IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 93

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: **STACEY LOUISE YEAN**

Delivered On:	23 March 2017
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Dates:	1 March 2017 – 2 March 2017
Findings of:	Coroner Phillip Byrne
Representation:	Mr Arushan Pillay, Counsel on behalf of the Yean Family Ms Shari Liby, Solicitor on behalf of the Yean Family Ms Naomi Hodgson, Counsel on behalf of Ambulance Victoria Ms Andrea De Souza, Solicitor on behalf of Ambulance Victoria
Police Coronial Support Unit	Leading Senior Constable Jo Allen

I, PHILLIP BYRNE, Coroner, having investigated the death of STACEY LOUISE YEAN
AND having held an inquest in relation to this death on 1 March 2017 and 2 March 2017
at Southbank
find that the identity of the deceased was STACEY LOUISE YEAN
born on 25 December 1992
and the death occurred on 6 January 2016
at 489 Ross Creek-Haddon Road, Haddon, Victoria 3351
from:

I (a) UNASCERTAINED

in the following circumstances:

BROAD BRUSH CIRCUMSTANCES

1. Ms Stacey Louise Yean, 23 years of age at the time of her death, resided at 489 Ross Creek-Haddon Road, Haddon with her father Mr James Yean, her brother Mr Matthew Yean and his friend Ms Stacey Rae. Her mother Mrs Adrienne Yean resided in Ballarat North.

2. Ms Yean had no significant past medical history other than asthma, although she had seen a general practitioner Dr Loba Haqui of the Eureka Medical Centre on 29 December 2015 due to what was diagnosed as a chest infection. Dr Haqui prescribed several medications, including antibiotics. I have no basis to conclude Ms Yean's condition deteriorated between 29 December 2015 and the morning of 5 January 2016. In fact, subsequent investigation established only one (1) prescribed Amoxicillin antibiotic capsule had been taken by Ms Yean.

3. However, late in the morning of 5 January 2016 Ms Yean became quite violently ill, experiencing stomach pain and vomiting profusely.

4. After Ms Yean's vomiting continued for approximately 2 hours Ms Stacey Rae made a call to the local hospital for advice on what options there were. She was transferred to the nurse on call. The nurse advised that if vomiting persisted Ms Yean's general practitioner should be contacted.

5. A call to the doctor's practice was made but the family were advised the general practitioner was not available. A locum service was suggested. A call to that service was made but the family were advised the locum service did not cover the Haddon area for home visits.

6. Subsequently, at 3:15p.m. as Ms Yean continued to experience vomiting, a 000 emergency call was made. The Emergency Services Telecommunication Authority (ESTA) call taker coded the call as a Code Three (non-life threatening) and referred the caller, Mrs Adrienne Yean, to RefCom for a secondary triage by an Ambulance Victoria Referral Service paramedic. The Referral Service paramedic, having been advised of Ms Yean's symptoms, concluded the criteria for the dispatch of a low acuity ambulance were not met and an ambulance would not be sent. The paramedic who undertook the secondary triage advised that if Ms Yean's condition did not improve, or worsened, 000 could be called again.

7. At 4:30p.m. as Ms Yean's condition had not improved and she continued vomiting the invitation to call back was accepted and a second call to the 000 number was made by Ms Stacey Rae. During this second call the symptoms described by Ms Rae included "abnormal breathing". This call resulted in a Code One dispatch of an ambulance (lights and sirens).

8. The ambulance arrived at the Haddon address at 4:47p.m. and ambulance paramedics, Ms Jessica Handley, an Advanced Life Support Ambulance Victoria (AV) clinical instructor, and Mr Billy Hodges, Advanced Life Support graduate paramedic, attended at Ms Yean's bedroom. Mr Hodges, with only about 2 weeks operational experience as a graduate paramedic, was under the supervision of clinical instructor Ms Handley.

9. Mr Hodges undertook a set of observations of Ms Yean's vital signs and at the request of Ms Handley auscultated Ms Yean's chest by stethoscope. He concluded Ms Yean's chest was clear and assessed her Glasgow Coma Scale Score at 15. At the conclusion of his assessment Mr Hodges concluded all Ms Yean's vital signs were within normal range.

10. Some ten (10) minutes later Mr Hodges undertook a second set of vital signs and again concluded they were within normal range. Shortly after the second set of observations of vital signs Ms Yean vomited in the presence of the paramedics.

11. Ms Handley advised those present that she thought Ms Yean may have a "gastric bug" and Ms Yean's presentation did not mandate transport to hospital.

