the Form 83 Victoria Police Report of Death . Dr Burke reported the post mortem examination showed a ruptured varicose vein to the right lower leg. There was no evidence of any other injury. There was no evidence of any natural disease process which would have contributed to or led to death.

12. Dr Burke commented that the initial contact record at Coronial Admissions and Enquiries indicated that Mrs Bartolome was on warfarin because of atrial fibrillation.[2] This anticoagulant therapy would exacerbate the bleeding from the varicose vein.

13. Post mortem toxicological analysis was not conducted.

14. Dr Burke provided an opinion that the medical cause of death was 1(a) EXSANGUINATION FROM RUPTURED VARICOSE VEIN RIGHT LOWER LEG.

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[2] It has since been established, as noted above, that Mrs Bartolome was prescribed Pradaxa (dabigatran) an oral anticoagulant medicine.

15. I determined to investigate the AV response time and requested statements from AV and ESTA.

Emergency Services Telecommunications Authority

16. Mark Richards, Quality Improvement Manager provided a statement to the Court on behalf of ESTA.

Background

17. Mr Richard's explained that ESTA is responsible for AV call-taking and dispatch functions for the entire state of Victoria. ESTA call-takers receive calls for ambulance assistance from members of the public via Telstra's 000 service. These calls are processed in accordance with AV service delivery requirements. AV is required to provide ESTA with its standard delivery requirements which comprise Communications Standard Operating Procedures (CSOPs) and other supporting documents. AV standard delivery requirements are the source of documents from which ESTA derives its Standard Operating Procedures (SOPs). The purpose of SOPs is to provide clear and concise instructions to all ESTA staff operating the Computer Aided Dispatching (CAD) system for AV operations.

18. The AV standard delivery requirements require ESTA to employ a formal, structured question and answer methodology set down by the Academy of Emergency Medicine Dispatch (USA), which is the Medical Priority Dispatch System (MPDS). The software is known as ProQA.[3] The protocol provides call-takers with key questions in respect of different event types to assist them to elicit relevant information from the caller and enter those details in CAD. Depending upon the answers to those questions, the protocol provides a determination which CAD then translates into a relevant event type for dispatch. The event type determines the priority to be ascribed to an event in accordance with a response grid determined by AV. Depending on the event type, ProQA will also provide a post-dispatch and pre-arrival instructions for ESTA call-takers to pass onto the caller.

19. When an event is accepted by a call-taker into CAD, an ESTA dispatcher will manage the dispatch of a CAD event in accordance with its urgency, which is based on the priority assigned to the event (Priority 0 being the highest and most urgent, Priority 4 being the least). Events are normally dispatched directly to an AV unit, however may be referred to an AV

[3] ProQA provides call-takers with key questions in respect of different event types to assist them to obtain relevant information from the caller and enter those details into ESTA's CAD system. These questions are scripted to: (a) identify the location for response; (b) identify what is happening and allow the call-taker to assign a chief complaint code (protocol) that most closely describes the foremost symptom or incident; (c) ask relevant key questions to determine the seriousness of the event, which CAD translates into a relevant event type for dispatch.

Duty Manager or Communications Support Paramedic for a dispatch solution in certain agreed circumstances.

Events of the early hours of 8 June 2015

20. Mr Richards reported that the ESTA call-taker created an event on the CAD at 1.22am. It was noted that Mrs Bartolome was at home at 44 Curlew Avenue, Altona and the call-taker used the event code 21B2-A "*haemorrhage/lacerations, serious haemorrhage.*"[4] This event type is used to signify a serious haemorrhage requiring urgent (but not immediately life threatening) attention. The priority for the event was 'priority = 1'.

21. At 1.24am, the ESTA dispatcher selected the recommended closest unit icon to identify the closest ambulance unit for dispatch. Hoppers Crossing ambulance (HC430) was identified as the closest appropriate unit and dispatched via CAD at a linear distance of 12km. HC430 was informed on the radio that it was a code 1[5] for a patient who was "*bleeding from the vein.*"

22. The ESTA call-taker asked Mrs Bartolome if she had a bleeding disorder or whether she was on blood thinners and she responded "*no*".

