IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000655

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Katherine Lorenz
Deceased:	Victor Dale Fenech
Date of birth:	7 November 1965
Date of death:	3 February 2022
Cause of death:	1(a) complications of metastatic colorectal carcinoma
Place of death:	9/171 Hoddle Street, Richmond, Victoria, 3121

INTRODUCTION

1. On 3 February 2022, Victor Dale Fenech was 56 years old when he died in a neighbour's unit in Richmond. Victor was living a few doors down from the neighbour and had reportedly moved out approximately 6 months prior because of pests. According to the neighbour, Victor was living on the street during this time and would return fortnightly.

2. In the two weeks prior to his death, Victor became unwell and spent more time at home or in the neighbour's unit. The units are two of many in the two-storey arcaded residence.

THE CORONIAL INVESTIGATION

3. Victor'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.

4. 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.

5. 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.

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

7. This finding draws on the totality of the coronial investigation into the death of Victor Dale Fenech 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.[1]

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

Circumstances in which the death occurred

8. On 1 February 2022, at about 8pm, the neighbour called for an ambulance as Victor could not communicate and was more unwell. The neighbour reported that the call-taker would not send out an ambulance unless Victor was unconscious and '*just wanted to know if he was okay*'.

9. Over the next two days, Victor stayed with the neighbour and continued to deteriorate. The neighbour thought that they called Triple Zero each day, but an ambulance did not attend. The neighbour and Victor smoked synthetic cannabis together during this time. The neighbour also reported that Victor had been injecting cocaine over the previous two weeks.

10. On 3 February 2022, the neighbour woke up at about 1pm and noticed that Victor was in the same position on the bed as he was earlier that morning and called for an ambulance. Paramedics from Ambulance Victoria attended, but unfortunately Victor was deceased.

Identity of the deceased

11. On 4 February 2022, Victor Dale Fenech, born 7 November 1965, was visually identified by his son, Dale Fenech.

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

Medical cause of death

13. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy and provided a written report of the findings.

14. The autopsy revealed metastatic colorectal carcinoma of the sigmoid (bowel cancer) complicated by significant tumour burden of the liver, severe bilateral bronchopneumonia (lung infection) on a background of severe bullous emphysema and pulmonary embolism (clots in the lung).

[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.

15. There was no evidence of violence or injury contributing to death.

16. Post-mortem toxicology detected cocaine and methylamphetamine metabolites, pregabalin,[2] and phentermine.[3] Alcohol was not detected.

17. Dr Bouwer provided an opinion that the medical cause of death was 1 (a) complications of metastatic colorectal carcinoma. Dr Bouwer also provided an opinion that the death was due to natural causes.

18. I accept Dr Bouwer's opinion.

FURTHER INVESTIGATIONS

19. At my request, and to investigate the reported absence of ambulance attendances, a representative from the Emergency Services Telecommunications Authority (**ESTA**, now known as Triple Zero Victoria) provided a statement outlining the various calls to Triple Zero and included the relevant audio files of each call, event chronologies, and extracts of relevant process guides.

20. Triple Zero Victoria provides the link between the Victoria community and the State's emergency services organisations by providing State-wide, around the clock, emergency call-taking and dispatch services. Specifically relating to this case, Triple Zero Victoria is responsible for ambulance call-taking and dispatch functions across Victoria. Triple Zero Victoria delivers its services for Ambulance Victoria (**AV**) in accordance with AV's service delivery requirements and operating procedures.

21. Ambulance call-takers use structured call taking (**SCT**) processes and clearly defined protocols with scripts to determine the best course of action to assist the caller.

22. There were three calls in total which were all made by the neighbour. These occurred approximately on:

    a) 1 February 2022 at 8.30pm (**first call**);

    b) 3 February 2022 at 6.30am (**second call**); and

    c) 3 February 2022 at 2pm (**third call**).

[2] Indicated for nerve pain..
[3] An appetite suppressant.

23. The representative explained that the neighbour was assigned a default phone number rather than their mobile number. This occurs when there is no SIM card in the mobile, there is no reception and the call has been routed to another carrier, or if the SIM card is deactivated because of an unpaid phone bill or failure to recharge prepaid credit. When assigned a default number, the caller's actual mobile number and billing address are not available to Triple Zero Victoria.

