IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 001193

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	AUDREY JAMIESON, CORONER
Deceased:	Jonathan Alan Uphill
Date of birth:	4 October 1937
Date of death:	3 March 2022
Cause of death:	1(a) ISCHAEMIC HEART DISEASE 1(b) CORONARY ARTERY ATHEROSCLEROSIS 2 TYPE 2 DIABETES MELLITUS, RECENT DENTAL CLEARANCE, HYPERTENSION
Place of death:	81 Franklin Road, Mount Duneed, Victoria, 3217
Keywords:	Ambulance Victoria, ambulance shortage, hospital ramping, delays

INTRODUCTION

1. On 3 March 2022, Jonathan Alan Uphill (**Jonathan**) was 84 years old when he died in his Mount Duneed home. Jonathan is survived by his wife, Ms Vicki Bradford (**Ms Bradford**).

Medical History

2. Jonathan had an extensive medical history including of Type 2 Diabetes Mellitus, gastroesophageal reflux, gastro-oesophageal reflux disease, hypertension, salivary squamous cell carcinoma with radical neck dissection and chemotherapy and in 2021, a subdural haemorrhage requiring a craniotomy.

3. Upon the referral of his general medical practitioner (**GP**), Jonathan attended upon Mr Martin Ching (**Mr Ching**), an oral and maxillofacial surgeon. Jonathan had severe neglect of his dentition, including severely decayed teeth with a poor prognosis and high likelihood of significant infections and pain. On 11 February 2022, in a consultation between Mr Ching and Jonathan, they decided to perform a total dental clearance – the removal of all Jonathan's 15 remaining teeth.

4. On 1 March 2022, at 8:30am, Jonathan attended the surgical centre and had a consultation with Mr Ching. Mr Ching discussed the procedure including its potential complications and provided information regarding after-hours emergency care. Jonathan was also consulted by the anaesthetist. The procedure time was 25 minutes, with no immediate complications and approximately 60 millilitres of blood loss. At around 11:00am, Jonathan was discharged home.

THE CORONIAL INVESTIGATION

5. Jonathan's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Jonathan's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Jonathan Alan Uphill. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

10. On 2 March 2022, the day following the dental clearance, Jonathan appeared *'stable'*, was eating food and able to speak.

11. At approximately 11:00pm, Ms Bradford was awoken by Jonathan, who had vomited *'green muck'*. He felt cold and clammy, complained of a fever and severe back pain.

12. On 3 March 2022, at 12:10am, Ms Bradford telephoned emergency services and described Jonathan's symptoms. The call taker told Ms Bradford there was not an ambulance on the way but instructed her to reassure Jonathan and make him comfortable until one was dispatched.

13. At 12:30am, an Ambulance Victoria Triage Practitioner contacted Ms Bradford and obtained further information regarding Jonathan's symptoms, which were largely unchanged. The Triage Practitioner asked whether Ms Bradford could take Jonathan to an Emergency Department herself, however, she stated this was not possible.

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

14. At 1:04am, Ms Bradford re-contacted emergency services and stated that Jonathan was now unconscious. Ms Bradford stated Jonathan's breathing deteriorated and that he was not breathing normally and was instructed to commence cardiopulmonary resuscitation (**CPR**).

15. At 1:20am, a Mobile Intensive Care Ambulance (**MICA**) arrived and found Jonathan was in cardiac arrest. An electrocardiogram (**ECG**) was performed and did not show any electrical output from the heart and at 1:30am, paramedics declared Jonathan deceased.

Identity of the deceased

16. On 3 March 2022, Jonathan Alan Uphill, born 4 October 1937, was visually identified by his spouse, Ms Vicki Bradford, who completed a Statement of Identification.

17. Identity is not in dispute and requires no further investigation.

Medical cause of death

18. Forensic Pathologist Dr Joanne Ho (**Dr Ho**) from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on the body of Jonathan Uphill on 7 March 2022. Dr Ho considered the Victoria Police Report of Death for the Coroner (**Form 83**), post-mortem computed tomography (**CT**) scan, medical records and provided a written report of her findings dated 20 June 2022.

19. The post-mortem examination revealed significant cardiac disease, comprising severe atherosclerosis of the left anterior descending coronary artery, age related valvular disease and subepicardial fibrosis of the posterior left ventricle. Also identified was significant pulmonary disease with pulmonary infarctions, pleural plaques and patchy pneumonia.

