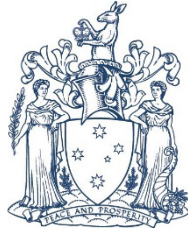

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004423

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, CORONER
Deceased:	Martin Barlow
Date of birth:	30 September 1954
Date of death:	6 August 2022
Cause of death:	1(a) HEAD INJURIES SUSTAINED IN FALLS
Place of death:	10/13 Eastbridge Court, Nunawading, Victoria, 3131
Keywords:	Ambulance Victoria, ambulance shortage, hospital ramping, delays

INTRODUCTION

1. On 6 August 2022, Martin Barlow (**Martin**) was 67 years old when he died while waiting for an ambulance following a head injury. At the time of his death, Martin lived in Mitcham, Victoria.

Medical history

2. Martin had an extensive medical history including heavy alcohol consumption, smoking and chronic lung disease. Around 2017, he experienced a cerebrovascular accident – colloquially known as a *'stroke'* – and according to his son, he experienced *'light headedness'* since.

3. He was prescribed medication including clopidogrel, an antiplatelet agent that prevents the formation of blood clots.

THE CORONIAL INVESTIGATION

4. Martin'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.

5. 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.

6. 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.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Martin'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.

8. This finding draws on the totality of the coronial investigation into the death of Martin Barlow. 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

9. On 5 August 2022, at approximately 7pm, Martin was spending time with his partner, Crimson Burrell (**Ms Burrell**) at his Mitcham residence. The couple *'shared a bottle of wine'*.

10. Martin and Ms Burrell decided to go to Ms Burrell's house in Nunawading. Shortly before 11pm, the couple arrived at the residence and as they approached the front door, Martin fell and struck his head on the concrete driveway.

11. Ms Burrell observed Martin rise to his feet, take a few steps before falling and hitting his head for a second time. She assisted Martin to his feet and according to her, he was bleeding from the head and there was a small *'pool of blood'* on the driveway.

12. At 11pm and 11:17pm, Ms Burrell contacted emergency services. During these telephone calls, there are significant miscommunications between herself and the call takers.

13. Ms Burrell helped Martin inside her house and placed him on a couch. Ms Burrell placed a blanket over Martin and informed him that she was going to bed. According to Ms Burrell, he wished her a good night.

14. At 3:48am, Ambulance Victoria paramedics arrived, knocked on the front door but did not receive an answer. Paramedics contacted Ms Burrell via her mobile phone, and at approximately 4:04am, she answered the door.

15. Paramedics assessed Martin on the couch, and found that he was not breathing, pulseless and in cardiac arrest. They commenced cardiopulmonary resuscitation (**CPR**) however, this was ceased as Martin was in asystole for over ten minutes.[2] At 4:11am, paramedics declared Martin deceased.

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[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.

[2] Asystole, colloquially referred to as 'flatline', indicates the cessation of electrical and mechanical cardiac activity.

Identity of the deceased

16. On 10 August 2022, Martin Barlow, born 30 September 1954, was visually identified by his daughter, Kim Herbert, who completed a formal Statement of Identification.

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

Medical cause of death

18. Forensic Pathologist Dr Melanie Archer (**Dr Archer**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on the body of Martin Barlow on 9 August 2022. Dr Archer considered the Victorian Police Report of Death for the Coroner (**Form 83**), post-mortem computed tomography (**CT**) scan and medical records provided by the Wantirna Road Clinic and provided a written report of her findings dated 22 August 2022.

19. The post-mortem examination revealed swelling over the scalp. The post-mortem CT scan identified diffuse subarachnoid haemorrhage, and right convexity subdural haemorrhage with a left midline shift. Also identified was hepatic steatosis – colloquially referred to as 'fatty liver' – and some pulmonary emphysematous changes.

20. Toxicological analysis of post-mortem samples identified the presence of ethanol – alcohol - at a concentration of 0.17 g/100mL. Dr Archer stated this concentration of alcohol in the blood can cause intoxication, though qualified that individual tolerance and drinking history ought to be considered. She continued that alcohol is a potential contributing factor to head injury-associated deaths, however, noted that the severity of the head injuries was sufficient to cause death on its own.

21. Dr Archer provided an opinion that the medical cause of death was 1 (a) HEAD INJURIES SUSTAINED IN FALLS.

FAMILY CONCERNS

22. During the course of my coronial investigation, Martin's daughter, Kim Herbert (**Ms Herbert**), expressed concerns about the period of approximately five hours between Ms Burrell's call to 000 at 11pm, and Ambulance Victoria arrival at 3:48am.

AMBULANCE VICTORIA DELAYS ON 5-6 AUGUST 2022

23. Ambulance Victoria was asked to provide a statement regarding the calls placed by Ms Burrell and their resourcing and availability on the night of Martin's falls.

