IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000929

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Robert Norman Spencer
Date of birth:	30 November 1962
Date of death:	18 February 2022
Cause of death:	1(a) Ischaemic heart disease in the setting of chronic ethanol use
Place of death:	4/33 McDowall Street, Mitcham, Victoria, 3132
Key words:	Natural causes; ambulance delay; fleet availability

INTRODUCTION

1. On 18 February 2022, Robert Norman Spencer was 59 years old when he was found deceased in his home. At the time of his death, Robert lived alone at 4/33 McDowall Street, Mitcham, Victoria.

2. Robert's family described him as a kind and generous man, who had many friends and loved music, fishing, travelling and helping in the community. Robert was on the board of the Victorian Country Fire Authority and was active in the local RSL at Mitcham. Throughout the COVID-19 pandemic, Robert worked from home as a regional manager employed in the insurance industry.[1]

3. Robert was a heavy smoker[2] and had a history of alcohol misuse, consuming approximately one to two bottles of wine per day.[3] During a hospital admission in January 2021 for treatment of a fractured right tibia, Robert was investigated for progressive weight loss and was found to have human immunodeficiency virus (HIV), mild acute liver injury, supraventricular tachyarrhythmia[4], and moderate emphysematous changes in his lungs.[5]

THE CORONIAL INVESTIGATION

4. Robert'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

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[1] Coronial Brief, statement of Susan Warren dated 10 December 2022; statement of Jessie Spencer dated 2 December 2022.
[2] Royal Melbourne Hospital records; Coronial Brief, statement of Katerina Myskova dated 9 January 2023;
[3] Coronial Brief, statement of Jessie Spencer dated 2 December 2022; Royal Melbourne Hospital records.
[4] A very fast or erratic heartbeat.
[5] Royal Melbourne Hospital records.

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 Robert'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.

8. This finding draws on the totality of the coronial investigation into the death of Robert Norman Spencer including evidence contained in the coronial brief. 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.[6]

9. In considering the issues associated with this finding, I have been mindful of Robert's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

10. At 4:27 am on 18 February 2022, Robert called 000 requesting an ambulance. He reported being unable to get up due to 'being too weak, lying on the couch', and said he was worried if he tried to move he would fall over again.[7]

11. During his call, Robert stated:

    a) he was home alone;

    b) he was breathing normally, with no pain, no bleeding or vomiting blood;

    c) he was not isolating due to COVID factors;

[6] 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.

[7] ESTA Chronology Report, 18 February 2022; Coronial Brief, statement of Andrew Keenan dated 24 January 2023.

d) he had had a fall the day previous, that ambulance members had attended and offered to transport him to hospital, but he had declined.[8]

12. The call was designated as a Code 3 response, indicating a non-acute/non urgent call. Under Ambulance Victoria's Clinical Response Model, Code 3 patients are considered to be suitable for transfer to the Ambulance Victoria (**AV**) Secondary Triage Services (for call-back).[9]

13. From 4:45 am, the Secondary Triage Practitioner attempted several calls to Robert's mobile phone with no answer. They left several voice messages and sent text messages to Robert's phone, then updated the dispatched event, noting 'Straight to voicemail on multiple callbacks, vm left sms sent'.[10]

14. Between 4:57 am and 5:34 am, the event was 'held' while an AV Communications Support Paramedic and AV Duty Manager attempted to find an ambulance to send to Robert's house. From 5:14 am to 7:08 am, five Ambulance Victoria units were assigned to the event and subsequently either diverted or removed.[11]

15. At 7:08 am, an ambulance unit was dispatched and arrived at Robert's house 7:38 am. On arrival, paramedics were unable to gain access to Robert's home and requested that a call be placed to Robert from the dispatch centre. At 7:48 am, the AV dispatcher called Robert's phone with no answer.[12]

16. At 7:49 am, the AV unit reported that they had gained entry to the unit and located Robert in in his kitchen in cardiac arrest. On examination, Robert was found to be pulseless, apnoeic and unresponsive. He was noted to be cyanotic, with rigor mortis and post-mortem lividity present. CPR was not commenced as Robert was determined to be already deceased. His death was formally verified at 7:50 am.[13]

Identity of the deceased

17. On 21 February 2022, Robert Norman Spencer, born 30 November 1962, was visually identified by his sister, Susan Warren.

