



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 5824

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Deceased:	Min GUO
Findings of:	Coroner Paresa Antoniadis SPANOS
Delivered on:	9 November 2018
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	25-29 June 2018 and 24 August 2018
Counsel assisting the Coroner:	Leading Senior Constable Duncan McKENZIE of the Police Coronial Support Unit, instructed by Ms Amira Kafka, Coroner's Solicitor at the Coroners Court of Victoria
Representation:	Ms Naomi HODGSON of Counsel appeared on behalf of Ambulance Victoria, instructed by Ms Kate Mellier of Lander & Rogers Lawyers

Mr Peter ROZEN of Counsel and Mr Fatmir BADALI of Counsel appeared on behalf of the Emergency Services Telecommunications Authority, instructed by Ms Jess Bayly of K & L Gates

Mr James FORSAITH of Counsel appeared on behalf of the Bureau of Meteorology, instructed by Mr Evan Evagorou, Australian Government Solicitor

Mr Morgan McLAY of Counsel appeared on behalf of the Department of Health and Human Services, instructed by Ms Margaret Mann

Catchwords:

Thunderstorm Asthma, asthma epidemic, respiratory distress, surge in '000' calls, delayed ambulance response, Emergency Services Telecommunications Authority (ESTA), Ambulance Victoria (AV), Inspector General for Emergency Management (IGEM), allergic asthma, rye grass pollen, hay fever, Bureau of Meteorology (BOM)

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GLOSSARY OF ABBREVIATIONS

AV	Ambulance Victoria
AV's ERP	AV's Emergency Response Plan
BOM	Bureau of Meteorology
CAD	Computer Aided Dispatch
The CHO's Report	Chief Health Officer's Report
CPR	Cardiopulmonary resuscitation
CSOPs	Communications Standard Operating Procedures
ED	Emergency Department
EMA	Emergency Management Act 2013 (Vic)
EMR	Emergency Medical Response
EMV	Emergency Management Victoria
EPA	Environmental Protection Authority
ERP	Emergency Response Plan
ESTA	The Emergency Services Telecommunications Authority
DHHS	Department of Health and Human Services
GP	General Practitioner
ICU	Intensive Care Unit
IAWG	Interagency Working Group
IGEM	Inspector General for Emergency Management
MICA	Mobile Intensive Care Ambulance
PMCT	Post-mortem computer assisted tomography scanning
RATeam	Rapid Assessment Team
RHEMS	Real-time Health Emergency Management System
SHERP	State Health Emergency Response
SDRs	Service delivery requirements

SOPs	Standard operating procedures
TA	Thunderstorm Asthma
VicSES	Victorian State Emergency Services
VIFM	Victorian Institute of Forensic Medicine
WFMT	Work Force Management Team

INTRODUCTION

1. Mr Min Guo (**Mr Guo**) was a 29 year old man who lived in Ballarat, having moved there from China in about 2008. Mr Guo met his wife, Ms Yashi Fan (**Ms Fan**) in 2009 while he was studying cookery at Ballarat University. Ms Fan then moved to Bundoora to attend university. The two married in 2012. Ms Fan briefly moved to Ballarat, before returning to Bundoora in 2015 after securing employment.¹ Mr Guo commenced working for BMW (Ballarat) in July 2016 and would see Ms Fan on the weekends.²
2. Mr Guo died as a result of the Thunderstorm Asthma (**TA**) event which occurred in Melbourne on 21-22 November 2016.³
3. Nine other Victorians are known to have died as a result of this event. They are:
 - (a) Omar Moujalled, an 18 year old man who had just completed his Year 12 studies and who died at the Greenvale Medical Clinic on 21 November 2016;⁴
 - (b) Hope Carnevali (Marsh), a twenty year old young woman who worked as a retail assistant and died at her home in Hoppers Crossing on 21 November 2016;⁵
 - (c) Apollo Papadopoulos, a 35 year old man who worked in a steelworks factory and died at a residential address in Epping on 21 November 2016;⁶
 - (d) Clarence Leo, a 37 year old married man who worked in security and died at a residential address in Keysborough on 22 November 2016;⁷
 - (e) Ling Ling Ang, a 47 year old married woman who worked as an accounts manager and died at the Northern Hospital, Epping, on 25 November 2016;⁸

¹ Statement of Ms Yashi Fan dated 25 May 2017 coronial brief pages 282-283.

² Ibid.

³ Although Mr Guo died on 9 December 2016, some time after 21 November 2016, I had been informed by the expert engaged by the Court for the purpose of this inquest, the Royal Melbourne Hospital Head of Allergy and Clinical Immunology Department Professor Jo Douglass (**Prof Douglass**) that those who became unwell secondary to the thunderstorm asthma event of 21 November 2016 remained unwell for a very long time. It is on this basis that I included Mr Guo's death in the thunderstorm asthma cluster inquest. Transcript page 74.

⁴ Coroners Court of Victoria reference 2016 5533.

⁵ Coroners Court of Victoria reference 2016 5534.

⁶ Coroners Court of Victoria reference 2016 5536.

⁷ Coroners Court of Victoria reference 2016 5542.

⁸ Coroners Court of Victoria reference 2016 5599.

- (f) Thao Minh La, a 48 year old spray painter who died at Maroondah Hospital, Ringwood East, on 26 November 2016;⁹
- (g) Priyantha Nirmale Panjith Pieris, a 57 year old married man who worked as an electrical fitter and died at the Northern Hospital, Epping, on 29 November 2016;¹⁰
- (h) Hoi Sam Lau, a 49 year old married man who died at the Austin Hospital, Heidelberg, on 29 November 2016;¹¹ and
- (i) Le Hue Huynh, a 46 year old married woman who worked as a part-time seamstress and died at Sunshine Hospital, Sunshine, on 25 January 2017.¹²

4. At the outset, I wish to express my sincere condolences to the family members, friends and colleagues of each deceased lest their loss and grief be forgotten with the focus on the State's emergency response, the phenomenon of Thunderstorm Asthma and the coronial imperative to contribute to a reduction in the number of preventable deaths wherever possible.¹³
5. Apart from matters personal to each deceased such as their background, personal circumstances, their clinical management and care, and the medical cause of their deaths, a finding in identical terms to this one will be delivered in respect of each deceased.

THE THUNDERSTORM & THE IMPACT OF EMERGENCY SERVICES

6. On Monday, 21 November 2016, Melbourne's temperatures peaked at 35°C. High levels of pollen from the plains to the north and west of Melbourne and certain meteorological conditions, including a cool, stormy change, combined to produce what has been referred to as a TA event and, in some contexts, as a TA epidemic.
7. On Friday, 18 November 2016, the Bureau of Meteorology (**BOM**) weather forecast for 21 November 2016 was for high temperatures followed by a cool change with thunderstorms. The Emergency Services Telecommunications Authority (**ESTA**) forecast the potential for an increase in calls for assistance from the Victorian State Emergency Services (**VicSES**). Such calls are usually taken by ESTA call-takers trained and dedicated to taking calls for police

⁹ Coroners Court of Victoria reference 2016 5616.

¹⁰ Coroners Court of Victoria reference 2016 5671.

¹¹ Coroners Court of Victoria reference 2016 5669.

¹² Coroners Court of Victoria reference 2017 0405.

¹³ See the Preamble to the *Coroners Act 2008* (Vic) (**the Act**) and Purposes, specifically section 1(c).

assistance (**police call-takers**). ESTA accordingly arranged for additional police call-takers to be rostered to process the expected increased number of calls requesting VicSES assistance.¹⁴

8. However, as will be discussed below, the likelihood of a TA event was not appreciated at the time. Therefore, ESTA did not expect an increase in the number of calls requesting Ambulance Victoria (**AV**) attendance and did not revise the staffing roster for call-takers trained and dedicated to taking calls for ambulance assistance [ambulance call-takers].¹⁵ This was consistent with the state of knowledge of key stake holders, now parties in this inquest, that such a weather forecast did not suggest a potential impending health emergency.¹⁶
9. At about 2.00pm on 21 November 2016, the BOM issued a severe thunderstorm warning for damaging winds, heavy rainfall and hailstones. This warning did not include the Central district which encompasses the Ballarat, Geelong and Melbourne Metropolitan regions.¹⁷ At about 4.00pm, the BOM extended its warning to other parts of Victoria, including Geelong and Melbourne.
10. The thunderstorm-induced gust front reached Geelong at 5.00pm and moved rapidly eastwards. Over the following hour and during the afternoon peak when many people were travelling home from work,¹⁸ a cold front and associated thunderstorm swept across Melbourne from the west bringing with it wind gusts of over 80 kilometres per hour.
11. At about 5.15pm, ESTA received a further warning from BOM indicating that thunderstorms were detected on the radar and were expected to affect the west of Melbourne by 5.40pm and Melbourne suburbs by 6.10pm. The warning did not refer to air quality or the possibility of a TA event.
12. While the precise mechanism of a TA event is not clear, it is generally understood that the moisture from the storm breaks pollen particles into respirable-sized particles capable of being breathed deep into the lungs, resulting in breathing difficulties in a large number of people.

¹⁴ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 806.

¹⁵ Inquest transcript (**transcript**) page 181. Ms Smith explained that the accuracy of the forecasting is dependent upon the information available to the ESTA's Workforce Management Team at the time – transcript page 182.

¹⁶ Coronial brief page 423.

¹⁷ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 806. See also IGEM's Final Report at coronial brief page 423.

¹⁸ Coronial brief page 423. The thunderstorm front comprised several small cells and although the storm front produced severe wind gusts, they swept through quickly. The BOM evidence provided to IGEM stated that there was nothing particularly remarkable about this storm.

13. By 6.00pm, ESTA call-takers received an unprecedented surge of calls requesting ambulance assistance, particularly for people suffering shortness of breath or asthma-related symptoms.¹⁹ It is important to appreciate that the cause of the surge of calls was unknown at the time it was occurring.²⁰
14. The twelve hour period from 6.00pm on 21 November to 6.00am on 22 November 2016 saw the single greatest volume of calls for ambulance assistance received by ESTA in its history. A total of 2,332 calls were received during this period, with demand peaking in the half hour period between 6.45pm and 7.15pm when 397 calls for ambulance assistance were received.²¹
15. Between 7.00pm and 7.15pm, the number of calls for ambulance assistance grew to almost 700% of the forecast call volumes. By 8.00pm, ESTA would have needed six times the forecasted ambulance call-takers to meet the demand. The number of received calls did not reduce to previously forecast or “normal” levels until after 6.00am on 22 November 2016.²²
16. By about 6.30pm, the ambulance fleet in the West region had been depleted and dispatchers had no available ambulance units to dispatch to incoming calls. The number of “events” pending dispatch consequently increased. The events pending list grew so large that it was not able to fit into one Computer Aided Dispatch (**CAD**) screen. An ESTA employee with seven years’ experience described this as the first time this had been seen.²³
17. The peak in demand for ambulances occurred between 7.00pm and 7.15pm, when ESTA call-takers answered 201 emergency ambulance calls.²⁴ By 7.30pm, there were 140 Code 1 events awaiting dispatch. By 8.00pm, there were in excess of 150 ambulance events awaiting dispatch, almost 100 of which were Code 1 events.²⁵

¹⁹ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 805.

²⁰ Ibid.

²¹ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 807. I am informed that the volume of requests for ambulance assistance received between 6.15pm and 8.15pm (1,329 calls) was comparable with the number of calls for ambulance assistance the ESTA would receive over a 12 hour period on a standard New Year’s Eve. I also note that these figures represent the volume of calls for ambulance only, and that calls for police, fire and VicSES assistance continued unabated. Transcript page 243.

²² Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 807 and transcript page 187.

²³ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 814. This employee’s experience included working during the Black Saturday Bushfires in February 2009.

²⁴ Coronial brief page 424. The longest call answer delay to ‘000’ relating to a request for an ambulance occurred at 6.49pm, when it was reported that the caller waited four minutes and 36 seconds from when they dialled ‘000’ until an ESTA call-taker answered. ESTA’s ambulance call answer speed performance target time is to answer 90% of all calls recorded over a calendar month within five seconds. According to evidence provided at inquest ESTA regularly meets this target. Transcript page 354.