12. Ms Handley maintains she told Ms Yean that if she wished they would transport her to hospital in Ballarat, but indicated as they have been at the hospital earlier and noted ambulances "ramped up", the likelihood would be that Ms Yean would experience quite a delay in the Emergency Department before being seen by a doctor. Ms Yean declined the offer of transportation to hospital and indicated she would prefer in those circumstances to remain at home.

13. Later in this finding I will address in some detail the adequacy/efficacy of the observations taken by Mr Hodges and the conclusions reached by the paramedics after their assessment of Ms Yean.

14. Further, later in this finding I will discuss at some length the bases upon which Ms Yean took the decision to stay at home rather than accept the offer of transportation to hospital for further assessment.

15. There is contention surrounding the issue of the non-provision of anti-emetic medication which I will return to later in the findings.

16. After the AV paramedics departed it would appear Ms Yean remained in her room. Mrs Adrienne Yean and Ms Stacey Rae continued to monitor Ms Yean and state she continued to vomit although it abated to some extent. Mr James Yean returned to the family home at approximately 6:00p.m. and Mrs Adrienne Yean left the premises at approximately 7:00p.m.

17. At about 11:00p.m. Mr James Yean states his daughter joined him on the couch watching television for some 20 minutes before returning to her bedroom. Mr Yean relates how he checked his daughter at approximately 1:00a.m. on 6 January 2016 and concluding she was asleep did not disturb her.

18. At about 11:00a.m. on the morning of 6 January 2016, Mrs Yean returned to the Haddon address and on checking her daughter found her on the bed apparently deceased. A call to the 000 emergency number resulted in the attendance of Victoria Police officers and AV paramedics, one of whom formally pronounced Ms Yean deceased.

REPORT TO THE CORONER

19. The matter was reported to the coroner as an "unexpected death". Having considered the circumstances, having conferred with a forensic pathologist, and being advised the family raised no objection to autopsy, I directed a full autopsy and ancillary tests.

20. An autopsy and ancillary tests, which can only be described as exhaustive, were undertaken at the Victorian Institute of Forensic Medicine (VIFM) by Forensic Pathology Fellow Dr Victoria Francis. Subsequently, Dr Francis provided a comprehensive 14-page Autopsy Report, together with a number of reports in relation to the ancillary tests performed including toxicology, biochemistry and microbiology.

21. In her Autopsy Report Dr Francis makes a comment on various potential causes of death, including asthma related, *clostridium sordellii* isolated in blood culture, and sudden onset of cardiac arrhythmia. However, in the final analysis Dr Francis was unable to determine the cause of death and advised it remained "unascertained".

22. From my coronial perspective, not being able to determine the cause of death presents problems; not only does it mean I am unable to make the second core finding required by section 67(1)(b) of the *Coroners Act 2008* (the Act), but it can also complicate/compromise the ability to make a reasoned finding as to the circumstances in which the death occurred. In any event, I will grapple with the dilemma later in this finding.

RELEVANT LAW/ROLE OF THE CORONER

23. Before turning to the issues in contention I think it important to refer to aspects of the law which explain my function and dictate the approach I am required to take.

24. In Keown v Khan Justice Callaway, adopting a statement contained in the Brodrick Committee (UK) Report, said:

    "In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest required, without deducing from those facts any determination or blame." [1]

25. Again quoting the Brodrick Committee Report, His Honour noted:

    "In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceeding which affords to others the opportunity to judge an issue and one which appears to judge the issue itself." [2]

26. So while not laying or appropriating blame a Coroner should endeavour to establish the CAUSE or CAUSES, of a death; the distinction is fine but real. As Callaway J.A. described it in Keown v Khan:

    "In determining whether an act or omission is a cause or merely one of the background circumstances, that is to say a non-causal condition, it will sometimes be necessary to consider whether the act departed from a norm or standard or the omission was in breach of a recognised duty, but that is the only sense in which para. (e) mandates an inquiry into

---

[1] (1999) 1 VR 69, 75.

[2] (1999) 1 VR 69, 75-76.

culpability, Adopting the principal recommendation of Norris Report, Parliament expressly prohibited any statement that a person is or 'may be guilty of an offence. The reasons for that prohibition apply; with even greater force, to a finding of moral responsibility or some other form of blame".[3]

27. Seeking to articulate the dichotomy between laying or apportioning blame, fault, culpability on one hand, and finding cause or contribution on the other is difficult. In Coroners Court v Susan Newton and Fairfax New Zealand[4], the following statement appears:

    "It is no part of the coroner's function to apportion blame for the death. The coroner must however be able to go beyond the mere cause of death if the coroners is to serve a useful social function, and must establish so far as is possible, the circumstances of the death. The implicit attribution of blame may be unavoidable in order for the coroner to ascertain or explain how the death occurred in the wider events that were the real cause." (my emphasis)

28. Lord Lane CJ held in R v South London Coroner; ex-parte Thompson[5]:

    "It should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning blame".