20. The examination also identified ischaemic heart disease, categorised by damage to the heart due to an insufficient supply of oxygen, caused by critical stenosis of one of the coronary arteries, in this instance, the left anterior descending artery. Stenosis is defined as a narrowing, of greater than 75%, of the vessel lumen and is associated with sudden cardiac death. On examination, the heart did not demonstrate histological signs of acute infarction, however, the earliest histological changes of myocardial infarction can be only seen after 12 to 24 hours of survival.

21. The post-mortem CT scan demonstrated a chronic right subdural membrane.

22. When examining the mouth, Dr Ho made note of the full dental clearance that had been performed within days of the death. There was mild erythema – redness of the tissue – mild ooze and a clot within the socket on the lower left side. There were no features of wound dehiscence or infection. Though, Dr Ho did comment that a full dental clearance can be a significant stressor, especially in individuals with underlying cardiac disease.

23. Dr Ho consulted with Dr Lyndall Smythe (**Dr Smythe**), a Forensic Odontologist also of the VIFM, who identified blood within the left maxillary sinus which suggested an oroantral communication – from the extraction site through to the antrum. Dr Smythe stated that the extraction of multiple teeth – 15 in this instance – creates a trough of bony defect and opening across the gums and alveolar processes which can make the development and maintenance of a clot more difficult.

24. Dr Ho considered the clinical history, which read *'excessive bleedings is noted'*, and stated that haemorrhage is a known complication of this procedure. There is no method, at post-mortem examination, to determine the amount of blood lost.

25. Toxicological analysis of post-mortem blood samples identified the presence of codeine at a concentration of ~ 0.07 mg/L and trace amounts of paracetamol. Toxicological analysis of post-mortem vitreous humour samples identified urea at a concentration of 16 mmol/L and creatinine at 132 umol/L which indicates mild renal impairment. Dr Ho considered that the cause of the renal impairment, was likely to be pre-renal, secondary to dehydration or reduced fluid intake.

26. C-reactive protein (**CRP**) – an inflammatory marker – was also elevated, at 31.6 mg/L. Dr Ho considered this was in keeping with the recent dental clearance.

27. Dr Ho provided an opinion that the medical cause of death was due to natural causes, specifically 1 (a) ISCHAEMIC HEART DISEASE 1 (b) CORONARY ARTERY ATHEROSCLEROSIS in the setting of 2 TYPE 2 DIABETES MELLITUS, RECENT DENTAL CLEARANCE, HYPERTENSION.

FAMILY CONCERNS

28. During the coronial investigation, Ms Bradford relayed concerns regarding the events which unfolded between 1 and 3 March 2022. Specifically, Ms Bradford queried the relationship, if any, between Jonathan's death and the total dental clearance, and between his death and the delayed attendance by Ambulance Victoria.

CORONERS PREVENTION UNIT

29. In light of the circumstances of Jonathan's death and family concerns, I sought the assistance of the Coroners Prevention Unit (**CPU**) to aid me in better understanding the events which occurred in the lead-up to 3 March 2022.[2]

Total dental clearance on 1 March 2022

30. In a statement to the Court, Mr Ching, discussed the total dental clearance performed upon Jonathan. Mr Ching stated that a *'total dental clearance in one procedure in elderly patients is a common procedure'* and that prior to the operation *'the risks and complications from the procedure were explained'* to Jonathan, including *'bleeding and infection'*. Mr Ching stated he considered Jonathan's medical diagnoses and medications such that *'all medical and health concerns were considered prior to surgery'* and concluded *'his health concerns were [not] a contraindication'* to the procedure.

31. Jonathan's blood glucose levels and blood pressure were recorded before and during the procedure and were consistently within the normal range. There were no complications during the procedure or post-operatively and a small amount of bleeding was recorded: *'all was an uneventful stay in the day hospital'.*

32. Following notification of Jonathan's death, the Medical Advisory Committee of the Specialist Surgicentre, where the procedure was conducted, investigated and discussed the same. The Committee did not identify any shortcomings in the procedure, nor in the post-operative care that might have contributed to Jonathan's death.