²⁵ Coronial brief page 424. Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief pages 815-817. Transcript page 260. Ms Michelle Smith explained that a Priority 0 event means an imminent threat to life and a Priority 1 event means that urgent assistance is required. Both are ‘Code 1 events’ which means they are events requiring ambulance responding with lights and sirens. Transcript pages 242 and 275. Adjunct Associate Professor Michael

18. Senior ESTA and AV personnel communicated about how both agencies could best manage the increased demand on AV's resources. A number of strategies were subsequently put in place, including:
- (a) cancelling all dispatches for non-emergency ambulance events;
 - (b) arranging with the Metropolitan Fire Brigade [MFB] for fire units to attend some Priority 1 events as well as the Priority 0 events they would usually attend;²⁶
 - (c) arranging with the Victoria Police for police units to attend appropriate events to conduct welfare checks where ESTA call-takers had been unable to re-establish contact with callers who had called earlier;²⁷ and
 - (d) AV directing that despite warnings being in place in relation to AV crews requiring welfare breaks (that in normal circumstances can only be interrupted for Priority 0 events) Priority 1 events could also be dispatched to such crews, as well as Priority 0 events.²⁸
19. Nevertheless, the demand for Code 1 responses continued to outstrip available resources.²⁹ Despite AV requesting and receiving assistance from partner agencies, their capacity to respond to Priority 0 events within their 15 minute target timeframe was achieved in only 57% of cases.
20. Having noticed the increased number of calls requesting ambulance assistance, senior ESTA personnel recalled staff from breaks, instructed mentors to take over call management from trainees, and a number of the day-shift call-takers continued working into the evening to assist in meeting the demand.³⁰ Furthermore, team leaders assisted with call-taking and dispatch rather than undertaking their usual supervisory duties.

Stephenson (A/Prof Stephenson) of AV explained that patients reporting an acute exacerbation of asthma are usually treating as a Priority 1. However if the patient's breathing is severely compromised, they will be treated as a Priority 0. Transcript page 276.

²⁶ Ms Smith explained that the MFB provides an emergency medical response (EMR) service to Priority 0 events that occur within a defined geographical area. On 21 November 2016, following communications between the ESTA, AV and the MFB, it was agreed that fire appliances would also respond to Priority 1 events deemed appropriate by the AV duty clinician. Transcript page 195. After 8.00pm, the MFB were sent to eleven Priority 1 events as well as Priority 0 events. Transcript page 246.

²⁷ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 815.

²⁸ Transcript page 197.

²⁹ A/Prof Stephenson explained that the increased number of Priority 0 and Priority 1 cases (where Code 1 response is required) on 21 November 2016 was a gross distortion of what would be seen on a 'business as usual' evening/night. Transcript pages 276-277.

³⁰ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief pages 819-811. The shift changeover between the ESTA staff rostered for ambulance call-taking and dispatch occurs daily at 6.00pm and 6.00am, with staggering for some staff to account for part-time/casual working arrangements and forecast variations in call demand.

21. At about 6.18pm, an ESTA team leader sent the first of four text messages which was addressed to police call-takers requesting additional staff to return to work due to storm activity. The second text message was sent at 6.48pm, the third at 7.46pm and the fourth at 7.50pm and were addressed to ambulance call-takers.³¹
22. All ESTA staff breaks were cancelled between 6.30pm and 9.00pm.³²
23. ESTA dispatchers focussed on dispatching the events as they were presenting, based on the event determinant and priority that had been provided to them, rather than reviewing the relevant associated information, as was required when it was business as unusual.³³
24. These measures, combined with the willingness of ESTA operators to come into or continue working after the end of their shifts, enabled ESTA to double the number of call-takers logged in to the system and able to process calls by 7.00pm.³⁴
25. A commensurate peak in demand was experienced by Victorian hospitals. In particular, the Emergency Departments of Geelong and Melbourne-based public hospitals saw an increase of nearly 50% in anticipated presentations and these predominantly involved respiratory-related presentations.³⁵
26. At about 8.10pm, the State Health Coordinator (DHHS) was notified that AV was experiencing a surge in demand. At that stage, neither the State Health Coordinator nor the State Health Commander (AV) knew about the cause of the surge.³⁶
27. The State Health Coordinator approved the use of private hospital beds for public patients.³⁷
28. Anecdotal evidence suggested that a large number of individuals attended community pharmacies due to lengthy waiting times for ambulances and took themselves to local emergency departments. Community pharmacies assisted with provision of medication and

³¹ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 812. It should be noted that ESTA call-takers are specifically trained in police, ambulance or fire call-taking or dispatch, with only some operators being multi-skilled. Where available, multi-skilled call-takers were transferred from fire to ambulance incidents during the TA event.

³² Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 813.

³³ Transcript page 193.

³⁴ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 812. Transcript page 186.

³⁵ See discussion of the Chief Health Officer's report at paragraphs 151 and following below.

³⁶ Transcript pages 430-431.

³⁷ Transcript page 431.

advice. Some remained open beyond their usual business hours and many redistributed salbutamol (Ventolin) to areas where it was needed.³⁸

29. Key decision-makers on the evening of 21 November 2016 were the State Health and Medical Commander (DHHS), the State Health Coordinator (DHHS)³⁹ and the State Health Commander (AV). Management and decision-making between the DHHS and AV occurred remotely, primarily through telecommunications and emails. Command and control arrangements for the TA event were formalised on the morning of 22 November 2016.⁴⁰ The Chief Health Officer was the Class 2 State Controller for TA event.⁴¹
30. At about 9.48am on 22 November 2016, the Emergency Management Commissioner requested a state coordination team meeting following advice that a number of deaths had been attributed to TA.⁴²
31. It is in the context of the thunderstorm with its associated surge in demand for emergency ambulances and over-stretched hospital emergency departments that Mr Guo and the nine other Victorians suffered exacerbations of asthma, respiratory distress and the insults which subsequently led to their deaths in the hours, days and even weeks that followed.

THE PURPOSE OF A CORONIAL INVESTIGATION

32. The purpose of a coronial investigation of a reportable death⁴³ is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.⁴⁴ Mr Guo's death clearly fell within the definition of a reportable death in section 4 of the Act as his death occurred in Victoria and was unexpected.⁴⁵

³⁸ Coronial brief page 446. I note that salbutamol is marketed in Australia as Ventolin, among other brand names. Ms McMillan (DHHS) explained that early in the morning of 22 November 2016, city hospitals contacted her as the State Health Coordinator with concerns about their diminishing salbutamol supply. Ms McMillan contacted the Pharmacy Guild, who directed her to supplemental supplies, which were purchased and distributed accordingly. There are now formalised processes to permit such purchase at any time of day or night. Transcript pages 452-453.

³⁹ These two DHHS roles had been assigned to one person. Transcript page 377.

⁴⁰ Coronial brief pages 439-440.

⁴¹ Coronial brief pages 456-457. Transcript page 379.

⁴² Transcript pages 379 and 380-381 and coronial brief pages 456-457. The Emergency Management Commissioner has a legislative responsibility for coordination, consequence management and recovery coordination. The State Coordination Team supports State coordination and the function of the Emergency Management Commissioner.

⁴³ The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria, a reportable death includes a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (sections 4(2)(a) and (b) of the Act, respectively).

⁴⁴ Section 67(1) of the Act.

⁴⁵ Section 4 of the Act.

33. The cause of death refers to the *medical* cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all the circumstances which might form part of a narrative culminating in death.⁴⁶
34. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the Coroner's prevention role.⁴⁷
35. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death that they have investigated, including matters of public health and safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health and safety or the administration of justice.⁴⁸ These are effectively the vehicles by which the Coroner's prevention role can be advanced.⁴⁹
36. It is important to stress that Coroners are not empowered to determine the civil or criminal liability arising from the circumstances in which a reportable death occurred, and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.⁵⁰

INVESTIGATION AND SOURCES OF EVIDENCE

37. This finding is based on the totality of the material the product of the coronial investigation of Mr Guo's death. That is, the initial coronial brief of evidence compiled by First Constable Michael Leger, the combined TA cluster brief compiled by my assistant, Leading Senior Constable Duncan McKenzie, from the Police Coronial Support Unit, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel.

⁴⁶ This is the effect of the authorities, for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* [1994] VSC (17 August 1994) per Harper J.

⁴⁷ The *prevention role* is now explicitly articulated in the Preamble and the purposes of the Act, compared with the *Coroners Act 1985* (Vic), where the role was generally accepted as implicit.

⁴⁸ See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

⁴⁹ See also sections 73(1) and 72(5) of the Act which requires publication of coronial inquest findings, comments and recommendations and responses respectively.

⁵⁰ Section 69(1) of the Act. However, a Coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe that an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the Act.

38. Particular mention should be made of the several prior inquiries undertaken by agencies impacted by the TA event, namely AV, ESTA, the Victorian Department of Health and Human Services (**DHHS**), as well as the Inspector General for Emergency Management (**IGEM**). These will be discussed in some detail below. Suffice for present purposes to say that, to a significant extent, the inquest involved an examination of the methodology and rigour of these prior inquiries. Such an examination is necessary in order to give effect to the exhortation to avoid unnecessary duplication of inquiries or investigations pursuant to section 7 of the Act.⁵¹
39. Furthermore, the existence of these prior inquiries or investigations expedited the coronial investigation of the death/s and facilitated a systemic approach, for example by obviating the need to obtain statements from each call-taker, each paramedic, each medical practitioner involved in the clinical management of the deceased before 21 November 2016 or in the aftermath of the TA event, and obviating the need to call each or any of them to give evidence at the inquest.
40. All of this material, together with the inquest transcript, will remain on the coronial Court file.⁵² In writing this finding, I do not purport to summarise all of the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

FINDINGS AS TO UNCONTENTIOUS MATTERS

41. There were no contentious issues surrounding Mr Guo's identity, not about the date and place of his death. I accordingly find, as a matter of formality, that Min Guo, born 26 June 1987, late of a Ballarat address, died at the Ballarat Base Hospital, 1 Drummond Street North, Ballarat Central, 3350, on 9 December 2016.

MEDICAL CAUSE OF DEATH

42. On 13 December 2016, Forensic Pathologist Dr Paul Bedford, of the Victorian Institute of Forensic Medicine (**VIFM**), reviewed the circumstances of death as reported by police to the Coroner, the relevant medical records and conducted a post mortem examination upon Mr

⁵¹ Entitled 'Avoiding unnecessary duplication' section 7 reads as follows 'It is the intention of Parliament that a coroner should liaise with other investigative authorities, official bodies or statutory officers – (a) to avoid unnecessary duplication of inquiries and investigations; and (b) to expedite the investigation of deaths and fires.' It follows that a Coroner should at least assess the methodology and rigour of the inquiries in order to ascertain if they are on all fours with a coronial investigation (which focuses on factors that caused or contributed to the death/s under investigation and/or prevention as that term is used in this jurisdiction) or at least, if they cover something of the same field.

⁵² From the commencement of the Act on 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

Guo's body. Dr Bedford noted haemorrhagic nucleoid material identified within the bronchi.⁵³
Dr Bedford noted that no underlying cardiac disease or pulmonary embolus was identified.⁵⁴

43. Dr Bedford provided a written report, dated 17 January 2017, which concluded that Mr Guo died from acute asthma⁵⁵ and expressed the opinion that his death was due to natural causes.⁵⁶
44. Toxicological analysis of post mortem⁵⁷ specimens taken from Mr Guo did not detect any commonly encountered drugs or poison thus excluding substances as a cause or contributor to his death.⁵⁸ Samples obtained from Mr Guo were not tested for common allergy markers.⁵⁹
45. Based on all of the available evidence, I find that the medical cause of Mr Guo's death is acute asthma.

PRIOR CLINICAL MANAGEMENT OF MR GUO

46. Mr Guo had a history of dermatitis,⁶⁰ a seafood and wheat allergy,⁶¹ childhood asthma usually requiring salbutamol once per week, increasing to twice daily during the hay fever season,⁶² and experienced hay fever during the pollen season.⁶³
47. Ms Fan considered that her husband's asthma was under control, that he did not often suffer from asthma, but suffered from it more frequently during hay fever season. His asthma symptoms would last for a couple of hours, and were responsive to salbutamol puffers. He had

⁵³ Dr Linda Iles, Senior Forensic Pathologist and Head of Pathology at the VIFM, explained that this signified an inflammatory response in the airways. Transcript, page 161.

⁵⁴ Coronial brief page 266.

⁵⁵ Ibid.

⁵⁶ Ibid.

⁵⁷ Transcript page 161. Professor Douglass indicated that it was her understanding that specimens were obtained from the majority of the deceased were ante mortem, at the time of death, or shortly after. She commented that specimens obtained at those times would usually be accepted as being quite reliable. Transcript page 26.

⁵⁸ Coronial brief page 267. Dr Linda Iles, Head of Pathology at the VIFM, gave evidence at inquest about post mortem examinations generally. Dr Iles explained that the post mortem sample obtained from Mr Guo was not sufficient to permit further specific allergy testing; transcript, page 161.

⁵⁹ Professor Jo Ann Douglass (**Prof Douglass**) is an immunologist and respiratory physician engaged by the Court to provide an independent expert opinion in relation to Mr Guo's death as well as the deaths of the other nine Victorians. At transcript pages 16-17 Prof Douglass lists the documents provided to her on which her expert report was based. Prof Douglass provided a written report with several appendices and a copy of her curriculum vitae, all of which were included in the coronial brief, and was the first witness to give evidence at the inquest. Prof Douglass explained that as Mr Guo died in an acute setting, and asthma treatment is the same regardless of the results of such tests, it is understandable that they were not performed. Transcript pages 77-78.