29. Hardie Boys J in Louw v McLean[6] stated:

    "In order to ascertain or explain how death occurred, in the wider sense of the events that were the real cause, the implicit attribution of blame is unavoidable". (my emphasis)

CAUSATION

30. Causation is a fundamental issue. In E and MH March v Stramare[7] Chief Justice Mason observed:

    "What was the cause of a particular occurrence is a question of fact which must be determined by applying common sense to the facts of each particular case."[8]

31. In Chief Commissioner of Police v Hallenstein[9] Justice Hedigan stated that the fundamentals of causation in the context of negligence are applicable to consideration of causation in the context of coronial matters. In my view, for an act or omission to be a causal factor in a death

---

[3] (1999) 1 VR 69, 76.

[4] [2006] NZAR 312.

[5] [1982] 126 SJ 625.

[6] (1998) High Court of NZ (unreported 12 January 1988).

[7] (1991) 171 CLR 506.

[8] (1991) 171 CLR 506, 17.

the connection must be logical, proximate and understandable, not strained, artificial or illogical.

STANDARD OF PROOF

32. The classic judicial statement concerning the standard of proof in civil cases including coronial matters is Briginshaw vs Briginshaw[10] where Dixon J said:

> "...*reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proof, indefinite testimony, or indirect inferences.*"

33. The applicable standard of proof in coronial matters where the performance of someone acting in a professional capacity is under scrutiny has been the subject of judicial consideration. To make an adverse finding against an entity in that capacity a "comfortable degree of satisfaction" must be reached.[11]

THE COURSE OF THE INVESTIGATION

34. In a poignant statement, Mr James Yean said:

> *"I am sure that if she was taken to hospital on the 5th of January 2016, my daughter Stacey would still be alive."*[12]

35. In a letter to the Court dated 11 May 2016 Mrs Adrienne Yean wrote:

> *"If the right call had been made Stacey would still be with us today or at the very least she would have passed in a hospital setting with people who could have tried to save her life, not alone in her room."*[13]

36. The fundamental thrust of the family's position is that claimed deficiencies in the management of Ms Yean on the afternoon of 5 January 2016 were causal factors in her death.

---

[9] [1996] 2 VR 1.

[10] [1938] HCA 34.

[11] Anderson v Blashki (1993) 2 VR 89; Health and Community Services v Gurvich (1995) 2 VR 69.

[12] Coronial Brief of Evidence, statement of James Yean, undated, 38 (Exhibit M).

[13] Coronial Brief of Evidence, correspondence of Adrienne Yean, dated 11 May 2016, 45 (Exhibit D).

37. In early April 2016 having received Dr Francis' Autopsy Report my registrar provided copies of the letters of concern lodged by the family to AV requesting formal statements in relation to assessment and treatment of Ms Yean by the ambulance paramedics who attended the Haddon address on the afternoon of 5 January 2016.

38. Subsequently statements were received from paramedics Ms Jessica Handley and Mr Billy Hodges, Professor Stephen Bernard, Senior Medical Advisor to AV, and Ms Angela Hodgkinson, AV Referral Service Manager. I directed this material be provided to Mrs Adrienne Yean who was from time to time in contact with my then registrar Ms Laura Royce. It would appear that although Professor Bernard's statement (and attachments) and Ms Hodgkinson's statement was provided to the family, the statements of Ms Handley and Mr Hodges were not.

39. Mrs Yean in a letter dated 26 September 2016 expressed "extreme concerns" that these latter statements had not been provided. I do not know why these statements, which were critical to my investigation, were not provided in a timely manner. The claim in Mrs Yean's letter that the statements were "withheld" is ill-founded. I had those statements and my investigation was ongoing.

40. Having provided the family with the material supplied to the Court by AV, Mrs Yean responded with a wide ranging, strong critique. That critique was provided to AV with an invitation to respond. This exchange of materials lodged by the two interested parties, with an invitation to respond was to ensure procedural fairness.

41. Having reviewed the body of evidence I had at that time I concluded the matter would need to proceed to inquest primarily for the purposes of hearing viva voce evidence from the "major players" to seek to determine the issues in contention. Consequently I settled a list of witnesses and the matter was listed for inquest.