23. The ESTA call-taker then instructed Mrs Bartolome to place a clean dry cloth directly onto the wound, to press down firmly and to keep the pressure on. The call-taker asked Mrs Bartolome if the bleeding was controlled when she applied pressure, to which she replied "*Yes I got it wrong a bit so it's still going. So I'll have to hang up and let you go...*" The call-taker asked Mrs Bartolome to stay on the line and again asked whether the bleeding was controlled when pressure was applied. Mrs Bartolome answered "*Well yes, but I haven't got it stopped right. It's still bleeding at the moment.*"

24. Following this exchange the call-taker reconfigured the event, changing the event type from 21B2 to 21A1 "*haemorrhage/lacerations, not dangerous, haemorrhage*" at 1.25am. The event was then re-prioritised to a "*priority = 3*". The event was automatically downgraded upon the reconfiguration of the event occurring. As a result of the downgrade the Hoppers Crossing ambulance was diverted from attending to Mrs Bartolome and redirected to attend a higher acuity patient in Altona Meadows. At 1.26am, the call taker entered "*NFD*" (no further details) in the event comments to indicate there was no further relevant information and ended the call with Mrs Bartolome.

25. The dispatcher attempted to re-dispatch Mrs Bartolome's event a further four times over the next 37 minutes. In each instance the event was referred to the AV Duty Manager for a

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[4] Protocol 21

[5] Code 1 instructs the ambulance crew to proceed on a lights and sirens response.

dispatch solution. There were no suitable ambulance crews available to attend to Mrs Bartolome with the units returned either MICA units or subject to dispatch warnings making them available to attend only Code 1 (priority=0 or priority=1) events.

26. At the last attempt the event was referred to AV's referral service before Altona ambulance AL224 was dispatched to Mrs Bartolome at 3.03am, marked en-route at 3.05am and arrived on scene at 3.16am.

ESTA review

27. Mr Richards reported that on reviewing the events of the morning of 8 June 2015, he found that the call-taker had incorrectly downgraded the event at 1.25am as Mrs Bartolome had not clearly indicated that she had controlled the bleeding in the conversation immediately preceding it. Had the event not been downgraded, the Hoppers Crossing ambulance would not have been diverted from Mrs Bartolome and would have attended to her earlier.

28. Mr Richards spoke to the call-taker on 8 July 2015 and advised them the call was the subject of an adverse event. He informed the call-taker the call was being reviewed to ensure they had a good understanding of the Academy's requirements to ensure that a patient's bleeding was controlled prior to reconfiguring the event in ProQA. Mr Richards reported he was satisfied the call-taker understood the requirements. They have since told Mr Richards that they ensure they get clear answers to all questions and will not reconfigure an event unless satisfied that they have a clear picture of what is happening with the patient.

29. ESTA has undertaken active additional auditing of other events completed on Protocol 21 since this event. No issues have arisen, with all operators ensuring that bleeding is controlled prior to reconfiguring the event. Mr Richards reported he does not believe there to be any systemic issue associated with ESTA's handling of protocol 21 events.

Ambulance Victoria

30. Carmen Petrotta, Acting Communications Centre Manager, provided a statement on behalf of AV.

Background

31. Ms Petrotta reported AV staff work alongside ESTA staff in the communications centre. All cases are managed using CAD which collects all case information from call start through to case completion. The details contained in CAD are visible to both ESTA and AV staff.

32. ESTA staff are responsible for call-taking and dispatch and AV staff are responsible for the operational, logistical and human resources aspects of service delivery. ESTA defers to AV

for dispatch advice during periods where case demand outstrips supply of available ambulances. All 000 calls for ambulances are taken by ESTA call-takers who primarily assess the information using the MPDS. The system categorises and prioritises case response based on answers to an algorithmic questioning hierarchy by the person making the call. The case is then dispatched to ambulances by ESTA. Cases are allocated a priority[6] rating between zero and three, where zero has the highest priority. When demand outstrips supply, the highest prioritised cases will take priority for case dispatch and response. This may mean that an ambulance that is responding to a priority 2 or 3 case may be redirected from that case to respond to a priority 0 or 1 case if it is the closest, or only, available ambulance at the time of dispatch.