⁶⁰ Statement of Dr Vani Peddi dated 25 May 2017 coronial brief page 271.

⁶¹ Statement of Dr Linda Danvers dated 13 April 2017 coronial brief pages 278-281. Statement of Ms Yashi Fan dated 25 May 2017 coronial brief pages 282-283.

⁶² Statement of Dr Linda Danvers dated 13 April 2017 coronial brief pages 278-281.

⁶³ Statement of Ms Yashi Fan dated 25 May 2017 coronial brief pages 282-283.

a spacer that he used occasionally and took antihistamine medication which assisted with his hay fever symptoms.⁶⁴

48. Mr Fan considered that her husband would get a bit worse about once per year, and have to attend an Emergency Department (**ED**) for a few hours during hay fever season. Mr Guo did not consult with a specialist in respect of his asthma, nor did he have a regular General Practitioner.⁶⁵
49. Mr Guo attended the Ballarat Health Services ED on 6 December 2012 and 3 December 2013 for treatment of asthma exacerbations. He provided a history of asthma and fever and his medications at the time were salbutamol inhaler (asthma reliever) and Telfast (antihistamine). Salbutamol (reliever medication), Seretide (preventer medication) and prednisolone were prescribed. There does not appear to be any objective measurement of his lung function (peak flow reading) on either occasion. Following discharge, further assessment by a General Practitioner or specialist did not occur.⁶⁶
50. Ballarat Health Services did not have record of lung function or allergy testing having been performed in respect of Mr Guo.⁶⁷
51. There are two PBS Patient Summary records of Mr Guo purchasing asthma preventer medications – in January 2015 and on 8 December 2016.⁶⁸

ACCESS TO MEDICAL ATTENTION ON 21 NOVEMBER 2016 AND THEREAFTER

52. At 8.28pm on 21 November 2016, Mr Guo presented to the Ballarat Health Services ED. He was assessed by ED Consultant Dr Heather Crook. Dr Crook reports that the ED was overwhelmed with patients at the time, many of whom were being treated in accordance with asthma protocols but on chairs located in corridors, as there were insufficient ED bays to accommodate all the presenting patients. The ED also ran out of salbutamol, and had to seek additional supplies from a local chemist.⁶⁹

⁶⁴ Statement of Ms Yashi Fan dated 25 May 2017 coronial brief pages 282-283.

⁶⁵ Ibid.

⁶⁶ Statement of Dr Linda Danvers dated 13 April 2017 coronial brief pages 278-281. Prof Douglass' report 'Expert Report Asthma Cluster Deaths' dated 17 October 2017 coronial brief pages 898-899. Prof Douglass explained that peak flow readings are an objective measure of lung function and can provide evidence as to severity and the degree of recovery. They may have provided evidence that Mr Guo's presentation was due to more severe asthma than described and would have justified decisions to discharge him. Prof Douglass however notes that in her opinion, the Ballarat Health Services asthma pathways meet relevant standard of care.

⁶⁷ Statement of Dr Linda Danvers dated 13 April 2017 coronial brief pages 278-281.

⁶⁸ Prof Douglass' report 'Expert Report Asthma Cluster Deaths' dated 17 October 2017 coronial brief page 897.

⁶⁹ Statement of Dr Linda Danvers dated 13 April 2017 coronial brief pages 278-281.

53. Mr Guo reported having been well until about three hours earlier, when he developed a sudden onset of severe shortness of breath and wheezing. He did not have any recent respiratory tract infections but reported hay fever. He had used a salbutamol inhaler four times with no relief. He said reported his regular medications were Telfast and salbutamol and that he had a ‘purple [asthma] preventer’, but was not currently using it.⁷⁰
54. Mr Guo was noted to be speaking in single words only and using accessory respiratory muscles. He had widespread expiratory wheeze and generally reduced breath sounds on auscultations. On examination, his heart rate was 126 beats per minute, his blood pressure was 138/82mmHg, his respiratory rate was 18 breaths per minute and his peripheral oxygen saturation was 97% on room air.⁷¹
55. Mr Guo was commenced on the ‘asthma protocol’. Following the second dose of salbutamol, Mr Guo appeared more comfortable. He was able to speak in short sentences, was no longer using accessory muscles to breathe and had increased breath sounds on auscultation, although the expiratory wheeze persisted.⁷²
56. Mr Guo was diagnosed with moderate asthma, which was responding to treatment. He was treated with salbutamol inhalers and 50mg oral prednisolone, in line with the asthma protocol. By 10.50pm, he appeared well, with no shortness of breath or increased work of breathing. His chest was clear on auscultation.⁷³ Mr Guo was provided with a script for salbutamol puffers and was discharged home, departing the ED at 11.00pm.⁷⁴
57. Ms Fan spent Sunday, 4 December 2016 with her husband in Melbourne. He appeared to be in good health, and Ms Fan could not recall him using his salbutamol inhaler at all over that weekend. As usual, he returned to Ballarat that evening.⁷⁵
58. Mr Guo self-presented to Ballarat Hospital ED again at 9.34am on 8 December 2016. He was seen by ED Intern Dr Todd. He reported an onset of shortness of breath the previous evening, with associated difficulty speaking. He had minimal relief with eight puffs of salbutamol over

⁷⁰ Statement of Dr Linda Danvers dated 13 April 2017 coronial brief, pages 278-281.

⁷¹ Statement of Dr Linda Danvers dated 13 April 2017 coronial brief, pages 278-281. Prof Douglass notes that no peak flow measure was obtained, and that it was evidence from the ED notes that Mr Guo had a slow response to salbutamol inhaler. Prof Douglass also notes that there is no record of referral for follow-up and that the ED discharge prescription is for salbutamol only, with no prescription for a preventer; Prof Douglass’ report ‘Expert Report Asthma Cluster Deaths’ dated 17 October 2017 coronial brief page 897.

⁷² Statement of Dr Linda Danvers dated 13 April 2017 coronial brief, pages 278-281.

⁷³ Ibid.

⁷⁴ Ibid. Prof Douglass observed that Dr Todd’s notes in Mr Guo’s medical record were ‘meticulous’; Prof Douglass’ report ‘Expert Report Asthma Cluster Deaths’ dated 17 October 2017 coronial brief page 899.

⁷⁵ Statement of Ms Yashi Fan dated 25 May 2017 coronial brief pages 282-283.

one minute. He reported no cough or viral symptoms and said he was not using an asthma preventer.⁷⁶

59. On examination, Mr Guo was able to speak in full sentences, his heart rate was 110 beats per minute, his blood pressure was 134/90mmHg, his respiratory rate was 20 breaths per minute and his peripheral oxygen saturation was 96% on room air. Widespread inspiratory wheeze was heard on auscultation.⁷⁷
60. Mr Guo was diagnosed with a non-infective exacerbation of asthma. He was commenced on the asthma protocol with regular inhaled salbutamol and 50mg oral prednisolone.⁷⁸
61. At 12.00pm, Mr Guo was transferred to the Short Stay Unit (SSU) for ongoing observation. He was administered three further doses (12 puffs as per asthma protocol) of salbutamol whilst in the SSU, at 12.21pm, 12.50pm and 2.40pm and four puffs of Atrovent⁷⁹ at 12.14pm.⁸⁰
62. Mr Guo's objective vital observations measures whilst in the SSU were recorded as a heart rate of 110 breaths per minute and his oxygen saturation was 96% on room air. Prof Douglass suggested that neither of these measurements would suggest he was completely well.⁸¹
63. At 3.30pm, Mr Guo was reviewed by a doctor. He reported feeling much better. A mild expiratory wheeze was heard on auscultation.⁸² He was assessed as fit for discharge home and was provided with a prescription for oral prednisolone, 50mg daily, and fluticasone/salmeterol inhaler to use twice daily, as a preventer. He was advised to continue treatment and consult with a General Practitioner for follow up and the development of an asthma action plan. Mr Guo was provided with a copy of the SSU discharge summary, and advised to return to the ED if he experienced further shortness of breath or breathing difficulty. He was discharged at 3.55pm.⁸³ The weather that night was cold following a mild day with high humidity.⁸⁴

⁷⁶ Statement of Dr Linda Danvers dated 13 April 2017 coronial brief pages 278-281.

⁷⁷ Ibid. Prof Douglass again notes that no peak flow measure was obtained at this time. Prof Douglass' report 'Expert Report Asthma Cluster Deaths' dated 17 October 2017 coronial brief page 897.

⁷⁸ Statement of Dr Linda Danvers dated 13 April 2017 coronial brief pages 278-281.

⁷⁹ Atrovent (ipratropium bromide) is indicated as a bronchodilator for maintenance treatment of bronchospasm associated with asthma and chronic obstructive pulmonary disease;

<https://www.ebs.tga.gov.au/ebs/picmi/picmirepository.nsf/pdf?OpenAgent&id=CP-2009-PI-01145-3&d=201808301016933> accessed 30 August 2018.

⁸⁰ Statement of Dr Linda Danvers dated 13 April 2017 coronial brief pages 278-281.

⁸¹ Prof Douglass' report 'Expert Report Asthma Cluster Deaths' dated 17 October 2017 coronial brief page 897.

⁸² Statement of Dr Linda Danvers dated 13 April 2017 coronial brief pages 278-281.

⁸³ Statement of Dr Linda Danvers dated 13 April 2017 coronial brief pages 278-281.

⁸⁴ Prof Douglass' report 'Expert Report Asthma Cluster Deaths' dated 17 October 2017 coronial brief page 897.

64. In the early hours of 9 December 2016, Mr Guo arrived at the Ballarat Hospital *via* taxi. It was noted that the taxi had been called at 1.32am and picked him up at 1.42am from his home. Mr Guo was waiting at the front door and the taxi driver observed that he was bent over.⁸⁵
65. Mr Guo got into the front seat of the taxi and asked to be taken to a hospital. The driver asked if wanted to go to Ballarat Hospital and he agreed, asking the driver to go quickly. Mr Guo opened the window, and appeared to squirm in the passenger seat. At one point, the taxi driver described Mr Guo was almost trying to sit in the footwell.⁸⁶ He then noticed Mr Guo ‘tense up’. Thereafter, Mr Guo did not say anything, and did not respond to his questions.⁸⁷
66. At 1.47am, having arrived at Ballarat Hospital, the taxi driver requested assistance from reception staff to move Mr Guo from the taxi to the ED, as he was unresponsive. Mr Guo was taken to the resuscitation bay, arriving at 1.52am and a cardiac rhythm check showed that he was already in asystole.⁸⁸
67. CPR was commenced at 1.54am, and a Code Blue was called. A Laryngeal Mask Airway was initially applied, and then replaced with an endotracheal tube (ETT) following the arrival of an Anaesthetic Registrar. A decision was made to re-intubate however as there were no breath sounds detected and capnography suggested incorrect placement of the ETT. An ETT was then successfully placed at 2.18am, however there were no breath sounds and capnography was not suggestive of gas transfer. Mr Guo’s oxygen saturation remained unchanged at less than 50%.⁸⁹
68. At 2.41am, Mr Guo’s oxygen saturation was 19% and his pupils were fixed and dilated and at 2.43am, the decision was made to cease resuscitation, and Mr Guo was pronounced deceased.⁹⁰

THE FOCUS OF THE CORONIAL INVESTIGATION

69. At a mention hearing on 19 October 2017 and based on the investigation to date, I foreshadowed the scope of the inquest and indicated those matters that I did not propose to further investigate.⁹¹ In large part the latter was informed by section 7 of the Act and the inquiries or

⁸⁵ Coronial brief pages 284-285. Statement of Dr Linda Danvers dated 13 April 2017 coronial brief pages 278-281.

⁸⁶ Coronial brief pages 284-285.

⁸⁷ Coronial brief pages 284-285

⁸⁸ Statement of Dr Linda Danvers dated 13 April 2017 coronial brief, pages 278-281.

⁸⁹ *Ibid.*

⁹⁰ *Ibid.* Prof Douglass notes that ‘[t]here are no reports of trials of apnoea during this resuscitation process’. Prof Douglass’ report ‘Expert Report Asthma Cluster Deaths’ dated 17 October 2017 coronial brief page 898.

⁹¹ The parties legally represented at the mention hearing were (in no particular order) Eastern Health, Northern Health, ESTA, AV, the DHHS and the family of Ms Hope Carnevali (Marsh). Several other family members of other deceased were also in attendance but did not seek leave to formally participate in the mention hearing.

investigations that had been undertaken by other entities to date which were briefly canvassed at the mention hearing.