THE INQUEST HEARING

42. An inquest was conducted over two days, 1 March 2017 and 2 March 2017. At the hearing parties were legally represented, respectively the family of Ms Yean by Mr Arushan Pillay of counsel, and AV by Ms Naomi Hodgson of counsel.

43. Over the two days I received oral evidence from Mrs Adrienne Yean, Ms Stacey Rae, Mr Matthew Yean, Mr James Yean, Ms Jessica Handley, Mr Billy Hodges, Ms Angela Hodgkinson, Mr Colin Grant and Professor Stephen Bernard. At the inquest hearing both parties were

afforded the opportunity to examine each witness called. At the conclusion of evidence I received oral submissions from Mr Pillay and Ms Hodgson and adjourned the matter for the preparation of a formal finding.

44. In broad terms my primary foci at the hearing were:

    a. The appropriateness of the response by AV to the 3:15p.m. 000 call which was referred to the AV Referral Service paramedic for a secondary triage;
    b. The appropriateness of the management of Ms Yean by paramedics Ms Handley and Mr Hodges at the attendance upon Ms Yean at Haddon following the 4:30p.m. 000 call, in effect whether they complied with the appropriate clinical guidelines in relation to transportation of a patient to hospital for medical assessment;
    c. Whether at an "Open Disclosure" meeting between family members and Mr Colin Grant, AV Manager Professional Standards, a concession/admission was made by Mr Grant that:
        i. An ambulance should have been dispatched following the 3:15p.m. 000 call; and
        ii. Having regard to Ms Yean's presentation the attending ambulance paramedics should have conveyed Ms Yean to hospital.

45. I will turn to consider those matters in chronological order.

THE 3:15P.M. 000 CALL

46. The 3:15p.m. call (the first call) was identified by ESTA as "low acuity", the caller Mrs Yean, was, following an established protocol, transferred to a RefCom paramedic for triaging. From the outset, one of the family's main complaints was that an ambulance should have been dispatched following that initial 000 call.

47. In light of that complaint I asked AV to provide a statement addressing that concern. I also obtained an audio recording of the dialogue between Mrs Yean and the AV Referral Service paramedic who conducted the secondary triage. That audio was subsequently tendered in evidence at the inquest (Exhibit L).

48. AV Referral Service Manager Ms Angela Hodgkinson provided a formal statement explaining the history behind the secondary triage system. Rather than me seeking to encapsulate the procedure followed in the secondary triage lest something be lost in the translation, I include in this finding the relevant paragraphs in Ms Hodgkinson's statement:

"8. In performing secondary triage, RefCom paramedics/registered nurses are required to use their clinical judgement, together with a prescribed procedure and systematic caller questioning from a specific guideline that relates to the patient's presenting symptoms, to ascertain and accurately assess a patient's condition. The procedure involves applying a triage tool and following a set of clinical guidelines.

9. All secondary triage is conducted in a structured way and in accordance with the Care Enhance Call Centre (CeCC) triage tool. The CeCC requires a patient's presenting symptoms to be obtained before progressing to a telephone triage clinical assessment, which determines the patient's need and how acute the need is.

10. The primary role of RefCom paramedics is to conduct a secondary triage on "Code Three" cases. Ordinarily a Code Three event is created by ESTA and it is picked up by RefCom in one of two ways; either by a direct transfer of the patient to RefCom telephone, or through the computer aided dispatching system, where the case is marked as "pending" and awaiting a call back within 15 minutes of the call being made to ESTA.

11. The RefCom operator will then triage the patient and determine how to achieve the best outcome for the patient. At the conclusion of the triage, there is a decision made as to whether to send an ambulance or refer the patient to an Alternative Service Provider (ASP), or provide home self-care advice, such as advising the patient to self-present to a doctor or other alternative. The RefCom operator must send an ambulance if the triage CeCC disposition requires such. All triaged calls are completed with advice to the caller to call 000 back if the patient deteriorates, together with self-care advice on what to do for their condition or what to be aware of occurring to the patient.

12. When performing their role, RefCom staff will have in front of them at all times the computer aided CeCC triage tool and a Computer Aided Dispatch (CAD) screen. The CAD screen indicates the number of Code Two and Three cases pending, which provides a good indicator of how busy a shift is. That said, RefCom is not responsible for managing ambulance demand. RefCom is responsible for applying the triage process to reach a disposition (or health outcome) then activating that outcome."[14]

---

[14] Coronial Brief of Evidence, statement of Angela Hodgkinson dated 20 May 2016, 62-63 (Exhibit S).