33. After a call is received and triaged by an ESTA call-taker, the case is forwarded to an ESTA dispatcher for dispatch. A function called Recommended Closest Unit (RCU) is undertaken by the dispatcher. The CAD assesses the seven closest ambulances within a 10 kilometre radius of the case location and recommends those units for dispatch to the case, ranking them in dispatch order from closest to furthest away from the case location. The dispatcher will then dispatch the closest available ambulance. When there are no nearby ambulances (within 10 kilometres), the dispatcher will either complete a "No Nearby Unit" workflow which involves referring the case via a CAD notification to the AV Duty Manager or Communications Support Paramedic who will attempt to provide a dispatch solution.

34. Ms Petrotta reported that in some instances it is necessary to hold low priority (priority 2 and 3) cases until resources become available to dispatch. The Duty Managers and Communications Support Paramedics determine which events can be held. When a case is held it is visible in CAD as pending and can be dispatched at any time by the ESTA dispatcher if an ambulance becomes available. However, a Duty Manager or Communications Support Paramedic can instruct ESTA to hold the case for a particular ambulance.

35. To manage logistical support of the emergency ambulance fleet, Duty Managers use 'dispatch warnings'. A dispatch warning has the effect of reducing the response availability of an ambulance. For example an ambulance may only be able to respond to certain priority cases and cannot respond to other priority cases. A consequence is that during particularly busy periods cases that are classified as code 2 and code 3 have increasing waiting times whilst the higher prioritised cases are attended to. Ms Petrotta reported that the system in place in June

[6] Case priority is also linked to the term "code". The term "code" describes how AV resources respond to a prioritised event. Code 1 = Priority 0 and 1 requiring an emergency vehicle (lights and sirens) response. Code 2 and 3= Priority 2 and 3 are normal driving conditions response.

2015 essentially meant that the code 1 and priority 0 dispatch warnings contributed to driving ambulance demand by reducing ambulance availability.

36. When there is no ambulance available to attend a case, the event is marked in the CAD chronology with "no nearby unit" by the dispatcher. This sends a notification via CAD which appears as a 'pop up' box on the computer screen of the AV Duty Manager/ Communications Support Paramedic. The Duty Manager/ Communications Support Paramedic will assess the situation and if no resource solution is available, will enter the term 'area of resource need' into CAD.

37. In some instances when this occurs it is necessary for the Duty Manager to hold lower priority code 2 and 3 cases until ambulances become available to dispatch. Duty Managers and Communications Support Paramedics determine which events can be held. Often these decisions are made in conjunction with an AV Clinician. The role of the clinician or Referral Service Call Taker when case delays occur is to contact and assess the patient, inform the patient of the delay and if necessary, reassess their medical condition for changes and case reprioritisation. When a case is held it is visible in CAD as 'pending' and can be dispatched at any time by the ESTA dispatcher if an ambulance becomes available. However this can change if the Duty Manager or Communications Support Paramedic has instructed ESTA to hold the case for a particular ambulance. Ms Petrotta reported that the risk that is inherent in case prioritisation and which requires management, is that the cases involving patients initially considered as having lower acuity at the point of first intake can deteriorate whilst waiting for an ambulance, therefore requiring more urgent attention.

Events of the evening of 7 June 2015 and the early hours of 8 June 2015

38. Ms Petrotta reported that upon reviewing AV data systems on the evening of 7 June 2015 and the early hours of 8 June 2015, there was a demand for ambulances that outstripped supply. Between 12.01am and 3.00am on 8 June 2015, 171 cases were presented to AV via 000. There were a significant number of vehicles on dispatch warnings, which restricted the availability of the ambulance fleet to respond to the incoming case load and there were between 20 and 40 ambulances at hospitals at any time over the time this case was pending with some delays of up to and over two hours.

39. Between 1.00am and 3.00am on 8 June 2015, there were between six and 15 code two and three cases pending dispatch at any given time, as they were waiting for ambulances to become available to respond. Code 0 and 1 cases were given priority. The Referral Service was also busy, managing 33 cases.