33. The CPU considered the response provided by Mr Ching and concluded that it was reasonable and usual practice to remove all remaining teeth in one procedure to avoid complications and the recurrence of pain and discomfort. The CPU informed me that the consent and pre-procedure assessments were reasonable and that in the absence of complications during the procedure or immediately following, Jonathan was discharged with the appropriate information.

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

34. The CPU did not identify a relationship between the total dental clearance and Jonathan's death.

Delayed attendance by Ambulance Victoria

35. The CPU considered the delays affecting Ambulance Victoria's attendance upon Jonathan. Ambulance Victoria was asked to provide a statement regarding their actions and ambulance availability on the night from 2 to 3 March 2022.

36. Ambulance Victoria discussed the categorisation of Mr Bradford's contact to emergency services. Based on the symptoms she described, including that Jonathan was *'alright'* during the day, was vomiting and in pain though otherwise *'alert'*, the event was categorised as a 'Priority 3' – which required non-urgent ambulance attendance within 60 minutes. As the Triage Practitioner had told Ms Bradford, there was no ambulance able to be dispatched at this time.

37. Ambulance Victoria stated that at 12:42am, a non-emergency ambulance was assigned to attend upon Jonathan and was to be dispatched once they were clear of the matter they were completing at that time.

38. At 1:04am, Ms Bradford re-contacted emergency services at and informed them Jonathan was now unconscious, the event was re-categorised as 'Priority 1', requiring attendance within 15 minutes. Upon being informed that Jonathan's breathing had deteriorated, this was changed to a Priority 0, necessitating urgent attendance.

39. At 1:20am, MICA paramedics arrived at the residence, approximately 70 minutes following Ms Bradford's initial contact, and 14 minutes after the re-categorisation.

40. On the requestion of resourcing, Ambulance Victoria stated that on 2 March 2022, at 11:45pm, around the time of Ms Bradford's first contact, only 3% of the ambulance fleet was available for dispatch, and there were 49 cases awaiting triage or awaiting dispatch.

41. The events of 3 March 2022 have been reviewed by Ambulance Victoria's Team Leader Clinical Triage, with specific reference to the triage process and did not identify any shortcomings with the categorisation process.

42. The CPU considered the response provided by Ambulance Victoria and concurred the triage process was reasonable. Upon being notified of Jonathan's deterioration, their attendance was timely. Additionally, the CPU concluded that as an elderly man, with multiple medical

comorbidities, it is not likely that earlier arrival by an ambulance would have prevented his death.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death:

1. Since the COVID-19 pandemic, the Victorian healthcare system including Ambulance Victoria, has faced a continually increasing demand on its services. On 1 August 2024, Ambulance Victoria announced that it had experienced its *'busiest quarter ever'* with 102,000 Code 1 events - 35.2% more than in pre-pandemic years.

2. In October 2024, Safer Care Victoria (**SCV**) released its report entitled *'Exploring safe care during the prehospital patient journey'* (**the Report**) which sought to understand Ambulance Victoria's patient management prior to hospital handover and explore initiatives currently underway to improve the same.

3. The Report analysed statewide delays in the prehospital patient journey and its phases including ambulance dispatch, attendance and patient offloading. It identified that from 2017-18 to 2023-24, the prehospital patient journey was prolonged by 35.1%.

4. Regarding ambulance attendance, the Report analysed dispatch delays and the average time taken for ambulances to attend patients in Code 1, 2 and 3 events. Attendance times for patients of all codes have steadily increased since 2018. By the end of 2024, average attendance times for Code 1, 2 and 3 events each fell short of their respective key performance indicators.[3] In its 2022-24 Annual Report, Ambulance Victoria reported that amongst Code 1 events, only 66.3% had ambulance attendance within the targeted 15 minutes – below the statewide target of 85%.[4]

5. With respect to patient offloading, the Report identified that *'this phase of the prehospital journey has seen the most significant increase in average time compared to other phases since the pandemic'.* The average pre-pandemic time awaiting patient offloading in Code 1 events was 31 minutes, this increased to 55 minutes post-pandemic.

[3] The key performance indicators (**KPI**) indicate the goal attendance time for each code event. The KPI for Code 1 events is 85% of attendances within 15 minutes.
[4] Ambulance Victoria, *Ambulance Victoria Annual Report 2023-2024,* page 67. Accessible at: https://www.ambulance.vic.gov.au/wp-content/uploads/2024/11/Ambulance-Victoria-Annual-Report-2023-2024.pdf.