First Call

24. An ambulance call-taker asked the neighbour, "*What address do you need the ambulance?*" The neighbour then began to explain "*I've got a sick friend that I'm looking after…*". The call-taker intervened and asked again for the address where an ambulance was required. The neighbour stated the address but not the unit number. As the call was assigned a default telephone number, the call-taker then proceeded to ask the neighbour for their mobile phone number, which they gave.

25. The call-taker then proceeded through the structured call taking (**SCT**) process and asked the neighbour exactly what had happened. The neighbour explained that Victor was homeless, "*his health [was] deteriorating*" since last week, and "*he [had] fluid in the lungs*". The neighbour asked whether the ambulance "*can just check him over*".

26. At this stage, it appeared that Victor was unconscious, and the Computer Aided Dispatch System (**CAD**) automatically assigned a Priority 1 emergency ambulance response. The different priorities that can assigned are:

    a) Priority 0 – Most critical events requiring an immediate response (lights and sirens). For example, cardiac arrest;

    b) Priority 1 – Time critical events requiring an immediate response (lights and sirens);

    c) Priority 2 – Acute events requiring an urgent response;

    d) Priority 3 – Non-urgent events, sent through to AV's Triage Services for secondary triage; and

    e) Priority 4 and 5 – Non-emergency events where there is no available non-emergency ambulance resource.

27. After further scripted questions, the call-taker asked the neighbour to see if Victor could be woken up. The neighbour did so, and Victor can then be heard in the background. Victor was pausing between words to catch his breath and later said that he will not go to hospital. As Victor was now no longer unconscious and was alert, the event type was automatically downgraded from a Priority 1 to a Priority 3 response. An ambulance dispatcher assigned an ambulance unit to attend.

28. The representative explained that Priority 3 events may be suitable for AV's secondary triage service (**Refcomm**). Refcomm is staffed by AV paramedics, registered nurses, and mental health triage nurses. Refcomm may update an event priority or response following assessment and may provide self-care advice or refer to alternative service provides if an emergency ambulance is not required. Given the change in priority, the ambulance dispatcher referred the event to be considered by Refcomm.

29. The call-taker then explained to the neighbour:

"*One of our nurses or paramedics is going to call you back within 60 minutes to further assess his condition and organise the most appropriate assistance. At this stage, an ambulance is not being sent but make sure the line is free for them to call you back. Just stay on the line…*"

30. Meanwhile, the assigned ambulance unit contacted the dispatcher to request the unit number of the address. The dispatcher then attempted to call the neighbour back to confirm the address, specifically the unit number, but was unable to connect the call.

31. The representative explained that there were resource issues in the area at the time. This resulted in the assigned ambulance unit being held for nearly two hours before being dispatched. However, when this occurred, the unit was diverted to a higher priority event. A second unit was dispatched soon after, but this unit was also diverted. Further dispatch requests were held as there were no nearby units and because of the resourcing issues.

32. Around midnight, a Communications Support Paramedic (**CSP**) instructed to hold for further calls as the address was a large complex and the unit number was unknown. This meant that until further calls were received about Victor, or the unit number became known, an ambulance would not be dispatched. AV attempted to call the neighbour again but remained unable to connect the call. Finally, at about 12.40am, another CSP closed the event.

Second Call

33. The call-taker asked for the address as part of the verification process. The neighbour again only provided the address of the complex and not the unit number. However, the call-taker did not specifically ask for a unit number. The call was again assigned a default number and the call-taker asked for the neighbour's mobile number, which was given as the same as the first call.

34. During the call, the neighbour suddenly became extremely verbally aggressive before the call was disconnected. As such, the call-taker was unable to complete the SCT process. From the information available, CAD assigned for a Priority 2 response. A practitioner attempted to call the neighbour back, but the phone number was not connected.

35. At about 7.10am, the event was held until a unit number could be confirmed or if a further call was made about Victor. At about 9.20am, a Duty Manager noted in CAD that there were no further calls about the patient and the provided phone number was not connected which meant that they were unable to obtain further information. The Duty Manager then closed the event, and an ambulance was not dispatched.