40. At 1.25am, the Hoppers Crossing ambulance dispatched to Mrs Bartolome was diverted to a higher priority code one case following the ESTA call-taker downgrading the case from a code 1 to a code 3. When the Hoppers Crossing ambulance was diverted, there were no ambulances able to attend Mrs Bartolome. At 1.27am the dispatcher used CAD to locate and recommend the closest available ambulance. CAD indicated that the closest eight ambulances were not available to attend non-urgent cases. As there were no ambulances available, the dispatcher followed their standard operating procedures and referred the case to the AV Duty Manager for a dispatch solution. There was no action noted or solution provided from the Duty Manager regarding a dispatch solution. At 1.37am, the dispatcher again referred the case to the AV Duty Manager for a dispatch solution. There was no action noted by the Duty Manager/Communications Support Paramedic to find a dispatch solution and the matter remained unresolved. At 1.49am, the dispatcher again referred to the Duty Manager for a dispatch solution. There was no action noted by the Duty Manager to find a dispatch solution and the matter still remained unresolved. At 2.04am, the dispatcher referred to the Duty Manager for the fourth time. Again, no action was noted by the Duty Manager to find a dispatch solution. At 3.02am the dispatcher used CAD to locate and recommend the closest available ambulance. On this occasion, Altona ambulance AL224 was available and dispatched.

AV review

41. Ms Petrotta reported that in the circumstances where a dispatcher refers a case to the AV Duty Manager, the standard practice for the Duty Manager would have been to review the status of ambulance resources at that time, including the location and availability of each ambulance (including the ambulances that are expected to be available shortly) and make a recommendation on which ambulance is to attend the case. The Duty Manager is required to enter a comment into CAD giving the dispatcher instructions on which ambulance to send. If it appears there are no such dispatch solutions available in the near geographic location, the Duty Manager may look further away for a suitable ambulance. When it becomes difficult to provide a dispatch solution, there are no suitable resources available for a case or there is concern an ambulance may not get to a case in the desired time frame, the Duty Manager is then expected to initiate Work Instruction "WIN/OPS/304 – Management of Response Delay."

42. The Duty Manager would insert a comment into the CAD remarks field and update the case so it can then be managed by the AV referral service, who would contact the patient and advise them of the response delays, assist the patient to make informed health decisions and to

perform a secondary triage of suitable patients to assist them to make a clinically informed health care decision. If on calling the patient the referral service finds that the patient's condition has deteriorated, or was more serious that the time of the initial call, the referral service operator can determine the case requires more urgent ambulance response and upgrade the case to a higher priority and send it back to ESTA dispatch for more urgent dispatch.

43. Ms Petrotta noted the contributing factors at the time of this case were:

    a. Lack of ambulance availability and dispatch restrictions due to dispatch warnings; and

    b. The lack of response from the Duty Manager to enact the welfare call back process after requests for assistance by the dispatcher.

44. Both the Duty Manager and the Communications Support Paramedic on duty at the time of the case were interviewed as part of AVs review into the circumstances of the event. Notwithstanding the role of a Duty Manager is to be responsible for the management of resource dispatching, the Duty Manager stated they were busy dealing with hospital delays, meal break management and management of an earlier incident. As a result, the cases listed on the Duty Manager/ Communications Support Paramedics pending box screen as requiring action were not attended to. The review also identified there had been a communication breakdown between the Duty Manager and Communications Support Paramedic rostered on together on that shift, with each of them understanding the other was managing the pending box.

45. As a result of the events in the early hours of 8 June 2015, AV have provided the Duty Manager involved with ongoing support and mentoring. They have also received further education in relation to the management of response delays and of AVs expectations of the Duty Manager role. The Duty Manager is extremely remorseful and deeply regrets the incident.

46. AV acknowledges an ambulance should have been dispatched to Mrs Bartolome much sooner than it was. AV also acknowledged there were four missed opportunities for AV to consider dispatching an ambulance to Mrs Bartolome earlier, namely at 1.27am, 1.37am, 1.49am and 2.04am on 8 June 2015. AV acknowledged there were four potential opportunities missed for the case to be referred to AV's referral service for further triage.

