IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006269

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, CORONER
Deceased:	EH
Date of birth:	[redacted]
Date of death:	1 November 2022
Cause of death:	1(a) COMPLICATIONS OF CHRONIC ETHANOL USE
Place of death:	[redacted] Victoria, 3121
Keywords:	Ambulance Victoria, ambulance shortage, hospital ramping, delays

INTRODUCTION

1. On 1 November 2022, EH was 51 years old when he died in his Richmond home whilst waiting for an ambulance.

Medical History

2. EH received a disability support pension and had an extensive medical history. He had multiple diagnoses including of alcohol dependence, chronic opioid usage, liver cirrhosis and an acquired brain injury. In May 2022, he underwent a total right hip replacement and sustained a periprosthetic fracture of the right hip the following month. Between July and September 2022, he was required frequent revision and repeated washouts of the fracture site.

3. EH frequently attended the Emergency Department (**ED**) of nearby St Vincent's Hospital. Between 27 August and 27 September 2022, EH was hospitalised for treatment of his hip fracture, which had become infected. He had a follow-up with the orthopaedic team scheduled for 6 October 2022.

4. Between 14 and 31 October 2022, EH attended the St Vincent's ED on nine occasions and was transported via ambulance each time. His presentations where largely due to pain in his right leg, and sometimes was intoxicated such as on 18 October 2022, when his blood alcohol concentration was 0.273 g/100mL. On each occasion, EH self-discharged within one to two hours of arrival, prior to being assessed by a clinician.

THE CORONIAL INVESTIGATION

5. EH'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 EH'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 EH. 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 31 October 2022, at 1:28pm, EH contacted emergency services and reported pain in his hip. At 2:10pm, an ambulance arrived at his apartment complex, but paramedics had trouble locating EH's unit. As paramedics searched, at 2:23pm, EH re-contacted emergency services and stated he was in extreme pain and had collapsed.

11. At 2:25pm, paramedics gained access to his apartment and suggested that EH be transported to St Vincent's Hospital. They documented his diagnoses primarily as a *'social problem'* with a secondary factor of *'alcohol intoxication'.*

12. At 3:07pm, EH arrived at the St Vincent's ED and at 3:16pm, paramedics provided a handover to hospital triage staff. By 3:35pm, EH self-discharged from the ED, prior to being assessed by a doctor.

13. At 7:57pm, EH again contacted emergency services and reported he was experiencing reflux and vomiting.

14. At 8:09pm, an Ambulance Victoria Triage Practitioner attempted to contacted EH to obtain further details for a secondary triage. The Triage Practitioner identified that EH was a regular

[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.

caller and left three voice messages on his mobile phone including a request for him to call back.

15. At 8:11pm, while the Triage Practitioner was calling EH, he contacted emergency services. EH asked for the ambulance's estimated arrival time and reported an increase in vomiting. At 8:36pm, EH re-contacted emergency services and reported he was now vomiting blood, however, the call taker could not ascertain the amount of blood loss.

16. On 1 November 2022, at 12:11am, paramedics arrived at EH's address and again, experienced some trouble locating his apartment. At 12:18am, paramedics entered his apartment and located EH on the couch. They assessed him and declared EH deceased.

Identity of the deceased

17. On 4 November 2022, EH, born [redacted] was visually identified by his mother, DH, who completed a Statement of Identification.

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

Medical cause of death

19. Forensic Pathologist Dr Heinrich Boower (**Dr Bouwer**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of EH on 9 November 2022. Dr Bouwer considered the Victoria Police Report of Death for the Coroner (**Form 83**) and post-mortem computed tomography (**CT**) scan and provided a written report of his findings dated 28 August 2023.

20. The post-mortem examination revealed the liver to be cirrhotic and severely infiltrated by fat. Dr Bouwer considered that the mechanism of death as likely multifactorial including metabolic derangement, alcohol related seizure or withdrawal. He furthered that cardiac arrythmias can cause sudden death in individuals with chronic alcohol consumption and that cardiac dysfunction in individuals with cirrhosis is well recognised.

21. The right hip area was described by Dr Bouwer as *'unremarkable'.*

22. Toxicological analysis of post-mortem samples identified the presence of ethanol (alcohol) at a concentration of 0.08 g/100mL. Post-mortem biochemistry testing demonstrated that beta-hydroxybutyrate was slightly elevated but was considered non-contributory to the death.