[8] ESTA Chronology Report, 18 February 2022; Coronial Brief, statement of Andrew Keenan dated 24 January 2023.
[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Ibid.
[13] Coronial Brief, statement of Christian De Jong dated 7 January 2023; VACIS Electronic Patient Care Record – Ambulance Victoria, 18 February 2022.

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

Medical cause of death

19. Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine conducted an autopsy on 22 February 2022 and provided a written report of her findings dated 26 May 2022.

20. The autopsy revealed significant single vessel coronary artery atherosclerosis[14] and myocardial fibrosis[15], in keeping with a diagnosis of ischaemic heart disease, as well as chronic inflammation and emphysema of the lung, and steatosis[16] in the liver. Post-mortem electrolytes also indicated some renal impairment.

21. Dr Parsons explained that ischaemic heart disease is the generic definition of a group of closely related disorders resulting in myocardial ischaemia. Myocardial ischaemia is the imbalance between supply and demand of the heart for oxygenated blood. In the vast majority of cases, as in Robert's case, this is due to coronary artery disease.[17] People with ischaemic heart disease are at an increased risk of sudden death, usually due to a cardiac arrhythmia. Risk factors for the development of coronary artery disease include hypertension, hypercholesterolaemia, smoking, being a male and having a family history of the disease.

22. Toxicological analysis of post-mortem blood samples did not identify the presence of any ethanol (alcohol), however acetone and isopropanol were detected in vitreous humour. Dr Parsons explained that these substances can be raised in the context of alcohol withdrawal and that complications of alcohol withdrawal and long-term alcohol abuse can cause sudden death irrespective of the blood ethanol level. Dr Parsons further explained that people who use alcohol long-term are at an increased risk of sudden death. The exact mechanism is not known, however it is thought to be a combination of electrolyte disturbances, fatty liver and seizures (as part of the alcohol withdrawal process). Ethanol can also cause structural changes to the heart.

23. Dr Parsons provided an opinion that the medical cause of death was 1(a) ischaemic heart disease in the setting of chronic ethanol use.

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[14] Thickening or hardening of the arteries caused by the build-up of plaque in the inner lining of the artery.
[15] Scarring of the heart muscle due to a sudden or chronic heart injury.
[16] Build-up of excess fat in the liver cells.
[17] Where the arteries of the heart cannot deliver enough oxygen-rich blood to the heart

24. I accept Dr Parsons' opinion.

FAMILY CONCERNS

25. In a statement dated 10 December 2022,[18] Robert's sister, Ms Susan Warren, expressed significant concern about the delay between Robert's call to 000 and the arrival of emergency services some three hours later.[19]

26. In order to respond to this concern, I made further enquiries with the forensic pathologist, Dr Parsons, in relation to the possibility of ascertaining the time of Robert's death. Dr Parsons advised that it was not possible to estimate the time of death in Robert's case and that she was unable to comment on whether or not earlier medical care would have affected the outcome in Robert's case.

Ambulance Victoria response

27. Mr Andrew Keenan, Director of Patient Safety and Experience at Ambulance Victoria, provided a statement dated 24 January 2023 in response to my investigator's enquiries as to the cause of the ambulance delay. In his statement, Mr Keenan sets out a timeline of events with explanatory comments and provides information about the demand on the ambulance service in the early morning of 18 February 2022.