49. In her statement Ms Hodgkinson also referred to an internal AV review of the adequacy of the secondary triage in this case. That review concluded the RefCom triage "fell short of the required standard" in that several questions that the relevant guideline required be put to the caller were omitted to be put. Ms Hodgkinson advised that following the deficiencies identified at the internal review additional training was provided to all RefCom triage staff.

50. From my coronial perspective, I have considered whether had the additional questions been canvassed with the caller would the decision not to dispatch an ambulance have been different. I have concluded it would not have altered the decision.

51. In any event, I do not think much turns on this question, primarily because an hour and a quarter later, when the 4:30p.m. call was received and an additional element, "abnormal breathing" was conveyed to the 000 call taker, the ambulance manned by paramedics Ms Handley and Mr Hodges was dispatched on a Code One basis and arrived at the Haddon address a short time later. The point is Ms Yean's condition did not deteriorate or alter significantly during that hour plus period. I maintain little turns on this issue of the non-dispatch of an ambulance following the 3:15p.m. secondary triage because if for no other reason adopting the Callaway dichotomy in Keown v Khan[15] what occurred would have to be viewed as a background circumstance, not a causal or contributing factor in Ms Yean's death.

THE ASSESSMENT OF MS YEAN BY THE ATTENDING PARAMEDICS AND THE DECISION NOT TO TRANSPORT

52. I turn to what I see as the primary issue of contention – the efficacy of the assessment of Ms Yean by paramedics Ms Handley and Mr Hodges, and whether in light of the patient's medical condition, transportation to hospital was mandated.

53. In considering AV performance I make two other points:

    a. I have to form a view as to their management without the not inconsiderable benefit of retrospection/hindsight; and
    b. I have to consider not whether AV management of Ms Yean was optimal, but whether it was reasonable in the circumstances.

54. Having arrived at the Haddon address paramedics Ms Handley and Mr Hodges attended upon Ms Yean in her bedroom. Present were the two paramedics, Ms Yean, Mrs Adrienne Yean and Ms

---

[15] (1999) 1 VR 69.

Stacey Rae. Mr Hodges took a history from Ms Yean while Ms Handley obtained personal and past medical details from Mrs Yean.

55. Mr Hodges checked Ms Yean's vital signs at 4:52p.m. His findings are detailed in paragraph 15 of his formal statement (Exhibit R). In short, Mr Hodges concluded all Ms Yean's vital signs were within normal range. At Ms Handley's request Mr Hodges also auscultated Ms Yean's chest and concluded her chest sounds were clear on both sides with equal air entry to the bases. He further concluded her Glasgow Coma Scale was 15.

56. After some discussion occurred between Mrs Yean and Ms Handley, 10 minutes later Mr Hodges completed a second set of vital sign observations. Again he assessed Ms Yean's vital signs as within normal range.

57. There is a dispute as to aspects of Ms Yean's presentation. Ms Yean's family maintain Ms Yean was sweating profusely during the period the paramedics were in attendance. It is also claimed she advised the paramedics she was consistently thirsty, but could not keep fluids down. There were other issues of contention, such as what clothing Ms Yean was wearing, and how she was positioned on the bed, as these latter issues, which at best are at the periphery, I do not pursue them further in this finding.

58. I have carefully examined the evidence as to whether the attending paramedics "refused" to take Ms Yean to hospital as was claimed in material lodged by the family[16]. I note that in the initial letter of concerns from Mrs Adrienne Yean dated 1 February 2016 it is conceded the paramedics stated:

> *"We could take you to the hospital if you would like but you would be sitting with a bucket in causality [sic] for 5-6 hours because the hospital is very busy today and we don't want to do that to you."*[17]

59. As to the issue both Ms Handley and Mr Hodges maintain an offer to convey Ms Yean to hospital was made. In her statement Ms Handley wrote:

> *"I told Stacey we were more than happy to take her up to hospital, but added that given she was compensating so well, and by that I mean she had good blood pressure, normal heart rate; she was fully alert, her temperature was normal and all her vital signs were within normal limits, I told her there may be a "bit of a wait" at the*

[16] Coronial Brief of Evidence, letter of concerns, dated 8 May 2016, 39-41 (Exhibit C).