70. I informed the parties that it was my view that the identity and medical cause of death of each of the deceased were not contentious. Furthermore, that in the context of the surge in demand for emergency resources in the immediate aftermath of the TA event, I did not propose to investigate the adequacy of the clinical management and care provided to the deceased.⁹² I indicated that it was apparent from the various investigations/reviews undertaken and Prof Douglass' expert report that there had been a lot of learnings since the TA event,⁹³ but that I intended to approach the BOM to identify a witness/meteorologist who could speak to the current understanding of the TA phenomenon from their perspective and to testify about the extent to which they could be able to contribute to a public warning system.⁹⁴
71. At the mention hearing, Counsel representing the family of Ms Carnevali (Marsh) raised concerns about the adequacy of ESTA's response to the emergency telephone call placed by them, and in particular the repeated assertions by the ESTA call-taker that an ambulance was on its way when it was not. I assured the family that this issue had been identified in the various inquiries/investigation and had already been addressed.⁹⁵
72. The scope and/or focus of the coronial investigation articulated at the mention hearing have not changed significantly since and were:⁹⁶
- (a) appraisal of the rigour of the inquiries/investigation already undertaken;
 - (b) what was known about the TA phenomenon prior to 21 November 2016 and by whom?;
and
 - (c) what has been learnt since the events of 21 November 2016 and the days following in terms of:

⁹² Transcript of mention hearing dated 19 October 2017 page 10. (Reiterated at Inquest Transcript page 14.) I note that the family of Mr Priyantha Peiris had raised concerns about the clinical management and care provided to him at the Northern Hospital. Statement of Mrs Ann Peiris dated 15 February 2017 coronial brief pages 239-243.

⁹³ Transcript of mention hearing dated 19 October 2017 page 10.

⁹⁴ Transcript of mention hearing dated 19 October 2017 page 12.

⁹⁵ Transcript of mention hearing dated 19 October 2017 page 12. The court was subsequently informed that the family did not propose participating in the inquest. I note that Ms Voong expressed similar concerns at the directions hearing on 18 May 2017 at page 13, as did Mrs Peiris in her statement dated 15 February 2017 at coronial brief pages 239-243.

⁹⁶ Transcript of mention hearing dated 19 October 2017 page 8 and inquest transcript page 14. Also reiterated at the directions hearing held on 18 May 2018, shortly before the commencement of the inquest – see transcript of the directions hearing at page 5. I note that the parties represented at the directions hearing on 18 May 2018 were the same parties represented at inquest – ESTA, AV, DHHS and BOM.

- (d) the optimal clinical management and care of people with asthma and/or hay fever generally and in anticipation of a TA event;
- i. the ability to predict or forewarn the public of a similar event in the future and the form such warnings should take;
 - ii. the preparedness of ESTA and AV in particular for another similar surge in demand for ambulance services; and
 - iii. the preparedness of Victorian public hospitals for another similar surge in numbers presenting to emergency departments.
73. Most of the inquiries and investigations already undertaken by the parties are in the public domain and therefore readily accessible in their entirety. While I do not propose to detail the inquiries and investigations already undertaken by the parties in this finding, a brief outline of key findings and recommendations is included for completeness.

EMERGENCY SERVICES TELECOMMUNICATIONS AUTHORITY (ESTA)

74. Michelle Marie-Anne Smith (Ms Smith) is the Executive Manager of Operations at the Tally Ho State Emergency Communications Centre with oversight of the Ambulance Victoria portfolio. Ms Smith provided two statements and gave evidence at the inquest on the ESTA's behalf. Ms Smith explained that the IGEM has responsibility for oversight of the ESTA's non-financial performance and therefore, whenever there is a significant event, IGEM is required to investigate the ESTA's performance and the ESTA is required to cooperate with this investigation.⁹⁷
75. Additionally, ESTA decided to conduct an independent post-incident review to investigate their response to the TA event on the night so as to identify any learnings they could take from the event [the ESTA review]. They engaged Price Waterhouse Coopers (**PWC**), in particular for their data analytical capacity, to assist them to produce an accurate representation of what occurred on the night.⁹⁸ A copy of the ESTA review entitled 'Emergency Services Telecommunications Authority – Thunderstorm Asthma – Post Incident Review' and dated January 2017 is included in the coronial brief in its entirety.⁹⁹

⁹⁷ Transcript pages 176-177.

⁹⁸ Transcript page 177.

⁹⁹ Coronial brief at pages 826-868.

76. Amongst its key initial observations, the ESTA review identified a number of positives. They noted that experienced staff showed initiative to implement ad hoc process to reduce the impact of the surge; there was diligent inter-agency collaboration at ESTA with AV, MFB and Victoria Police; and a mature major event activity summary report including quality review of events, was prepared in real time.¹⁰⁰
77. Key initial observations of a more negative nature were also made. These included:
- (a) insufficient resources available to respond to the surge;
 - (b) escalation and notification processes were not followed and not performed in a timely way;
 - (c) the draft critical incident response plan was found to be overly focused on event type rather than increase number of calls and therefore not formally invoked;
 - (d) the absence of established data based triggers led to instinctive decision making which may create an over reliance on key individuals; and
 - (e) the lack of a sentinel dashboard to provide early indication of a likely surge and triggers for activating a response.¹⁰¹
 - (f) Not surprisingly, the ESTA review identified areas for improvements analogous to the deficiencies identified and prioritised those from highest to lower priority.¹⁰² Among the areas for improvement considered of the highest priority were:
 - (g) the development of strategies to increase workforce availability and flexibility for rapid response that addresses people, technology/facilities and process;
 - (h) increased call-taking and dispatching skills/multi-skilling across higher demand channels and eliciting quicker response from surge workforce;

¹⁰⁰ Coronial brief page 829.

¹⁰¹ Ibid. The Executive Summary at coronial brief page 828 includes the following – ‘*The response of ESTA staff was commendable – aided by practical decision making on the ground by experienced people and, fortuitously, by the vent commencing during a change in shift which meant that some additional staff were on site to respond to heightened call activity. Performance analysis has highlighted the criticality of being able to rapidly scale up the number of staff within the State Emergency Control Centres to handle the additional call volume and therefore the importance to ESTA of rapid access to its staff and additional resourcing to respond to events similar/greater in magnitude or more sustained in nature. A number of other observations led to recommendations to refresh/strengthen critical incident response planning, escalation procedures and dashboard reporting/early warning systems...*’

¹⁰² Coronial brief pages 830, 856 and following.

- (i) implementing a real-time dashboard to support timely decision making within the State Emergency Control Centres; and
- (j) developing triggers and procedures for activation during severe/extreme events (including recorded voice announcements, ‘urgent disconnect’ and the provision of ambulance estimated time of arrival information, subject to the approval of relevant stakeholders).¹⁰³

78. Ms Smith was on duty at the Tally Ho State Emergency Communications Centre on 21 November 2016. Her evidence about ad hoc arrangements made as the enormity of the surge in calls for ambulances was becoming apparent is encapsulated above.¹⁰⁴ Ms Smith also gave evidence about the ESTA’s role, its relationships with AV in particular and about changes made by the ESTA in the aftermath of the TA event aimed at improving the ESTA’s performance in future.

79. ESTA was established on 1 July 2005 by the *Emergency Services Telecommunications Authority Act 2004* (Vic) (**the ESTA Act**) as a statutory authority providing State-wide around the clock emergency call-taking and dispatch services for police, fire, ambulance and the VicSES. In the 2017 financial year, the ESTA managed close to 2.6 million calls and dispatched emergency resources to over 2.1 million events.¹⁰⁵

80. The ESTA call-takers receive calls for ambulance assistance from the public *via* Telstra’s dedicated emergency ‘000’ number. The ESTA delivers services to each of the emergency services in accordance with service specific administrative arrangements made pursuant to the ESTA Act. AV is required to provide the ESTA with its service delivery requirements (**SDRs**), which comprise Communications Standard Operating Procedures (**CSOPs**) and other supporting documents.¹⁰⁶

81. Using these source documents, the ESTA develops its standard operating procedures (**SOPs**) which, effectively, operationalise the SDRs, providing clear and concise instructions to all ESTA staff operating the CAD system, in particular ambulance call-takers and dispatchers.¹⁰⁷

¹⁰³ Ibid. See also the evidence of Ms Smith and A/Prof Stephenson.

¹⁰⁴ See Introduction, especially at paragraphs 7 and following and transcript page 186 and following. This includes the calls serviced on 21-22 November 2016.

¹⁰⁵ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 803. Transcript pages 175 and following.

¹⁰⁶ Ibid.

¹⁰⁷ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 804. Ms Smith explained that the SDRs are a statutory requirement under the ESTA Act. Transcript page 175.

82. Through their SDRs AV require the ESTA to employ a formal, structured question and answer methodology established by the International Academies of Emergency Medical Dispatch [the Academy]. Originally manual and entitled the Medical Priority Dispatch System, the software version of the protocol is currently known as ProQA. Based on a caller's main reported problem, the call-taker selects from one of 32 ProQA protocols which then prescribes a series of questions designed to elicit information relevant to the problem. Based on those answers, ProQA arrives at an event determinant (or event type), which the call-taker will input into the CAD system for dispatch. The event determinant is used to determine the priority to be given to dispatching an event in accordance with an AV sanctioned response grid. ProQA also provides call-takers with post-dispatch and, depending on the event, pre-arrival instructions to be relayed to the caller.¹⁰⁸
83. As one indication of the impact of the surge, Ms Smith's testified that during the TA event, the ESTA was unable to meet its metropolitan call-answer speed and performance target of five seconds for most of the received calls. The longest call duration between the '000' call to Telstra and an ESTA call-taker answering the call was determined to be four minutes and 36 seconds. Ms Smith's evidence was that the cause of these delays was that every ambulance call-taker was already engaged in a live call and unavailable to answer new incoming calls.¹⁰⁹
84. Ms Smith gave evidence about a number of aspects of existing ESTA/AV processes that were identified by the inquiries and investigations already undertaken as having a negative impact on ambulance call-taking during the TA event and represented potential areas for future improvement.
85. At the time of TA event, ProQA required call-takers to remain on the line when the call was coded Priority 1 and the patient was either not alert, unstable or worsening. In such circumstances the call-taker was to provide pre-arrival instructions and to monitor changes in the patient's state.¹¹⁰ The impact of the surge of calls for ambulances on 21 November 2016 combined with the call duration associated with monitoring and reassessing a patient's condition meant that call-takers could not disengage from calls to take other incoming calls,

¹⁰⁸ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief pages 804-805. Transcript pages 240-243.

¹⁰⁹ Transcript pages 247-248, 252.

¹¹⁰ Exhibit D, statement of Michelle Smith dated 22 September 2017 page 20. I am advised that the majority of events requesting ambulance assistance for shortness of breath with respiratory or asthma-related symptoms are Priority 1 events by default.

even where the caller was comfortable monitoring the patient on the basis that they would call back if there was any change while waiting for an ambulance.

86. AV subsequently endorsed changes authorising call-takers to disconnect from Priority 1 events provided there was a second party with the patient and the patient was not unstable or worsening, in which case the call-taker is to stay on the line.¹¹¹ Regardless, call-takers are still required to provide all relevant pre-arrival instructions prior to disconnecting.¹¹²
87. To similar effect, ProQA had embedded “urgent disconnect” scripting which provides clear consistent scripting to provide to callers when disconnecting from calls to answer other calls during times of high workload. As at 21 November 2016, there was no approved policy to support the use of the urgent disconnect scripting¹¹³ and, in any event, as envisaged in ProQA, it is only to be used in limited medical emergencies and unlikely to encompass calls made by or on behalf of any of the deceased the subject of this inquest.¹¹⁴
88. In February 2017, the ESTA advised the IGEM that it was working with AV to develop the triggers, workflows and script and governance require to employ urgent disconnect during a surge of calls.¹¹⁵ As at the time of the inquest, Ms Smith gave evidence that AV had provided a direction around deploying urgent disconnect which was being incorporated into the ESTA’s draft policy, and once formally endorsed, call-takers would be trained accordingly and urgent disconnect available as an option during future surges.¹¹⁶
89. Thought to allay callers’ concerns, AV has mandated that the ESTA’s ambulance call-takers use specific phrases during ‘000’ calls and specific ‘exit scripts’ when they are ending a call. According to Ms Smith, the phrases and exit scripts have developed organically over many years in response to feedback and testing in the live call-taking environment and, relevantly,

¹¹¹ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 823. As ESTA is Academy-accredited, it has to comply with academy standards unless there is a local policy in place endorsing otherwise, with sign off from the AV medical director.

¹¹² Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 824.

¹¹³ Ibid and transcript page 248. Ms Smith’s evidence was that she and her AV counterpart Ms Carmen Petrotta considered the urgent disconnect policy, inter alia, and decided that they could not safely deploy the policy for reasons including absence of approval and lack of staff training.

¹¹⁴ Relevantly, urgent disconnect should not be considered in the presence of priority symptoms (abnormal breathing, chest pain, decreased level of consciousness or serious haemorrhage) where the patient’s condition could be life threatening, including ... having an allergic reaction which is worsening or when the patient is unstable or not alert. Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 824.