28. Mr Keenan explains that Code 3 events have a target response timeframe (expected ambulance arrival) of within 60 minutes. Ambulance Victoria data shows that between 00:00 (midnight) to 08:00 hours on the morning of 18 February 2022, the caseload of incoming-triple zero calls was higher than usual and that the key performance indicator for AV code 1 responses (responses within 15 minutes) was at 64.29%, meaning that there was moderate demand on the prioritised dispatch system.

29. During this period, Computer Aided Dispatch (CAD) data indicates significant delays experienced by AV ambulances at hospitals (known as hospital ramping) which was noted as resulting in wait times of three to four hours.

30. AV also recorded a shortage of staff in its Melbourne metropolitan operations overnight on 17 February 2022, with two afternoon and two nightshift ambulance vehicles (at each base) unable to be used due to lack of staff. Mr Keenan notes that the closest AV branch to Robert's

[18] Now contained in the Coronial Brief.
[19] Coronial Brief, statement of Susan Warren dated 10 December 2022.

house (Nunawading AV Branch – 1.9 km away) had no appropriate AV resource rostered to be dispatched to him.

31. Mr Keenan concluded that decreased fleet availability significantly influenced ambulance response delays and was the major leading factor leading to the delay in reaching Robert in a timely manner.

FURTHER INVESTIGATIONS

32. As described above, at the time of Robert's initial 000 call, he was designated as requiring a Code 3 response, suitable for transfer to AV Secondary Triage Services. The evidence indicates that a Secondary Triage Practitioner made several attempts to call Robert following his initial contact with the Triple Zero call-taker, but was unable to make contact, and left multiple voicemails and text messages requesting that he call back.

33. On review of Ms Warren's concerns and the statement provided on behalf of Ambulance Victoria, I directed that further information be obtained specifically in relation to Secondary Triage Services, with a view to assessing the merit and feasibility of amending relevant Ambulance Victoria triage guidelines to provide for patients who cannot be reached via call-back to have their priority code upgraded.

34. Mr Keenan provided a supplementary statement in response to my enquiries, dated 17 August 2023, in which he set out a number of reasons why Ambulance Victoria considers that this change would not be advisable.

35. Mr Keenan names a number of challenges associated with a policy of automatically upgrading priority where a triage practitioner is unable to make contact with a caller, including:

    a) it is very common for callers to fail to answer Ambulance Victoria call-backs for a range of reasons, including not keeping their phone on their person or hearing it ring, being intoxicated, and their battery going flat; in many cases the reason for a caller not answering does not have clinical significance;

    b) there are on average 1,634 cases per month in which Ambulance Victoria is not able to successfully call back a caller; and

    c) given that one of the major issues facing Ambulance Victoria is fleet availability, increasing the priority code attached to patients without a clear clinical basis would

worsen issues of fleet availability and delay response times to other priority 2 and 3 events.

36. Mr Keenan also refers to a multiagency review currently underway between the Department of Health, Safer Care Victoria, Ambulance Victoria and other health services to investigate and address fleet availability and delays.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Robert Norman Spencer, born 30 November 1962;

    b) the death occurred on 18 February 2022 at 4/33 McDowall Street, Mitcham, Victoria, 3132, from ischaemic heart disease in the setting of chronic ethanol use; and

    c) the death occurred in the circumstances described above.

38. Having considered all of the circumstances, I am satisfied that Robert's death was due to natural causes.

39. I am further satisfied that the delay between Robert's 000 call and the arrival of Ambulance Victoria members was the regrettable result of staff shortages and consequent decreased fleet availability in the context of moderately high demand on ambulance services. I am satisfied that Ambulance Victoria has recognised these shortcomings as systemic and is undertaking a multiagency review of practices with a view to addressing inadequate fleet availability and delays such as those seen in Robert's case.

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

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

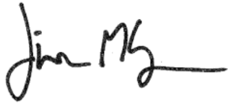
I direct that a copy of this finding be provided to the following:

Jessie Spencer, Senior Next of Kin

Marie Pham, Ambulance Victoria

Senior Constable Matthew Davis, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 23 April 2024

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.