[17] Coronial Brief of Evidence, letter of concern from Mrs Adrienne Yean, dated 1 February 2016, 29-31 (Exhibit B).

hospital before she was seen in ED. I did not specify how long the wait might be. I was also aware the hospital was very busy at the time, given we had been there earlier and I was aware of other ambulances ramped at the hospital. I then said to Stacey, "Having said that, we are more than happy to run you up (to the hospital)."[18]

60. In viva voce evidence Mrs Yean conceded that Ms Handley had in fact said she would take Ms Yean to hospital if she liked, but added that she might wait in the Emergency Department for 5-6 hours with a bucket between her legs.

61. There is a dispute as to whether Ms Handley nominated a specific period of delay at the Emergency Department Ms Yean was likely to wait before being seen. Ms Handley maintains she did not specify a period. The family maintain she suggested the wait would likely be "5-6 hours".

62. I asked Mr James Yean, Ms Yean's father, whether any consideration had been given to a family member transporting Ms Yean to hospital if in fact there was further concern about her condition. Mr Yean stated he offered "*more than three times*"[19] to transport Ms Yean to hospital but she "*refused*"[20] on the basis the paramedics told her she would be sitting in the waiting room for 5-6 hours with a bucket.

63. The contention surrounding the likely delay in being seen in the Emergency Department is only relevant in this matter because the family maintain that the reason Ms Yean did not accept the offer to transport her to hospital was due to the paramedics advising there would be an inordinate delay.

64. On behalf of the family Mr Pillay submitted that the discussion regarding the probable delay in being seen by a doctor should Ms Yean be transported to hospital, whether it be 5-6 hours, or a "significant wait", was the reason Ms Yean did not accept the offer of transportation. While the prospect of a significant wait in the Emergency Department was no doubt one of the factors, perhaps even the main reason Ms Yean declined the offer of transportation, that cannot reasonably be seen as a causal or contributing factors in her subsequent death; it was merely stating a likely fact.

---

[18] Coronial Brief of Evidence, statement of Jessica Handley, dated 17 May 2016, 51, 25 (Exhibit P).

[19] Transcript of Proceedings, Inquest into the death of Stacey Yean, Coroners Court of Victoria, COR 2016 93, Coroner Phillip Byrne, 1-2 March 2017, 50, 24.

[20] Transcript of Proceedings, Inquest into the death of Stacey Yean, Coroners Court of Victoria, COR 2016 93, Coroner Phillip Byrne, 1-2 March 2017, 50, 31.

65. I find the interpretation put on the issue of transportation by both parties, AV and the family, interesting. Ms Handley states Ms Yean "refused" the offer of transportation. I would have thought a more appropriate interpretation would be "declined" rather than "refused". The family maintain Ms Yean was "talked out" of going to hospital; both interpretations are, in my view, strained.

66. I do not consider it unreasonable for a paramedic to advise a patient there may well be a significant delay in being seen at an Emergency Department, particularly if that paramedic has observed ambulances "ramped" earlier in the day. The decision taken, while no doubt influenced by the prospect of a significant delay, ultimately was taken by Ms Yean, I do not accept she was refused transport to hospital.

67. The bottom line is, the offer of transportation was made, but declined. Of course no one could have predicted the tragic event which unfolded sometime overnight, at a time I am unable to determine.

68. Another matter of dispute relates to the non-provision of anti-emetic medication. The family claim that Ms Handley told them that they normally carry anti-nausea medication but they did not have any with them that day. The paramedics maintain that what they conveyed was that as they were not transporting Ms Yean to hospital they were precluded from providing the medication.

69. Due to either a misunderstanding and/or miscommunication Mrs Yean and Ms Rae believe they were told the paramedics did not have anti-emetic medication available. I do not accept that was the message meant to be conveyed. While the protocols upon which the paramedics were precluded from administering anti-emetic medication (at the time by way of injection) were in all likelihood not conveyed to the family, Ms Handley, appropriately following clinical guidelines, advised it would not be provided.

70. There are a number of issues which are at the periphery, background circumstances, not causal or contributing factors in Ms Yean's death, which are in dispute. I have found seeking to reach a comfortable degree of satisfaction as to which version to accept virtually impossible. There was nothing in the manner of witnesses to these issues that would enable me to reject their evidence as mistaken, false, or unreliable. Often these types of disputes are founded upon confusion, misunderstanding, and/or miscommunication; that may well be the case here.

71. My view that these remaining areas of contention are not determinative is supported by the position taken by Ms Hodgson, both in her examination of Professor Bernard and in her final

submission. In what, on the face may have been seen as a rather bold approach, Ms Hodgson invited Professor Bernard to accept, for the purpose of the question, that the family's claims as to Ms Yean's presentation to the paramedics, sweating profusely, wet hair, the prospect of a level of dehydration were true, would those conditions, as well as those observed by Mr Hodges and his colleague, have mandated, under AV clinical guidelines, Ms Yean's transportation to hospital for further assessment by a medical practitioner.