6. It is commonly accepted that ambulance delays are a *'system-wide issue'* with several contributing factors. One such cause is hospital overcrowding, which can cause access blocks and lead to ambulance ramping – where ambulances are unable to offload patients to emergency departments (**EDs**) causing them to be 'ramped' at hospitals for prolonged periods.

7. The impact of access block and ramping issues on Ambulance Victoria's services was clearly enunciated in the Report: *'AV will likely continue to not meet their Key Performance Indicators (KPI's) until broader systems issues resulting in hospital access block and ambulance fleet availability are addressed'*. The Report continued that the *'ability for emergency departments to efficiently offload patients from ambulances is impacted by multiple contributing factors including the demand within the ED and access block within the hospital'.*

8. Health service performance data demonstrated a steady increase in hours spent in EDs, however, the number of patient presentations themselves *'[has] not drastically changed according to that data'.* The Report stated this data *'affirms [Ambulance Victoria's] concerns that access block in hospital EDs and beyond is impacting fleet availability and transfer of care'.*

9. Statistics demonstrate that since 2018-19, ED presentations in Victoria are increasing at an average annual rate of 1.3%. According to the Report, this is due to lingering disruptions to Victoria's healthcare system following the COVID-19 pandemic, increased complexity and acuity of patient attendances and increased barriers for patients to access primary healthcare for example due to a reduction in Bulk Billing and increased cost of living.

10. Recently, the Department of Health and the Institute for Healthcare commenced the TEC2 program, entitled *'Timely Emergency Care 2'*. Facilitated by hospital participation, the program aims to improve hospital-wide patient flow through the testing and implementation of new initiatives. Regarding TEC2, the Report encouraged:

> *'The Department of Health and [Ambulance Victoria] to progress the TEC2 program to translate and implement national and international best evidence and practices to enhance Ambulance/ED patient flow strategies to improve access and safety. Peak bodies for consultation may include the Council of Ambulance Authorities, the Ambulance Association of Chief Executives and Paramedic Chiefs of Canada.'*

11. At the time of writing, the TEC2 program remains ongoing.

12. Other initiatives have been implemented to assist the broader Victorian healthcare system to manage the large volume of ED presentations. One such program is the Victorian Virtual Emergency Department (**VVED**) which was commenced in October 2020. The VVED is a telehealth platform which connects patients to emergency clinicians from their home environment or GP clinic, and which facilitates virtual clinical assessments and the delivery of medical advice. The VVED service is available to all Victorians over three months of age.

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Jonathan Alan Uphill, born 4 October 1937;

    b) the death occurred on 3 March 2022 at 81 Franklin Road, Mount Duneed, Victoria, 3217;

    c) I accept and adopt the medical cause of death as ascribed by Dr Ho and find that Jonathan Allan Uphill died due to ischaemic heart disease and coronary artery atherosclerosis in the setting of type 2 diabetes mellitus, recent dental clearance, and hypertension.

2. AND I find that the recent total dental clearance was a stressful event which may have had a physiological impact on Jonathan Alan Uphill. I nevertheless find that, on the information available to him, Mr Martin Ching appropriately warned Jonathan Alan Uphill of the risks associated with the procedure.

3. AND I find that in the absence of any complications associated with the procedure, clinicians could not have foreseen Jonathan Alan Uphill's death.

4. AND having commented on the delays experienced by Ambulance Victoria on the night of Jonathan Alan Uphill's death, I am unable to find that these delays were causal or contributory to the death on account of Jonathan Alan Uphill's advanced age and comorbidities.

I convey my sincere condolences to Jonathan's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Ms Vicki Bradford, Senior Next of Kin

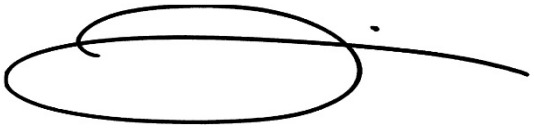
Martin Ching

Ambulance Victoria

Hon Mary-Anne Thomas MP, Minister for Health and Ambulance Services

Senior Constable Alicia Gangell, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 26 February 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.