Third Call

36. The call-taker again asked the neighbour to confirm the address but did not specifically ask for a unit number. The neighbour provided the address without the unit number. The neighbour became increasingly aggressive after explaining that they had called twice before but an ambulance had not attended.

37. The call-taker proceeded with the SCT. The neighbour said that Victor was not awake, that he was dead, and not breathing. This resulted in a Priority 0 event. The call-taker requested police assistance and entering comments into CAD that there was a violent bystander. The neighbour remained verbally aggressive before hanging up the call. The call-taker attempted to call the neighbour back, but could not get through.

Issues

38. There are four main issues that contributed to an ambulance not attending after the first and second calls. These are:

    a) The unit number was unknown;

b) The mobile number provided by the neighbour could not receive calls;

c) The neighbour was aggressive during the calls and disconnected the calls; and

d) Ambulances were diverted to higher priority calls.

Unknown Unit Number

39. The three different call-takers did not specifically ask for a unit number when verifying the address. The neighbour consistently provided the address for the building only and did not include a unit number. It appears that subsequent call-takers were unaware that this had been an issue.

40. It is not unreasonable to hold dispatch of an ambulance unit without this information. If an ambulance is sent to a large complex without knowing the unit or apartment number, there is a risk that the paramedics will be unable to find caller or the person in need of assistance. This may unnecessarily delay attendance to other emergencies. This risk was heightened in these circumstances because of the known resourcing issues at the time.

41. This is a difficult clinical decision which was reasonably made in the circumstances.

Disconnected Mobile Phone

42. The evidence suggests that the neighbour was calling from a mobile phone with a disconnected service. Provided there is still mobile coverage on any network, calls can still be made to Triple Zero without active service. However, as demonstrated in this case, the same phone will not be able to receive any incoming calls such as a scheduled call back from Refcomm.

43. Functioning telecommunications are essential in the provision of emergency services. No one should be disadvantaged in an emergency by not having an active phone service. Ideally, all telecommunications to and from emergency services such as Triple Zero should not be conditional on an active and paid for phone service. However, I recognise the practical limitations of implementing such a policy and have not made a recommendation on this. Instead, there need to be contingencies in place for when follow up calls fail for whatever reason, including attempting to call back to disconnected services.

44. The messaging from the first call taker unfairly places this onus on the caller as AV were waiting for further calls to Triple Zero in the absence of a direction to do so. It was not

unreasonable for the neighbour to not call Triple Zero again after the 60 minutes had elapsed. I acknowledge that this must be balanced against a competing consideration to not overwhelm callers with too much information and overly complex instructions.

Aggressive Callers

45. The representative explained that when dealing with threatening or abusive calls during requests for emergency services, the call-taker must process the event and:

    a) Maintain a professional approach;

    b) Not engage in 'like' conversation with the caller;

    c) Not encourage the caller by engaging in argument, ridicule, or unnecessary discussion; and

    d) At all times, adhere to the relevant emergency call-taking procedures for their respective agency.

46. The corresponding Triple Zero Victoria call-taking manual also provides directions for responding to threatening or abusive callers.

47. In this case, when the neighbour became threatening and abusive during the second and third calls, Triple Zero Victoria recognised that the call-takers remained calm and professional, and followed the normal call-taking process for ambulance attendance as requested by the caller. I agree with Triple Zero Victoria, and I commend the professionalism and level-headedness of the call-takers in the face of extremely unpleasant and threatening language.

Ambulance Resourcing

48. Ambulances are a finite resource and must be diverted to the highest priority cases that are immediately life threatening. At the time of the first and second calls, Victor certainly needed medical attention but did not require immediate attendance by paramedics.

49. It is a misconception that paramedics and ambulances are available to "*just check over*" patients. Triple Zero should be reserved for genuine emergencies. The evidence suggests that Victor was more suited for a review by other health practitioners. However, I accept that there are significant barriers to accessing medical care for people like Victor who experience

homelessness and use injecting drugs. It is unfortunate that other forms of medical attention were not pursued.