¹¹⁵ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 825.

¹¹⁶ Transcript pages 252-253.

call-takers have no discretion to deviate from the mandated exit script and are not permitted to provide callers with an estimated time of an ambulance’s arrival.¹¹⁷

90. As at 21 November 2016, the mandated exit script for Priority 0 and Priority 1 calls was “the ambulance is on its way”.¹¹⁸ Ms Smith explained that in business as usual circumstances, this is accurate information as an ambulance would be either be dispatched immediately or would be about to be dispatched, or would be diverted from another event thus prioritising Priority 0 and Priority 1 events. However, during the TA event when the AV fleet was so significantly depleted, dispatch of ambulances to these high priority events had generally not occurred and would not occur for some time, rendering the exit script wholly inaccurate (and arguably misleading).¹¹⁹
91. In February 2017, in response to callers experiencing long waiting times during the TA event and reported community uncertainty about whether to wait for an ambulance or arrange their own transportation to hospital, AV approved a revision of its CSOPs in consultation with the ESTA. The resultant changes to exit scripts are summarised in the table below:¹²⁰

	Script as at 21 November 2016	Updated Scripts
Surge	N/A	We are experiencing an extremely high demand for ambulance resources at present. If someone is available to provide medical help or you can seek alternative medical assistance, please do so. If you decide to seek alternative medical assistance, please call back to advise. ¹²¹

¹¹⁷ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief pages 820-821.

¹¹⁸ Ibid.

¹¹⁹ Ibid and transcript pages 207-210.

¹²⁰ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 822. Note that the prohibition on call-takers providing an estimated time of arrival of an ambulance continues. Transcript page 213.

¹²¹ Ms Smith explained that this recorded announcement *when implemented* would be heard by a member of the public prior to the Telstra ‘000’ operator answering a call. Transcript pages 204-205. She explained that the option of using a recorded voice announcement was considered around 9.30pm on 21 November 2016, but was not implemented as calls had already peaked and they did not want to discourage callers from remaining on the line, for example, to receive CPR instructions.

Priority 0	The ambulance is on its way.	Help is being arranged.
Priority 1	The ambulance is on its way.	Help is being arranged. ¹²²
Priority 2	I've sent the details to the dispatcher to organise the next available ambulance.	I've sent the details to the dispatcher to organise the next available ambulance.

92. The surge script is an innovation as there was no surge script in place on 21 November 2016. The script can only be deployed by the ESTA call-takers with AV authorisation, and when deployed, would be used for all '000' calls during a surge.¹²³ The hope is that the surge script and changes to the Priority 0 and Priority 1 exit scripts will better equip callers with information to enable them to make independent decisions about their health emergency during periods of surge or high demand for emergency services.¹²⁴
93. Another proposed change to ProQA relates to the instructions call-takers give to callers about CPR pending ambulance arrival. In the usual course of administering CPR for cardiac or respiratory arrest, instructions are to administer compressions before ventilations. However, pursuant to the Academy's guidelines and protocol, CPR instructions for patients with a history of asthma in cardiac arrest provided that ventilations should precede the commencement of compressions.¹²⁵ According to Ms Smith's evidence, although this remains the position under the current Version 12.2 of ProQA, the Academy has advised that Version 13 will provide for modified CPR instructions such that the call-taker is to instruct to provide compressions first for patients with a history of asthma in cardiac arrest if a medical decision to that effect has been made.¹²⁶

¹²² Ms Smith explained that the 'help' could be from an MFB unit where the event was within an **EMR** Zone or a community ambulance officer, and not necessarily an ambulance in the first instance, so the script did not specify the type of help. Transcript pages 248-250.

¹²³ Transcript pages 212-213. As at the date of the inquest, Ms Smith advised that the surge script had not been used.

¹²⁴ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 822. Ms Smith also explained that the changes are anticipated to reduce the likelihood of callers placing further calls seeking estimated time of ambulance arrivals during periods of high demand, thereby freeing up further call-taking capacity.

¹²⁵ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 825. As at September 2017, Version 13 was anticipated to be deployed in 2018. In the meantime, the ESTA has tabled a request to AV to consider endorsing this (anticipated) change to CPR instructions.

¹²⁶ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 825.

94. As at 21 November 2016, the ESTA had a Critical Incident Response Plan (CIRP) which enabled the ESTA to escalate its functions in response to a critical incident.¹²⁷ The CIRP was developed in late 2009 in response to the Black Saturday Bushfires of February 2009,¹²⁸ aligns with the State Emergency Management Plan, the State Health Emergency Response Plan and AV's Emergency Response Plan and aims to ensure that adequate planning and coordination occurs to reduce the impact of demand surges on the ESTA's service provision. Reflective of its genesis, the ESTA's CIRP was designed with fire and/or weather-related incidents in mind such that a severe fire or storm could trigger the CIRP. The expectation was that these would lead to an increased demand on police, fire and VicSES resources.¹²⁹
95. The CIRP did not envisage a health-related emergency, even if weather-related as was the TA event.¹³⁰ On 21 November 2016, the CIRP was not formally activated. It should be acknowledged, however, that the ESTA staff focused on escalation and meeting surge demands and undertook a number of steps consistent with the CIRP.¹³¹
96. Following the ESTA review and the IGEM review, the ESTA committed to review its CIRP to ensure that events requiring CIRP activation are clearly defined and that activation occurs at agreed time points. Also, the ESTA has also incorporated a health sub-plan into its CIRP. According to Ms Smith, the most significant change is that activation of the CIRP is no longer confined to fire and weather events but extends to natural disasters, siege situations and any event that impacts service delivery, even if the underlying cause of the event is unknown during the surge.¹³²
97. Moreover, the CIRP under its current iteration can be triggered either externally or internally by those on the ground.¹³³ Ms Smith testified that it was likely that the primary trigger for the CIRP activation would still be email notification or contact from an external agency advising of an event likely to impact emergency services, for example the BOM advising of a forecast weather event, or the DHHS advising of a health-related outbreak. However, the CIRP can also

¹²⁷ Transcript page 199.

¹²⁸ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 817. ESTA's CIRP was updated in 2014 and 2016.

¹²⁹ Transcript page 199.

¹³⁰ Transcript page 199.

¹³¹ Transcript pages 199-200, 247. Ms Smith testified that although internal and external notifications that now occur with CIRP activation did not occur as prescribed during the TA event, '*...otherwise all the actions that would have been required out of the CIRP around staffing levels and everything else were enacted on the night*'.

¹³² Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 819. Transcript page 200.

¹³³ Transcript pages 219-220.

be activated internally by the ESTA staff where a surge event becomes apparent to the ESTA staff through a spike in '000' calls or calls of a particular type.¹³⁴

98. Ms Smith testified about a number of the ESTA's processes relevant to staffing levels that had been improved following the TA event, largely but not entirely software-related. First, ESTA updated its 'Whispir' text messaging templates, in particular the messages sent to staff requesting they work overtime (or report urgently for work) so that they are better informed about the reasons underlying the request, presumably in the hope that they will be more responsive in exigent circumstances such as another TA event.¹³⁵
99. A second 'Whispir' application, developed since the TA event, is 'One Click', a red button with pre-formatted staged messages for notification to designated internal and external stakeholders of surge events. Once pressed, the application instantly notifies what is unfolding via Whispir's text messaging and email service, ensuring prompt notification of external stakeholders.¹³⁶
100. Previously, the ESTA's staffing levels were determined by the Work Force Management Team (WFMT) applying its experience generally, any particular demands relevant to the period in question (for example New Year's Eve and the AFL Grand Final are generally busy times for '000' call takers) and applying an overlay to address anticipated demand arising from weather forecasts (previously anticipated to increase demand for police and VicSES resources). Since the TA event, the potential for increased demand for ambulances has been recognised.
101. Currently, the DHHS is responsible for notifying the ESTA of a forecast TA event.¹³⁷ When the ESTA receives a high alert for TA from the DHHS, the WFMT uses this information to apply an overlay¹³⁸ to the calls predicted to be received during the high alert period, and takes steps to increase staffing levels accordingly, in anticipation of increased demand.¹³⁹ The

¹³⁴ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 818 and transcript page 200. Ms Smith noted that the CIRP was activated in January and February 2017 in response to the Bourke Street and Essendon Airport incidents, respectively, with alerts being sent to various emergency services organisations. Transcript page 202.

¹³⁵ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 819.

¹³⁶ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 820. Ms Smith explained that external stakeholders include the IGEM, Emergency Management Victoria [EMV] and DHHS. Transcript page 203. A/Prof Stephenson from AV described the 'One Click' application as '*very important*' in providing an '*early warning system in essence that there's an increase in demand*' regardless of cause, to facilitate appropriate response. Transcript page 309.

¹³⁷ Transcript page 200.

¹³⁸ Ms Smith explained that an 'overlay' functions to re-forecast expected emergency services call volumes. Transcript page 221.

¹³⁹ Ms Smith explained that forecasters in the WFMT look at the number of forecasted calls together with the average handling time and service target levels and compute the number of staff required. Transcript page 187.

WFMT can also recommend that the CIRP be activated in the absence of a specific alert from an external agency.¹⁴⁰

102. The ESTA also uses a variety of software tools to monitor real-time information relating to events of a particular type, call activity levels and resource demands, enabling the ESTA to validate alert information received from the DHHS and the BOM. For example, regional Situational Awareness Dashboards provide real-time and interactive information regarding pending¹⁴¹ and active events and AV unit availability. The dashboards are displayed on large screens throughout the communication centres and enable the ESTA to quickly identify a surge in demand and respond accordingly.¹⁴²
103. The ESTA has also developed greater capacity to develop systemic intelligence. For example, the ESTA now monitors pollen levels, as informed by external agencies, recording this information against the impact it has on the demand for ambulances. This enables the ESTA to identify when an event-type cluster is arising in a particular geographical area.¹⁴³

AMBULANCE VICTORIA (AV)

104. Ambulance Victoria's Chief Executive Officer also commissioned an internal review of AV's TA related activities. The review entitled 'The Ambulance Victoria Debrief and Review Final Report Thunderstorm Asthma – November 2016' is dated 28 August 2017 (**the AV review**)¹⁴⁴ was undertaken by AV's Emergency Management Unit with oversight from former Victorian Police Deputy Commission, Mr Timothy Cartwright, and a copy is included in the coronial brief.¹⁴⁵
105. The AV review identified a number of positive steps taken during the TA event which increased its capacity, by moving quickly from managing a routine increase in demand, to an extreme demand surge over a wide geographical area. This included recalling operational staff and requesting additional resources from AV's six contracted non-emergency patient transport providers, mobilising key partner organisations such as the MFB to provide first responder

¹⁴⁰ Exhibit E, supplementary statement of Michelle Smith dated 22 June 2018 pages 2-4. According to Ms Smith, in practice, with the TA forecasting tools developed since the TA event, if a TA event was forecast, a CIRP could be activated and increased staffing would be arranged in advance of the event. Transcript pages 221-223.

¹⁴¹ A/Prof Stephenson explained that AV 'pending' events refer to cases where an ambulance cannot be dispatched at that time due to resource unavailability. Transcript page 259.

¹⁴² Exhibit E, supplementary statement of Michelle Smith dated 22 June 2018 pages 5-9.

¹⁴³ Exhibit D, statement of Michelle Smith dated 22 September 2017 coronial brief page 820. Transcript page 247.

¹⁴⁴ Coronial brief pages 748-801.

¹⁴⁵ Statement of Mr Justin Dunlop dated 7 September 2017 coronial brief page 746.

support, Victoria Police to conduct welfare checks, and the Field Emergency Medical Officer program to provide in field responders and assistance at hospitals.¹⁴⁶

106. The key recommendations emanating from the AV review are that AV:
- (a) approach the DHHS as the control agency for public health to develop an early warning/predictive system for TA and other public health emergencies;
 - (b) utilise its Emergency Response Plan (**ERP**) for demand surge of ‘000’ calls;
 - (c) develop a public messaging plan to inform the community when AV is experiencing high demand; and
 - (d) approach Emergency Management Victoria (**EMV**) regarding use of Emergency Alert and the State Emergency Warning System by AV for demand surge where they are not the control agency.
107. Briefly, and without doing justice to the detail of the AV review, 34 recommendations were made in support of the key recommendations, all aimed at improving AV’s capability to identify and respond to similar surges in demand in the future. As at 1 September 2017, AV had already commenced work on all 34 recommendations, with 17 already implemented and a further 15 planned to be implemented by 1 October 2017.¹⁴⁷
108. Adjunct Associate Professor Michael Stephenson (A/Prof Stephenson)¹⁴⁸ is AV’s Executive Director of Emergency Operations and gave evidence at inquest, including speaking to the statement provided by his colleague Mr Justin Michael Dunlop, AV’s Acting Director, Emergency Management at the time he made a statement for the coronial brief.¹⁴⁹
109. Prior to the night of 21 November 2016 and speaking on behalf of AV, A/Prof Stephenson testified that he had not heard of TA, nor had he heard anyone else in AV use the term. In the aftermath, he first heard the term used during a phone call and then an internet search took him to some published literature and a newspaper article about an occasion in 2010 thought to be a

¹⁴⁶ Executive Summary to the AV review at coronial brief page 751.