24. Ambulance Victoria provided information about the difficulty encountered by the call takers when speaking with Ms Burrell, specifically that they were unable to ascertain crucial information regarding Martin's state. It explained that *'this impacted the call taking with some [key questions] required to be answered not known'*.

25. Ambulance Victoria staff made multiple attempts to contact Ms Burrell. At 11:34pm, a secondary triage was completed and at 11:33pm, the event was categorised as a 'Code 2', requiring ambulance attendance within 25 minutes.

26. Ambulance Victoria also stated that between 11:33pm and 3:28am there was no available ambulance to be dispatched to Martin. At 1:34am, an ambulance was dispatched to attend the residence however, it was diverted to a higher priority event prior to its arrival.

27. On the question of resourcing, Ambulance Victoria stated that a Code Green was in effect from 10:40pm on 5 August 2022 to 7:30am on 6 August 2022. A Code Green indicates a *'medium impact on service delivery'* due to a greater-than-anticipated workload demand.[3] At the time, there were approximately 23 delayed events awaiting ambulance dispatch and only 6% of the Ambulance Victoria response fleet available to respond to Code 1 events. There was between 40-60% of the fleet at hospitals, with extended ramp times of between three to four hours.

28. There were additional factors which compounded the low availability of the ambulance fleet, including mandated fatigue and other breaks including end-of-shift management, and decreased staff availability on the roads and in communication centres.

29. Ambulance Victoria acknowledged that:

> *'A decreased fleet availability significantly influenced ambulance response delays and was the major factor leading to the delay in reaching [Martin] in a timely manner'*.

30. And,

[3] I note that the 'anticipated' workload of Ambulance Victoria was based off 7-day and 31-day seasonal trends of the previous year's records.

'As a result, there was a significant response delay to this Code 2 event outside the target response timeframe for 25 minutes'.

CORONERS PREVENTION UNIT

31. In light of family concerns regarding Ambulance Victoria delays, I sought the assistance of the Coroners Prevention Unit (**CPU**) to better understand the circumstances of Martin's death.[4]

32. The CPU considered the high proportion – up to 60% – of the metropolitan Melbourne fleet that was unavailable due to ramping and agreed with Ambulance Victoria that this was the primary contributor to poor resource availability on the night of Martin's death.[5]

33. The CPU turned to consider the particulars of Martin's death, including whether the delay by Ambulance Victoria changed his clinical course. The CPU could not conclusively determine whether Martin would have survived had he received earlier treatment, particularly since the precise time at which Martin died is unclear.

34. It is likely that had Martin been transported to a nearby hospital, that he would have received a CT scan, revealing the intracranial bleed and would likely have been considered for neurosurgical care.

35. The CPU qualified however, that it is not clear whether Martin would have survived even if such intervention occurred, and that if he did, it is unlikely he would have returned to his baseline functioning.

36. The CPU nonetheless concluded that the best chance of a positive outcome for Martin would have involved emergency medical assessment and a neurosurgical opinion at the earliest opportunity after the falls.

COMMENTS

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

[4] 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.

[5] As opposed to mandated meal and fatigue breaks, end-of-shift handovers and other staff unavailability.

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.[6] 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%.[7]

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.

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*

[6] 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.

[7] 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.

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. With regards to Ambulance Victoria delays in general, 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. The TEC2 program, entitled *'Timely Emergency Care 2'*, is a program of the Department of Health and the Institute for Healthcare Improvement. Facilitated by hospital participation, the program aims to improve hospital-wide patient flow through the testing and implementation of new initiatives. 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 Martin Barlow, born 30 September 1954;

   b) the death occurred on 6 August 2022 at 10/13 Eastbridge Court, Nunawading, Victoria, 3131; and

   c) I accept and adopt the cause of death as ascribed by Dr Archer and find that Martin Barlow died due to head injuries he sustained in falls.

2. AND although I am unable to definitively find that the delayed ambulance arrival caused or contributed to the death of Martin Barlow, I am able to find that his best opportunity to survive his head injuries was to be transported to hospital proximate to the time of sustaining his injuries. The delayed ambulance attendance prevented timely treatment from occurring.

3. AND I note that Martin Barlow's death forms part of a broader issue of Ambulance Victoria delays which has been thoroughly analysed by several bodies in recent times. This issue, and its causes, are currently the subject of several initiatives across the State. I am hopeful that these initiatives will help in the prevention of deaths in like circumstances while patients await ambulance attendance.

I convey my sincere condolences to Martin'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:

Kim Maree Herbert, Senior Next of Kin

Ambulance Victoria

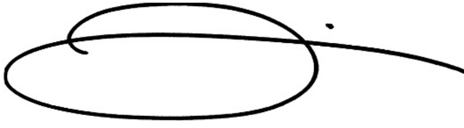
Safer Care Victoria

Department of Health

The Hon Mary-Anne Thomas MP, Minister for Ambulance Services

Senior Constable Philip Gibby, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 14 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.