23. There were no injuries or evidence of violence contributing to the death.

24. Dr Bouwer provided an opinion that the medical cause of death was 1 (a) COMPLICATIONS OF CHRONIC ETHANOL USE.

FURTHER INVESTIGATION

25. Ambulance Victoria was asked to provide a statement regarding the actions of its staff, and of the availability of ambulances and resources between 31 October and 1 November 2022.

26. On 31 October 2022, at around 8pm, when EH contacted emergency services for the second time, the event was categorised as 'Priority 3', requiring non-urgent ambulance attendance.

27. At 9:09pm, when EH updated Ambulance Victoria staff that he was now vomiting blood, the event was re-categorised as 'Priority 2', requiring urgent ambulance attendance within 25 minutes.

28. At this time, Ambulance Victoria staff were aware that EH frequently contacted emergency services, that he had attended the St Vincent's ED earlier that day and had self-discharged. Staff nonetheless recognised *'the need for [EH] to be reviewed in the hospital and for an ambulance to be dispatched'.*

29. Ambulance Victoria stated that attempts were made to locate an ambulance to dispatch at 9:10pm, 11:12pm and 11:33pm.

30. On the question of resourcing, Ambulance Victoria stated that a 'Code Green' was in place from 2:57pm on 31 October 2022. This indicates a shortage of ambulance resources available across metropolitan Melbourne. A 11:13pm on 31 October 2022, the Code Green was escalated to a 'Code Orange'. At this time, there were approximately 45 delayed cases awaiting dispatch and the small proportion of ambulances available were to response to 'Priority 0' events only, such as a cardiac arrest.

31. Ambulance Victoria also stated that hospital ramping was a significant contributing factor to the ambulance delays at this time. Between 25-47% of the ambulance fleet was unable to respond due to significant hospital delays, including some being ramped for longer than eight hours at certain metropolitan hospitals.

32. Ambulance Victoria stated that:

'In this instance, [Ambulance Victoria]'s reduced fleet availability was due to a combination of factors including significant hospital delays, and resource restrictions'.

33. And,

'A decreased fleet availability significantly influenced ambulance response delays and was a major factor leading to the delay in dispatching an ambulance to [EH]'.

CORONERS PREVENTION UNIT

34. In order to better understand the circumstances of EH's death I sought the assistance of the Coroners Prevention Unit (**CPU**).[2]

35. The CPU considered the statement provided on behalf of Ambulance Victora and concluded there were multiple factors which lead to the delays experienced on 31 October and 1 November 2022. Of these the prevailing factor was vehicle availability, which was compounded by factors such as meal and fatigue breaks mandated under the governing Enterprise Agreement.

36. The CPU concluded that the unavailability of vehicles was underpinned by a significant proportion of the fleet – up to 47% - being ramped at hospitals for significant periods of time. As a consequence, the available vehicles were '*held'* to respond only to the highest priority events.

37. When considering the particulars of EH's death, the CPU concluded it was not possible to conclusively determine whether the Ambulance Victoria delay contributed to this passing. Having considered the post-mortem autopsy report of Dr Bouwer, the CPU did not consider there to be an infective cause of the death and noted Dr Bouwer's comments that it was likely multifactorial including metabolic derangement, alcohol related seizure or withdrawal. The CPU concurred with this conclusion and furthered that if these complications had arisen whilst EH was in hospital, there was a reasonable prospect they would have been recognised and treated early, and that EH may have survived.

[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.

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.

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

[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.

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 EH, born [redacted];

   b) the death occurred on 1 November 2022 at [redacted] Richmond, Victoria, 3121; and

   c) I accept and adopt the medical cause of death ascribed by Dr Bouwer and find that EH died due natural causes, being the complications of chronic ethanol use.

2. AND although the weight of the available evidence does not permit me to make a finding that the delayed ambulance arrival caused or contributed to EH's death, I do find that EH's death may have been preventable had he been in hospital at the outset of him symptoms.

3. AND I note that EH'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 EH'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:

DH, Senior Next of Kin

St Vincent's Hospital

Ambulance Victoria

Safer Care Victoria

Department of Health

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

Senior Constable Kyle Hardy, 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.