72. Ms Hodgson took Professor Bernard to what she referred to as "clinical flags". Professor Bernard identified the material contained in pages 187-191 of the Coronial Brief of Evidence as the relevant guidelines in place as at 5 January 2016. Alterations to the guideline became operative after 5 January 2016 and are therefore not relevant to the issues I am required to determine.

73. As I understood Professor Bernard, he opined that even if those additional symptoms did exist at the time of the paramedic assessment it would not require/mandate Ms Yean to be transported to hospital. Because of its significance I include an excerpt from the transcript. Ms Hodgson posed the following question to Professor Bernard:

> *"If I can ask you to go back now to what I've asked you a moment ago to accept as truth, two things. One, as the family says she was sweating profusely at the time the paramedic saw her, and two, that she was saying words to the effect of I'm so thirsty, repeatedly, and, I need a drink. In those circumstances, and perhaps to be fair, to put it in its whole scale, and that she wasn't able to keep any fluids down with that, do you then, if you accept those things to be true, stand by your conclusion in paragraph 33 that her presentation would not have identified her as a patient at risk if not transported?"*[21]

74. Professor Bernard replied:

> *"Correct. Even under these revised guidelines ah we would not consider her to be at risk."*[22]

75. In response to a number of questions put to him by Mr Pillay, Professor Bernard held his ground on this issue responding that the most significant factor at play was that Ms Yean's vital signs were within normal range.

---

[21] Transcript of Proceedings, Inquest into the Death of Stacey Yean, Coroners Court of Victoria, COR 2016 93, Coroner Phillip Byrne, 1-2 March 2017, 183-184 30-3; 1-2.

[22] Transcript of Proceedings, Inquest into the Death of Stacey Yean, Coroners Court of Victoria, COR 2016 93, Coroner Phillip Byrne, 1-2 March 2017,184, 3-4.

76. Professor Bernard also confirmed that it would not have been appropriate under the clinical guidelines operative as of 5 January 2016 to provide anti-emetic medication in the absence of transportation to hospital.

77. Mr Pillay questioned Professor Bernard in relation to what relevance should be placed on observations by family members of symptoms claimed to be displayed by a patient. Mr Pillay asked:

> *"Is it simply that you do the vital signs assessment and disregard what the family's saying?"*[23]

78. Professor Bernard responded:

> *"---Well, if you arrive, interview the patient, do a – your examination and at that time there's no evidence that the patient is struggling to breathe, then you would take that as being the case um, it's – I think whatever was said on the phone, I think would be made more clear by actually taking a history, doing a physical examination and it's not uncommon – I can say it's actually quite common for people, when asked on the phone "Is the breathing normal" to say "no" and subsequently, paramedics arrive and realise that that's not the case. Observations are normal, their oxygen levels are normal, so that then doesn't become a priority symptom."*[24]

79. Not surprisingly, Professor Bernard did however concede it would be important to listen to a patient.

80. Bearing in mind that the paramedics are the professionals, I suggest that in the final analysis their assessment of the patient, following clinical guidelines, is the appropriate basis upon which a decision is taken to transport, or not.

81. Having carefully reviewed the evidence, particularly that of Professor Bernard, I have concluded that Ms Handley and Mr Hodges' assessment of Ms Yean's condition was in accordance with AV's clinical practice guidelines, their performance did not depart from a norm or standard, nor did it fall short of a recognised duty. Consequently, in my considered view, I conclude the

---

[23] Transcript of Proceedings, Inquest into the Death of Stacey Yean, Coroners Court of Victoria, COR 2016 93, Coroner Phillip Byrne, 1-2 March 2017, 187, 24-25.

[24] Transcript of Proceedings, Inquest into the Death of Stacey Yean, Coroners Court of Victoria, COR 2016 93, Coroner Phillip Byrne, 1-2 March 2017, 187-188, 25-31; 1-6.

weight of the evidence does not warrant the making of an adverse finding, or indeed comment, against the paramedics or AV.

82. In any event, there were two further bases upon which I believe adverse findings against Ms Handley and Mr Hodges would not be sustainable:

    a. As the cause of death remains "unascertained" despite exhaustive autopsy and ancillary tests, one could not reasonably establish a causal link or nexus between the cause of Ms Yean's death and the malaise she was experiencing causing her vomiting; and
    b. It is possible perhaps even probable, that Ms Yean, even if transported to hospital, would have been discharged home, probably after the provision of anti-emetic medication, rather than be admitted.