50. In this case, the question of ambulance resourcing is outside the scope of the coronial jurisdiction to comment further or make recommendations.

Draft Recommendations

51. I proposed the following recommendations pursuant to section 72(2) of the Act:

"That Ambulance Victoria, in consultation with the Emergency Services Telecommunications Authority, consider:

i. *mechanisms to confirm the type of dwelling, or that additional address information is required, when verifying the address of an event to prompt direct questioning of this information; and*

ii. *providing information in closings script about when to call Triple Zero again in cases where callers are expecting a call back from another health profession, including what to do if the call back does not occur."*

52. These proposed recommendations and draft findings were provided to AV for comment. In response, AV submitted that the first recommendation would be more appropriately directed to Triple Zero Victoria as these issues are not unique to ambulance call-takers and would equally apply to calls requesting other emergency services.

53. AV also provided additional information about transfers in secondary triage events. AV explained that prior to the COVID-19 pandemic, the main way in which Triple Zero Victoria call-takers transferred caller to AV secondary triage was via transfer while the caller remains on the call. This is known as a 'warm transfer'.

54. One of the COVID-19 measures enacted during the height of the pandemic and the associated call surges to Triple Zero was to replace warm transfers with Triple Zero Victoria call-takers ending calls and explaining that a paramedic or nurse would call back. This change reduced the amount of time a call-taker was required to remain on the line with a low acuity caller to increase their available to answer the next Triple Zero call. This process was previously reserved for when there was no secondary triage practitioner immediately available.

55. AV stated that following the cessation of COVID-19 pandemic related call surges, AV is strongly supportive of returning to warm transfers as the primary means of facilitating secondary triage. This has partly been implemented with priority 2 callers 'warm transferred' to secondary triage since April 2023. However, priority 3 callers still receive a call back.

56. With these considerations in mind, AV submitted the following modified recommendations as follows:

    (i) That Triple Zero Victoria consider mechanisms to confirm the type of dwelling, or that additional address information is required, when verifying the address of an event to prompt direct questioning of this information.

    (ii) That Ambulance Victoria, in consultation Triple Zero Victoria, consider:

        (a) providing information in closing scripts about when to call Triple Zero again in cases where callers are expecting a call back from another health professional, including what to do if the call back does not occur; and

        (b) reinstating the inbound call warm transfer process as the primary means of facilitating secondary triage.

57. I accepted AV's submissions and modified recommendations and provided these with my draft findings to Triple Zero Victoria for comment. Triple Zero Victoria advised that they accept the draft findings and proposed recommendations and do not seek to make any further comment.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Victor Dale Fenech, born 7 November 1965;

    b) the death occurred on 3 February 2022 at 9/171 Hoddle Street, Richmond, Victoria, 3121, from complications of metastatic colorectal carcinoma; and

    c) the death occurred in the circumstances described above.

59. I am unable to say if Victor's death was preventable. It is unclear whether the outcome would have been different if an ambulance had attended after the first or second call given that Victor

can be heard saying that he will not go to the hospital. It cannot be known if Victor would have accepted treatment and transport to hospital or if he would have declined this. Similarly, it is unknown if Victor would have survived any hospital admission given his significant disease burden from presumably undiagnosed and untreated metastatic bowel cancer and associated complications.

60. Regardless, pursuant to my function to promote public health and safety, any potential for improvement should be identified and considered. As such, I have made recommendations below with the aim to prevent similar deaths from occurring in the future.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) That Triple Zero Victoria consider mechanisms to confirm the type of dwelling, or that additional address information is required, when verifying the address of an event to prompt direct questioning of this information.

(ii) That Ambulance Victoria, in consultation Triple Zero Victoria, consider:

(a) providing information in closing scripts about when to call Triple Zero again in cases where callers are expecting a call back from another health professional, including what to do if the call back does not occur; and

(b) reinstating the inbound call warm transfer process as the primary means of facilitating secondary triage.

I convey my sincere condolences to Victor'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:

Dale Fenech, Senior Next of Kin

Ambulance Victoria

Triple Zero Victoria

Senior Constable Sean Cronin, Coroner's Investigator

Signature:

Coroner Katherine Lorenz

Date : 13 May 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.