¹⁴⁷ Statement of Mr Justin Dunlop dated 7 September 2017 coronial brief page 747. As at that date, recommendations 5 and 26 were outstanding. The former related to post-incident reporting and was expected to be implemented by 1 October 2018 and the latter relating to AV’s use of a smartphone application to mobilise registered community responders was scheduled to be implemented by 31 January 2018.

¹⁴⁸ Transcript page 256. A/Prof Stephenson is an Associate Professor at Monash University in two departments – Epidemiology/Preventative Medicine and Community Health/Paramedicine.

¹⁴⁹ Transcript page 257. Statement of Mr Justin Michael Dunlop dated 7 September 2017 coronial brief page 745.

TA event. Subsequent discussion in AV about that 2010 incident suggested a ‘sustained spike in workload but not to the point that the service was overwhelmed’.¹⁵⁰

110. According to A/Prof Stephenson, at a broader level, the coincidence of weather changing and ambulance paramedics noting an increase in respiratory cases was not unknown and indeed somewhat normalised. Anecdotally, paramedics would say that it happens but never before to the extent that it was overwhelming in terms of the service AV provide.¹⁵¹
111. As regards AV’s progress with the recommendations made by the AV review, A/Prof Stephenson testified that as at July 2018, all but three of the recommendations had been implemented. One of the outstanding recommendations relates to post-incident reporting and has no bearing on AV’s response to future TA events. The other two outstanding recommendations relate to a public messaging plan to inform the community when AV is experiencing a high demand and the development of a public messaging plan to inform the community of relevant health related emergencies.¹⁵²
112. According to A/Prof Stephenson, as the DHHS is the controlling or lead agency for health-related emergencies, there is a legal impediment to AV acting unilaterally in this space and AV have an arrangement for the DHHS to send out community messages on their behalf. As at the date of the inquest, AV had an in-principle agreement with the Commissioner of Emergency Management that AV will have the authority to directly remit their own messaging in the future. In the interim, in the event of another TA event or surge in demand of a different (or even unknown) aetiology, A/Prof Stephenson was ‘*entirely satisfied*’ that those warnings would go out as envisaged by AV.¹⁵³
113. AV has a range of government and internal key performance indicators and targets that the IGEM considered in its Final Report. A number of these relate to timeliness of the AV response. A/Prof Stephenson conceded that AV resources were overwhelmed during the TA event, despite positive ad hoc steps taken during the TA event to bolster resourcing. By any measure, but particularly on the basis of sheer demand, the number of cases pending and the relatively high acuity of cases, AV was unable to meet its targets for the delivery emergency ambulance assistance.¹⁵⁴

¹⁵⁰ Transcript pages 257-259.

¹⁵¹ Transcript page 258.

¹⁵² See Recommendation 26 of the AV review at coronial brief page 798 and transcript pages 267 and following.

¹⁵³ Transcript page 267-268.

¹⁵⁴ Coronial brief page 461 and transcript pages 383-394.

114. With respect to AV's performance target of the number of ambulances that arrive at Code 1 events within 15 minutes, the Victorian target is 85%. During the five weeks prior to the TA event, AV was 5% below the performance target on average. On 21 November 2016, AV attended only 57.1% of Code 1 cases within their 15 minute target, due to unprecedented demand. This improved to 70.6% on 22 November 2016.¹⁵⁵
115. A/Prof Stephenson explained that AV's Emergency Response Plan (ERP) is the governing mandate dictating AV's response to incidents in terms of escalation, response and recovery and provides staff with checklists relevant to their roles to ensure that their roles are performed at the expected standard.¹⁵⁶ As at 21 November 2016, neither the ERP nor any of its sub-plans addressed TA events. However, AV had a draft policy in their communications centres dealing with abnormal workload levels. That draft policy, which is very similar to the TA sub-plan developed subsequently, was activated by AV during the TA event.¹⁵⁷
116. As of August 2017, AV now have a dedicated TA sub-plan to the ERP.¹⁵⁸ The sub-plan describes how and from whom AV receives TA warnings and what AV does as a result of receiving such warnings. As at the time of the inquest, AV receive TA warnings from the DHHS by way of a risk forecast from the Chief Health Officer (or their delegate) two days before a potential TA event. These warnings rate the risk of TA as low, moderate or high and AV response in accordance with the level of forecast risk. Low risk warnings tend to be a 'heads up' and translate to a 'business as usual' response on the part of AV; moderate risk and high risk warnings trigger specific responses on the part of AV, including escalating by communicating with all internal and external stakeholders so that they are aware of the potential for a TA event and starting preparations such as resourcing the roster, ensuring that fleet and equipment is available, and may also involve a regional health commander's teleconference to assist in coordinating the response.¹⁵⁹

¹⁵⁵ Coronial brief page 462 and transcript page 394.

¹⁵⁶ Transcript pages 277-278. A/Prof Stephenson explained that sub-plans are addenda to the ERP formed through the evolution of the ERP because they become known events that AV may be called upon to manage. Sub-plans can refer to other relevant sub-plans, such as the operational logistics sub-plan which provides for vehicle and equipment availability and maintenance or the roster sub-plan which provides for staff resourcing. Transcript pages 295-296.

¹⁵⁷ Transcript page 265. A/Prof Stephenson explained that the ERP is a longstanding arrangement, commencing some time in about the 1980s. Transcript page 277.

¹⁵⁸ Transcript pages 278 and 292 and Exhibit H.

¹⁵⁹ Transcript pages 293-295. A/Professor Stephenson explained that Metropolitan Melbourne has about half of the ambulances in the State, with the others remaining in rural Victoria. As rural regions have less capacity to respond to a large event, their escalation triggers have a lower threshold. He also explained that an example of escalating AV resources could be engaging contracted providers located in Metropolitan Melbourne who normally assist in non-emergency transport of low acuity patients to be activated for code 1 (lights and sirens) cases and transport critically-ill patients to hospital. All those employed by the contracted providers have undertaken recognised registered qualifications, are trained in resuscitation and can usefully be deployed in a surge situation. Transcript pages 301-304. He also explained that AV

117. A/Prof Stephenson testified about an AV conducted drill in November 2017, aimed at exercising the ERP and some sub-plans and stated that the results provided ‘quite a degree of comfort’ that AV would be able to deploy a significant number of ambulances on the road in a very short period (40 within one hour).¹⁶⁰
118. Another improvement improvised during the TA event and formalised since by an exchange of letters between AV and MFB involves the deployment of MFB EMR to attend Priority 1 events during a surge as first responders, as well as Priority 0 events attended during ‘business as usual’ times. The now formalised arrangements mean a more seamless deployment and incorporation of the MFB (and the CFA) into AV’s escalation and communication plans for surge events.¹⁶¹
119. Although AV had draft plans at the time of the TA event relating to recalling staff, A/Prof Stephenson described the SMS alert system used during high-demand periods as ‘not being as functional as they would have liked’. AV have since changed their staff communication system and use ‘Whispir’ (as do the ESTA) which he felt was a ‘much more failsafe, seamless system which has been tested’. In addition to the change in software, staff are also now told why they are being recalled, the nature of the emergency and the corresponding ERP/sub-plan being escalated.
120. Other improvements in communications are also underway within AV. These include the rollout of digital radio across metropolitan and rural regions to promote interoperability within their systems, as well as across various emergency services organisations. AV now also has four running radio channels (an increase from three available to them during the TA event) and critical incident channels to address radio congestion.¹⁶²
121. During a surge event, AV has other avenues available to free up ambulance and paramedic resources. One avenue is the AV referral service which can function to hold off lower acuity patients who might otherwise require an ambulance transfer to hospital.¹⁶³ Also, under the AV roster sub-plan, AV managers are assigned to hospitals experiencing high demand and feed

do not receive forecasts directly from the BOM but from the DHHS. Transcript page 314. There are a number of sub-plans that overlap and outline AV’s response to surge events in a variety of ways either prior to or during an event. These sub-plans refer to AV resources (fleet, equipment, and staff) and formal arrangements with other agencies.

¹⁶⁰ Transcript pages 305-307. A/Prof Stephenson stated that their goal, which matched what they were able to achieve during the drill, was to have about 40 more ambulances on the road within the first hour of an event. This compares favourably with AV’s ability to mobilise an extra 48 ambulances (involving 79 paramedics) during the TA event, albeit not within one hour. Transcript page 318.

¹⁶¹ Transcript pages 315-316.

¹⁶² Transcript page 319.

¹⁶³ Transcript page 320.

intelligence between hospitals and AV to improve efficiencies, decrease ‘ramping’ and free up paramedics as soon as possible.¹⁶⁴

122. A/Prof Stephenson gave evidence that as at 21 November 2016, there was no agreed process in place about the use of a surge script. He conceded by the time consideration was given to the use of a surge script on an ad hoc basis on the night, it was probably too late, as by then cases requiring a Code 1 lights and sirens response had been cleared from the CAD cases pending list.¹⁶⁵
123. According to A/Prof Stephenson, the impetus behind AV’s new surge script was that AV had heard ‘loud and clear from the community that they were unhappy about being told that an ambulance was on the way when this was not necessarily so and many complained that they would have made their own arrangements to get to hospital if they knew an ambulance was not coming’.¹⁶⁶ He noted in this respect that the TA event marked the first time that the community had collectively communicated an expectation that AV would inform them of a surge in demand and its effect on AV resources.¹⁶⁷ Although the effectiveness of the surge script was as yet untested, A/Prof Stephenson was confident that, had it been used during the TA event, some people would have made alternative arrangement or at least had that option.¹⁶⁸
124. When challenged at inquest about whether the surge script, the new Priority 0 and Priority 1 exit scripts and the prohibition on the ESTA call-takers giving an estimated time of arrival, enabled callers to make an informed decision to arrange alternative transportation to hospital, A/Prof Stephenson explained that the dispatch of an ambulance to a particular event and its arrival time were unknown to the ESTA call-taker at the time that the call is ending and, in any event, remained subject to diversion to a higher priority event during a surge event and even during normal business. A/Prof Stephenson expressed the view that this reflects good ambulance practice.¹⁶⁹ As regards the adequacy of the new exit script ‘help is being arranged’, he said ‘I’m not sure that there are any perfect words, that’s the problem’.¹⁷⁰
125. It is appropriate to note that A/Prof Stephenson took the opportunity of testifying at the inquest to convey his sympathies to the family members of the deceased and to say how confronting

¹⁶⁴ Transcript page 321.

¹⁶⁵ Transcript page 323.

¹⁶⁶ Transcript page 280.

¹⁶⁷ Transcript pages 280-281. AV was responsible for the development of the surge script, which was circulated internally and broadly approved.

¹⁶⁸ Transcript pages 281-282.

¹⁶⁹ Transcript pages 282-284 and 313-314.

¹⁷⁰ Transcript page 333.

the TA event was both professionally and personally. He referred to the ‘humanity’ of paramedics and gave examples of some of the extraordinary actions taken by them on the night.¹⁷¹ His conclusion about this aspect of his evidence is worth quoting verbatim:

*I’ve said it publicly, I think I’m right, I don’t think I’ve seen so many lives saved on any given night...and yet again, I’ve not seen any organisation so together and so connected and so purposeful in what they did...so, it was an extraordinary event and...in many ways, it’s still um knowing that we couldn’t do what we wanted to do, a very confronting event.*¹⁷²

DEPARTMENT OF HEALTH AND HUMAN SERVICE (DHHS)

123. The DHHS published the Chief Health Officer’s Report dated 27 April 2017 entitled ‘The November 2016 Victorian epidemic thunderstorm asthma event: an assessment of the health impacts’ (the CHO’s report) which is a publically available document that was also included, for convenience and completeness, in the coronial brief.¹⁷³ The CHO’s report is an invaluable aid to the understanding of the TA event, both in terms of the environmental and meteorological conditions associated with TA, and the broad health impacts and associated demands placed on emergency responders and the health system.¹⁷⁴
124. Key findings of the CHO’s report pertaining to AV are that on 21 November 2016 there were 1,626 more calls to the ESTA requesting an emergency ambulance than forecast, an increase of 73% and that in the six hours from 6.00pm, 814 ambulance cases were generated, 643 of these for Code 1 events.¹⁷⁵
125. In terms of the impact on Victorian public hospital emergency departments, there were 12,723 presentations on 21 and 22 November 2016, being 3,867 or 44 % more than expected, based on the three-year average. Whereas the impact was even greater on public hospital emergency departments (EDs) in Melbourne and Geelong with 9,909 presentations over the two days,

¹⁷¹ The AV review contains some personal accounts of the night from paramedics. Coronial brief pages 799-801.