THE CLAIM THAT MR COLIN GRANT ACKNOWLEDGED FAULT ON BEHALF OF AMBULANCE VICTORIA

83. I turn to the third of the principal issues that was the focus of my investigation. Mrs Yean, in material lodged, claimed that in various contacts with Mr Colin Grant, Manager of Professional Standards Ambulance Victoria, he, in effect, admitted that AV's performance on 5 January 2016 was deficient in several respects. It was claimed Mr Grant was not only "very apologetic", but admitted:
    a. An ambulance should have been dispatched following the 3:15p.m. secondary triage referral; and
    b. The paramedics who attended upon Ms Yean should have transported her to hospital.

84. I am aware from previous matters, and it was confirmed during this investigation, that AV have what they term an Open Disclosure process where, in matters where issues of concern are raised by a family, senior AV managers offer to meet with families to discuss issues of concern. There is no obligation on a family to engage in this process, it is merely an offer to meet. The Open Disclosure process is apparently coordinated by the Manager of Professional Standards.

85. In this case, on 12 January 2016 and again on 12 February 2015 Mr Grant made telephonic contact with Mrs Yean explaining the process and offering to meet to discuss the issues of concern. Mr Grant apparently advised Mrs Yean at the initial contact that the internal review had not been completed and it is clear that at that time the cause of death was not known.

86. Mrs Yean, in correspondence with the Court, alleged Mr Grant, at the second contact, in effect admitted liability, conceding an ambulance should have been dispatched in response to the 3:15p.m. call and when an ambulance did attend it should have conveyed Ms Yean to hospital.

87. In response to my invitation to AV to respond to Mrs Yean's allegation, the Acting Manager of Professional Standards Mr Huw Colechin, in a letter to the Court dated 20 May 2016, denied Mr Grant made any such concession.

88. More importantly, In oral evidence at the formal inquest hearing, Mr Grant denied he made any such concession explaining that not only is it not his role to make such concessions, but in any event he stated that the internal review, in which he played no part, had not been finalised so that he was not in a position to make such a concession.

89. The Act contains an interesting provision in relation to this issue. Section 70(1) and (2) of the Act provide that an apology means an expression of sorrow, regret and sympathy but does not necessarily include an admission or an acknowledgement of fault. Over the years I have quite often observed a mere apology or expression of sympathy construed as an acknowledgement of fault/culpability when clearly it is not.

90. I do not accept the contention that Mr Grant, on behalf of AV, admitted a deficiency in performance by AV staff. I believe any belief to the contrary is likely founded upon a misunderstanding, miscommunication, misinterpretation or a combination of all three, of what Mr Grant sought to convey.

COMMENT

91. I had made a request to AV to take statements from the attending paramedics to give them the opportunity to put their version of events, and address the specific concerns raised by the family. In his examination of Mr Grant, Mr Pillay canvassed the circumstances of Ms Handley and Mr Hodges making formal statements in May 2016.

92. Mr Pillay's examination demonstrated that there were a significant number of paragraphs in the statements of Ms Handley and Mr Hodges which were not only similar, which is not particularly surprising, but were word for word identical. Having indicated this concerned me I invited Mr Grant to elaborate on what process was undertaken by him and his colleague in the taking of statements from Ms Handley and Mr Hodges. I must say the methodology adopted did not inspire confidence in the veracity of what was contained in these statements.

93. However, I do <u>not</u> consider the circumstances of the preparation of these statements necessarily fatal to AV's version of events. More importantly, in considering what weight to attach to their evidence, I had the benefit of hearing and observing Ms Handley and Mr Hodges during viva voce evidence when counsel for both the family and AV had the opportunity to examine them as to what was done and said at Ms Yean's residence on the afternoon of 5 January 2016.

94. I trust that in future Mr Grant will adopt a different procedure for taking statements from attending paramedics whose professional performance is the subject of criticism.

CONCLUSION

95. In the final analysis, I conclude the weight of evidence, particularly that of Professor Bernard whose expert opinion was not countered by competing expert opinion, does not support adverse findings against Ms Handley, Mr Hodges or indeed Ambulance Victoria.

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

Mrs Adrienne Yean and Mr James Yean, Senior Next of Kin;
Ms Shari Liby, Maurice Blackburn;
Ms Andrea De Souza, Minter Ellison; and
Leading Senior Constable Jo Allen, Counsel Assisting;

Signature:

PHILLIP BYRNE
CORONER
Date: 23 March 2017