47. Ms Petrotta reported AV is in the process of updating the operational work instruction "*WIN/OPS/304 – management of response delay*", which will enable AVs referral service call-takers to carry out welfare call backs, for cases noted in pending box to be suitable

without having to wait for the Duty Manager prompt to be added. This will provide significant further risk mitigation for those cases which may not have had a prompt by the Duty Manager/ Communications Support Paramedic staff, as in Mrs Bartolome's case.

48. Ms Petrotta also reported that AV is now staggering a number of the AV fleet's shift start times and altering the duration of a number of shifts to combat the decreasing resource availability due to the application of dispatch warnings. This change in effect means dispatch warnings are placed on ambulance crews at different, staggered times of the day, rather than the entire fleet being restricted at the same time.

49. AV's preference is that the AV Duty Manager respond to requests for assistance from ESTA dispatchers. AV and ESTA have an agreed position that when a case is referred to a Duty Manager/Communications Support Paramedic and no solution is found, or there is no immediate solution and the case is placed on hold, ESTA are required to re-recommend that case when it comes off hold, within required benchmarked timelines. The situation that occurred for Mrs Bartolome on 8 June 2015, where a dispatcher referred the case multiple times and there was no immediate response solution is currently under review at various AV/ESTA joint committees. Ms Petrotta reported that in the very near future, an escalation process to assist both the dispatchers and the Duty Manager/Communications Support Paramedic will be in place. At the time of making her statement on 15 September 2015, Ms Petrotta reported that a proposed escalation is for the dispatcher to refer the matter to an ESTA team leader who will then verbally notify the Duty Manager was being finalised.

Inspector-General for Emergency Management

50. The Inspector-General for Emergency Management (IGEM) has the functions to monitor and investigate the non-financial performance of ESTA. On 17 November 2015, the IGEM, Mr Tony Pearce, advised the Court that he opted to monitor ESTA's internal investigation of its management of the ambulance event for Mrs Bartolome on 8 June 2015, rather than undertake an IGEM led investigation. Mr Pearce reported that ESTA notified his office of its involvement of the incident on 10 June 2015. When ESTA completes its investigation, the IGEM will review it to ensure that ESTA conducted a robust investigation and if necessary, identified opportunities for improvement. IGEM will then monitor ESTA's implementation of any actions arising from its recommendations.

FINDING

51. I find that Lorraine Bartolome died on 8 June 2015 from 1a) *exsanguination from ruptured varicose vein right lower leg.*

52. I find that if the original ambulance had attended to Mrs Bartolome, medical intervention would have occurred earlier. I further find an opportunity for intervention was missed at this time and on four more occasions on the morning of 8 June 2015. However, I am unable to determine whether the earlier intervention would have prevented her death.

53. I find that there were a number of missed opportunities by Ambulance Victoria and the Emergency Services Telecommunications Authority that in combination resulted in an unreasonable delay in Mrs Bartolome obtaining medical assistance. I accept the concessions made by Ambulance Victoria and the Emergency Services Telecommunications Authority in relation to the unfortunate series of events that occurred on the early morning of 8 June 2015.

54. I acknowledge that Ambulance Victoria has made changes to their operational work instructions, policies and operating model. I also acknowledge that the Emergency Services Telecommunications Authority and Ambulance Victoria are working together to develop and implement an escalation process to assist dispatchers, duty managers and communication support paramedics when faced with similar events.

55. I also acknowledge the pressure placed on the Emergency Services Telecommunications Authority and Ambulance Victoria when there are unusually busy periods and their resources cannot meet demands.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that the finding be published on the internet.

I direct that a copy of this finding be provided to the following:

The family of Mrs Bartolome;
Ambulance Victoria;
Emergency Services Telecommunications Authority;
Inspector-General for Emergency Management
Coroner's Investigator, Victoria Police; and
Interested Parties

Signature:

Jacqui Hawkins
Coroner
Date: 17 February 2016

Coroners Court of Victoria