¹⁷² Transcript page 264.

¹⁷³ Coronial brief pages 321-400. See also <https://www2health.vic.gov.au/emergencies/thunderstorm-asthma-event>. Note that the report refers to the eight deaths known to be associated with the TA event at the time of the CHO’s report which was in any event confined to the period 21-30 November 2016. The deaths of Mr Min Guo and Ms Le Hue Huynh occurred outside this period and their identities had not been publicly disclosed as at the date of the report.

¹⁷⁴ As to the purpose of the CHO’s report see page 2 of the Executive Summary (page 328 of the coronial brief) – ‘*The purpose of this report is to provide the Victorian community, health service providers, policymakers and government and non-government organisation with a record of the health impacts from this previously unimagined event. It has created a new benchmark for emergency and health service delivery that requires planning and preparations, as these infrequent but recurrent events are now known to be capable of generating an impact of such magnitude.*’

¹⁷⁵ Ibid.

being 3,643 or 58% more than expected, based on the three-year average, resulting in a 672% increase in respiratory-related presentations in the thirty hours from 6.00pm on 21 November 2016, 3,365 more presentations than expected based on the three-year average.¹⁷⁶

126. Asthma-related hospital admissions also increased commensurately and, reflecting the acuity of those patients requiring admission, thirty more patients were admitted to intensive care units in the Melbourne and Geelong public hospitals in the thirty hours commencing 6.00pm on 21 November 2016, than expected based on the three-year average.¹⁷⁷
127. Two witnesses gave evidence at inquest on behalf of the DHHS, Ms Alison Jayne McMillan, Deputy Director of Strategy and Policy, and one of the State Health Coordinators¹⁷⁸ and Dr Danny Csutoros, a Senior Medical Advisor in the Health Protection Branch, specifically the Environmental Health Unit and a General Practitioner working in primary care.¹⁷⁹
128. The DHHS, via the Chief Health Officer, is the control agency for a health emergency, including a TA event. As such, the DHHS is responsible for sending out associated warnings, a responsibility shared with Emergency Management Victoria.¹⁸⁰
129. The IGEM Final Report found that communication between the DHHS and public hospitals was not effective on the evening of 21 November 2016. Rather, communication was described as *ad hoc*, inconsistent across the various health services impacted and not timely, preventing a shared understanding on the part of the DHHS and senior hospital staff of the surge in patients requiring urgent medical attention and limiting their ability to plan and respond accordingly.¹⁸¹

¹⁷⁶ The CHO's report Executive Summary page 3 at coronial brief page 329.

¹⁷⁷ Ibid. The thirty admissions to an ICU amounted to a 3,000% increase than expected based on the three-year average. It follows that statistically somewhere between 0 and 1 admission was expected.

¹⁷⁸ Ms McMillan's statement dated 30 May 2018 is at coronial brief pages 985-992 and outlines actions taken by the DHHS following the TA event and progress made in relation to those IGEM review recommendations directed to the DHHS.

¹⁷⁹ Dr Csutoros described himself as a public health specialist and is a Fellow of the Australian College of Public Health Physicians. Dr Csutoros' statement dated 31 May 2018 is at coronial brief pages 993-1002 and sets out the DHHS' and the Health Protections Branch's response to what he describes as the Epidemic Thunderstorm Asthma Event or ETSA. Predominantly this involved getting safely through the remainder of the pollen season; understanding the phenomenon; scoping, co-developing and implementing a new forecasting system; developing and implementing an ETSA preparedness and response plan; and developing and delivering a community awareness and health promotion and education program about ETSA. Coronial brief page 993.

¹⁸⁰ Transcript page 268.

¹⁸¹ Coronial brief page 444 and transcript pages 386-388. The DHHS typically gathered information by contacting hospital Chief Executive Officers rather than their emergency controllers, communicating with individual hospitals rather than using methods capable of communicating with multiple hospitals simultaneously. Health services suggested that if a similar event occur in the future, the DHHS should activate its formal incident management arrangements as soon as possible to communicate information as it comes to hand through agreed channels.

130. Since the TA event, the DHHS has undertaken work to address the relevant IGEM Final Report recommendations, work that falls under four key strategic areas:
- (a) revision of the State Health Emergency Response (**SHERP**) arrangements;
 - (b) real-time monitoring of demand for hospital emergency department services;
 - (c) epidemic TA forecasting and monitoring systems; and
 - (d) community and health professional engagement and education program.¹⁸²
131. Extensive work has been undertaken by the DHHS following the TA event to address the recommendations, including:
- (a) revision of the SHERP and its release to stakeholders in October 2017;
 - (b) establishment of a single point of contact for each hospital with a requirement that the hospital is required to maintain a 24/7 mobile number, email address and contingency landline;
 - (c) development of a private hospital protocol to increase community access to medical treatment, permitting public patients to be treated at private hospital emergency departments during an emergency;
 - (d) development of the Community Pharmacies Liaison Protocol in conjunction with the Pharmacy Guild of Victoria to enable efficient distribution of important information and warnings through pharmacies;
 - (e) development of the Primary Health Liaison Officer Protocol for coordination of information between the DHHS and key primary and community health stakeholders;
 - (f) development of an emergency department checklist to facilitate self-assessment of preparedness for epidemic TA events;
 - (g) implementation of the Real-time Health Emergency Management System (RHEMS) which provides the DHHS with ongoing real-time monitoring of the number of people presenting to emergency departments within a three minute window. This provides the DDHS with proactive early notification of potential health emergencies by notifying the DHHS through

¹⁸² Statement of Ms Mc Millan dated 30 May 2018 coronial brief page 986.

automated email and SMS alerts when a surge in demand occurs. By March 2018, all 38 Victorian public hospitals were added to the RHEMS system;

- (h) development and implementation of a Code Brown guideline to health services to remind hospitals of their responsibility to notify the DHHS when a Code Brown is activated;
- (i) expansion of the Victorian pollen monitoring system through the inclusion of five new monitoring sites, operational from October 2017;
- (j) implementation of the enhanced epidemic TA forecasting system from 1 October 2017, enabling the DHHS to provide advice to health and emergency services and the community about the possibility of any epidemic TA events during the pollen season;
- (k) the development and implementation of an epidemic TA public health campaign, launched 1 September 2017 for the duration of the 2017 pollen season, which included publication of new and updated Better Health Channel and Health Vic web sites' resources, including videos, posters, fact sheets and social media and radio advertising. The campaign highlighted the importance of community members knowing, understanding and managing their risk in relation to TA for those with: hay fever and therefore possibly undiagnosed asthma; a past history of asthma who are not actively managing their condition; and severe asthma. Part of the rationale for DHHS' public health campaign was that to reduce the number of people requiring assistance during future TA events and thereby reducing the pressures of surge experienced in hospital emergency departments;
- (l) the development and implementation of a health professional education program, including four new online TA training modules and face-to-face training sessions held across Victoria;
- (m) updating existing asthma-related online training modules for schools and early childhood facilities, sports and recreation groups and workplaces; and
- (n) evaluation of the DHHS TA program.

132. At inquest, Ms McMillan testified that the Vic Emergency website¹⁸³ and mobile telephones can be used to provide either state-wide warnings or community advice and warnings specific to a particular geographical area.¹⁸⁴ Like the other agencies (the ESTA and AV specifically),

¹⁸³ <https://emergency.vic.gov.au/prepare/#understanding-warnings>, accessed 26 October 2018.

¹⁸⁴ Ms McMillan further explained that mobile SMSs can be sent to people within a specified geographical area even if they have not downloaded the mobile telephone application. Transcript pages 438-440.

the DHHS have also formalised their processes for recalling staff during a TA event or other emergency.¹⁸⁵ These and other initiatives were tested in ten DHHS facilitated mass casualty simulations within Victorian public hospitals and involving AV.¹⁸⁶

133. Ms McMillan's evidence gave a sense of what the DHHS' approach to TA events now looks like in practical terms. All days in the pollen season (1 October – 31 December) are considered days of potential risk for epidemic TA. During the pollen season, the DHHS will prepare a daily risk forecast for TA for that day and the ensuing three coming days throughout Victoria. The risk for TA will be assessed by reference to a risk matrix developed since the TA event as either low, moderate or high risk.¹⁸⁷ The response to the risk assessment will vary according to the level of risk. On a day assessed as high risk for a TA event, the DHHS activate their State Emergency Management Centre, which is co-located with AV. Designated DHHS staff will then actively monitor systems in real-time to ascertain if in fact Victoria is experiencing a TA related impact.¹⁸⁸
134. While the initiatives described by Ms McMillan arose in the aftermath of the TA event and there was a clear imperative to understand that particular phenomenon and its health impacts, Ms McMillan explained the broader focus saying that '...our modern approach now is that the cause is not necessarily what we should concentrate on, despite the amount of work we've done importantly for epidemic Thunderstorm Asthma. Our planning and processes now should be able to accommodate any cause for a surge in demand irrespective of its cause.'¹⁸⁹
135. Dr Csutoros testified about the pressing need in the aftermath of the TA event to improve the State's readiness for any other TA event during the remainder of the 2016 pollen season and, in furtherance of that aim, the need to better understand the phenomenon of TA. He gave evidence about a number of DHHS initiatives, in which other parties such as ESTA, AV and BOM were also involved.
136. An Interagency Working Group (IAWG) was rapidly convened in the days following 21 November 2016. The IAWG included representatives from the DHHS, the BOM, pollen experts from the University of Melbourne and Deakin University and the Environmental Protection Authority (EPA). An epidemic TA Preparedness and Response Plan was developed

¹⁸⁵ Transcript page 454.

¹⁸⁶ Coronial brief page 988 and transcript pages 477-478.

¹⁸⁷ Exhibit H and transcript pages 313-314. All hospitals receive the same high-risk forecast to allow for relevant planning and preparation. Transcript page 467.

¹⁸⁸ Transcript page 467.

¹⁸⁹ Transcript page 448.

and a Rapid Assessment Team (**RATeam**) was formed to assess daily pollen levels, meteorological forecasts and air quality data in order to provide expert advice to the DHHS's Chief Health Officer during the remainder of the grass pollen season.¹⁹⁰

137. The National Thunderstorm Asthma Epidemic Symposium was held on 22 March 2017. Participants included the ESTA and various experts.¹⁹¹
138. Another important initiative was the DHHS's commissioning of a detailed literature review relating to TA which was undertaken by Queensland University of Technology and was published in May 2017.¹⁹²
139. At inquest, Dr Csutoros agreed that current thinking based on the preponderance of evidence was that rye grass is an important variable or precondition to a TA event. However, he referred to a number of other unknowns and potential variables contributing to a TA event and cautioned that we need to keep a very open mind.¹⁹³
140. Consequently, the current Victorian TA Surveillance Program, which includes eight pollen traps, is not solely focused on counting pollen, but is counting other particles such as *Alternaria* (mould). Dr Csutoros indicated that to his knowledge, expert/botanists at the University of Melbourne had turned their mind to whether *Alternaria* was present in the air on 21 November 2016, and to his knowledge, the research, which was still underway at the time of the inquest, was inconclusive. Dr Csutoros indicated that while *Alternaria* did not appear to be an important broader environmental factor, it had not been excluded as being causal in a small group of people.¹⁹⁴
141. Dr Csutoros gave evidence that the phenomenon of TA is a complicated story that sits in the context of the prevalence of asthma and hay fever within the Victorian population which in turn

¹⁹⁰ Statement of Dr Danny Csutoros dated 31 May 2018 coronial brief page 994. The RATeam was formed within days of the TA event and comprised representatives from the DHHS, the BOM, Associate Professor Ed Newbigin (University of Melbourne), Associate Professor Cenk Suphioglu (Deakin University) and the EPA. Transcript page 484.

¹⁹¹ Ibid.

¹⁹² Statement of Dr Danny Csutoros dated 31 May 2018 coronial brief page 994. Entitled '*Literature review on thunderstorm asthma and its implications for public health.*' The review is available at <https://www2.health.vic.gov.au/about/publications/researchandreports/thunderstorm-asthma-literature-review-may-2107>.

¹⁹³ Transcript pages 501-502. '*...we've got to keep a very open mind as to what else...could be there...could it be fungus, could it be spherics, like could it be electric charge, could the Rye grass be more allergenic now than it was before, is it simply more Rye grass...more allergen, is it that the weather is actually stronger? So there are elements of climate change that come into this. Is this now something...that's going to happen more commonly because we're in a different weather pattern?...it may be that the environmental factors were the predominant thing...We don't know if...there are more susceptible people because people are using just Ventolin rather than their steroids or that there's...the impact of migration...I don't think we have a full explanation as to why it is so big.*'

¹⁹⁴ Transcript pages 509-511. Dr Csutoros noted that it is not known whether *Alternaria* travels with Rye grass pollen.

gives some sense of the potential scale of future TA events. He noted that asthma, which is best regarded as a chronic disease rather than an episodic one, affects 10% of the Victorian population, translating to 600,000 people in Victoria (and 2.5million people in Australia). Three quarters of the cohort of asthma sufferers also suffer from hay fever. Hay fever affects one in five or six people in Victoria, translating to one million people.¹⁹⁵

142. As regards the developing forecasting system for TA events, Dr Csutoros expressed the view that the system is relatively new, largely untested, should form only one part of the response to a TA event, only one aspect of the response and should not be solely relied upon to manage the risk of a future TA event.¹⁹⁶ He noted the inherent risk with any system that produces some false positive, that of desensitising the public by over-warning about TA events, or the development of ‘warning fatigue’ and indicated that the DHHS is mindful of this challenge.¹⁹⁷

INSPECTOR GENERAL FOR EMERGENCY MANAGEMENT (IGEM)

143. On 9 December 2016, the Victorian Government requested that the IGEM review the emergency responses to the TA event.¹⁹⁸ The purpose of the review was to identify opportunities to learn from the TA event, to improve future preparedness of public health emergency planning, response arrangements and performance.¹⁹⁹
144. The IGEM’s involvement in review and investigation of the TA event resulted in three separate reports, as follows:

- (a) ‘*Review of response to the thunderstorm asthma event of 21-22 November 2016 – Final Report*’, published April 2017 and publicly available and referred to in this finding as the **IGEM Final Report**,²⁰⁰
- (b) ‘*The management of call-taking and dispatch for eight deceased patients during the thunderstorm asthma event of 21-22 November 2016 Investigation Report*’, finalised in

¹⁹⁵ Transcript page 486.

¹⁹⁶ Statement of Dr Danny Csutoros dated 31 May 2018 coronial brief page 996.

¹⁹⁷ Transcript page 565-566. Dr Tupper from the BOM testified that the forecasting decision matrix does produce some false positives. Transcript page 617.

¹⁹⁸ Statement of Mr Christopher Petty dated 15 June 2018 coronial brief page 1005.

¹⁹⁹ Transcript page 347.

²⁰⁰ IGEM provided the Court with a copy of the IGEM Final Report pursuant to section 72(1)(c) of the *Emergency Management Act 2013* (Vic) (**EMA**), in consideration of the public interest and having regard to the Coroner’s function. That report is available at <https://www.igem.vic.gov.au/reports-and-publications/igem-reports/review-of-response-to-the-thunderstorm-asthma-event-of-21-0>.

July 2017 and referred to in this finding as the **IGEM Investigation Report**. This report remains confidential and is not publicly available;²⁰¹ and

- (c) ‘*Progress Report – Implementation of recommendations from the Review of response to the thunderstorm asthma event of 21-22 November 2016 (IGEM Progress Report)*’, finalised May 2018, published 20 July 2018 and now publicly available.²⁰²

145. Mr Christopher Petty, IGEM Senior Officer, Performance Monitoring, was involved in the compilation of these reports and was authorised by the IGEM to give evidence on his behalf at the inquest.²⁰³
146. The IGEM Final Report examined the emergency response of the entire sector, and made 25 findings and 16 recommendations.²⁰⁴ In April 2017, the Victorian government indicated its in principle acceptance of all 16 recommendations. On 22 September 2017, the government endorsed a detailed response to the IGEM Final Report which set out the activities addressing the 16 recommendations.²⁰⁵
147. The IGEM Investigation Report examined ESTA’s performance of call-taking and dispatching services for specific cases where IGEM was aware that they involved a deceased patient. The purpose of this report was to identify any causal factors that either delayed dispatch or response

²⁰¹ The IGEM Investigation Report was provided to the Minister. The IGEM also provided me with the report in confidence due to the patient related confidential information contained within it. Submissions were heard on 29 June 2018 in relation to the status of this document. Counsel acting on behalf of the IGEM indicated that it was the IGEM’s position that once the document had been given to the Coroner pursuant to section 72(1)(c) of the EMA, how it was distributed or used in the inquest was at my discretion. The IGEM had commenced an investigation in November 2016 pursuant to section 64(1)(f) of the EMA. On 9 December 2016, the Minister for Ambulance Services and Minister for Emergency Services requested a review pursuant to section 64(1)(c) of the EMA and the work done prior to this request was absorbed into the latter request. IGEM’s position is that Investigation Report was therefore subject to the confidentiality provision in section 72 of the EMA and the IGEM requested that if I were to release the Investigation Report or any part of it, that I ensure redaction of any personal/confidential information prior to its release. I acceded to this request. See discussion at transcript pages 519 and following.

²⁰² On 22 May 2017, the Victorian government requested IGEM to monitor the implementation of these 16 recommendations and to provide a report to the Minister of Emergency Services and the Minister for Health and Ambulance Services. Transcript pages 396-397. IGEM provided me with an embargoed copy of this report in April 2018, prior to receiving the Minister’s approval for publication. The Progress Report is now available at <https://www.igem.vic.gov.au/reports-and-publications/thunderstorm-asthma-review-implementation>. I indicated at the commencement of the inquest that in the absence of ministerial approval for release of the progress report to interested parties, I intended to rely on Mr Petty’s statement and *viva voce* evidence in relation to the Progress Report’s Executive Summary, on the understanding that the Minister (which one) had no objection to that information being before the court. Transcript pages 4-5.

²⁰³ Statement of Mr Christopher Petty dated 15 June 2018 coronial brief page 1004. The IGEM is a statutory assurance entity established under the EMA with the objectives of providing assurance to the government and community in respect of Victorian emergency management arrangements and fostering continuous improvement of Victorian emergency management. Under the EMA, the IGEM undertakes system wide reviews, prepares advice and reports at the request of the Minister for Emergency Services (**the Minister**), investigates and monitors the ESTA’s service provision, make recommendations to the Minister and determines, in consultation with the ESTA, standards for the ESTA’s performance of emergency telecommunications.

²⁰⁴ Coronial brief pages 415-418 and transcript page 300.

²⁰⁵ Transcript page 396. This response was published on the DHHS and EMV websites.

of ambulance crews or affected the level of care and advice given to callers while waiting for ambulances to arrive. IGEM sought to identify root causes and make recommendations where appropriate in the interest of continuous improvement.²⁰⁶ They did so by predominantly relying on an analysis of evidence provided by the ESTA and AV to make 27 findings and 11 recommendations.²⁰⁷

148. The IGEM Investigation Report identified a number of performance issues relevant to ESTA. Findings (or issues) found across a number of cases included:

- (a) call answer speed performance;²⁰⁸
- (b) recognition of ineffective breathing;²⁰⁹
- (c) advice to callers about a surge in demand and estimated arrival times;
- (d) *no nearby unit* dispatch workflow;²¹⁰
- (e) recognition of unstable and not alert patients; and
- (f) pre-arrival instructions – ventilations first (instead of compressions for CPR).²¹¹

149. The IGEM Investigation report also noted that six of the deceased were located outside of the EMR zone²¹² and identified issues around the availability of defibrillators, the recording of

²⁰⁶ Transcript page 399. I note that these were causal factors for the purpose of the IGEM investigation.

²⁰⁷ Statement of Mr Christopher Petty dated 15 June 2018 coronial brief page 1006. I note that this was an extremely thorough report that examined over 500 items of evidence, in addition to more than 600 items that were examined in preparing the IGEM Review – Final Report. Transcript page 399. Mr Petty indicated that the IGEM had in August 2018 reviewed progress in relation to these 11 recommendations and advised that nine are complete and three are in progress. Inquest transcript 24 August 2018 pages 47-48.

²⁰⁸ Transcript page 400.

²⁰⁹ I note that in the case of Ms Hope Carnevali (Marsh) (COR 2016 5534), the IGEM identified that although the ESTA call-taker adhered to the correct process, the event type assigned to Ms Carnevali was changed from a Priority 0 to a Priority 1 based on Ms Carnevali experiencing ineffective breathing *in the context of having a history of asthma*. Mr Petty explained that although the International Academies of Emergency Dispatch (responsible for the product overseeing the medical priority dispatch call taking system) recommend priorities and responses, it is up to the local agency (AV) to assign the priorities. Inquest transcript 24 August 2018 pages 22-26 and coronial brief page 592.

²¹⁰ Mr Petty explained that this is an issue specific to the dispatch of ambulance, in situations where there is no ambulance available for dispatch, the ESTA's workflow is that dispatchers will alert an AV Communication staff member or Duty Manager. It is then their job to appraise the ESTA dispatcher of which AV resource to send. Inquest transcript 24 August 2018 pages 10-11.

²¹¹ Coronial brief page 533 and transcript pages 403-404.

²¹² The EMR zone relates to a geographical zone whereby arrangements are in place so that the MFB or CFA can attend Priority zero matters. Transcript page 404. Exhibit R. At the time of 21 November 2016, the CFA had indicated that there were going to roll out EMR to more stations within the per-urban fringe. I am informed that they are still rolling out such a service and will continue to do so, with the current plan to be completed by 30 June 2019. Inquest transcript 24 August 2018 page 18 and coronial brief page 684.

relevant information in the CAD system and the confirmation of and recording of callers' telephone numbers.²¹³

150. The recommendations made in both reports were aimed at improving future preparedness and response arrangements for rapid-onset health emergencies.²¹⁴
151. On 22 May 2017, the Minister for Emergency Services requested that the IGEM monitor the implementation of the 16 recommendations it made in its Review – Final Report, resulting in the IGEM Progress Report.²¹⁵ Overall, that report found significant improvements to the arrangements, systems, communications and capacity to prepare and respond to future rapid-onset Victorian emergencies, beyond TA events. Furthermore, the IGEM Progress Report found that 11 recommendations had been completed, eight led by the DHHS, and that four recommendations were progressing satisfactorily. One recommendation is considered closed, with no further planned activity.²¹⁶ IGEM is continuing to monitor progress in the implementation of the recommendations made in both the IGEM Final Report and the Investigation Report.²¹⁷

PROFESSOR JO DOUGLASS' EXPERT EVIDENCE & OVERVIEW

152. In addition to the appraisal of clinical management and care provided to each deceased, as an experienced respiratory physician and immunologist and an active clinician and researcher, Prof Douglass was an invaluable expert witness able to inform the coronial investigation about knowledge of the phenomenon of TA prior to 21 November 2016, and learnings since, especially in terms of the optimal clinical management of asthmatics and/or hay fever sufferers and identifying those groups or individuals at greatest risk. Except where otherwise indicated, the evidentiary source for this section of the finding is the evidence of Prof Douglass.
153. Worldwide, deaths from TA have only been described on one previous occasion in a report from the United Kingdom in 2002 involving a single fatality.²¹⁸

²¹³ Coronial brief page 534 and transcript pages 405-406. Mr Petty explained that while the findings were directly leading to issues or delays from the IGEM's perspective for the purposes of their investigations, the observations are potentially issues, but did not specifically contribute to any patient problems.

²¹⁴ Statement of Mr Christopher Petty dated 15 June 2018 coronial brief page 1009.

²¹⁵ Statement of Mr Christopher Petty dated 15 June 2018 coronial brief page 1007.

²¹⁶ Transcript pages 397-398.

²¹⁷ Statement of Mr Christopher Petty dated 15 June 2018 coronial brief pages 1007 and 1009.

²¹⁸ Transcript pages 20-21.

154. There was also a prior reported TA event in Wagga Wagga, New South Wales, in October 1997, but one not associated with any fatalities.²¹⁹ Coincidentally, a local asthma study was underway in Wagga Wagga at the time, and local clinicians were able to contemporaneously capture information relating to patients and controls when the TA event occurred. The study showed that of the 183 people who presented to hospital during the TA event, 95% reported hay fever, 96% were found to be sensitised to ryegrass pollen, and only 27% were taking inhaled corticosteroids. Moreover, 56% of the control group were taking inhaled corticosteroids, was considered fair evidence that inhaled corticosteroids could be protective against TA.²²⁰ As a result, the Murrumbidgee district health service established a TA warning system, which distributes hospital and community warnings during the pollen season.²²¹
155. Consistent with other evidence heard at the inquest, Prof Douglass noted an earlier TA event experienced in Melbourne in November 2010 when she happened to be on duty at the Alfred Hospital. Although this was a busy night in EDs across Melbourne, it was not on the scale associated with the TA event of 21 November 2016 and she was not aware of any associated fatalities.²²²
156. In terms of awareness of the phenomenon of TA prior to the impact of the event on 21 November 2016, Prof Douglass expressed the view that while she expected that respiratory physicians would have been aware of the phenomenon, she did not believe that specialist or generalist primary care physicians, pharmacists, emergency physicians or health administrators or planners were likely to have been aware of the dangers that TA posed.²²³
157. While studies going back to 1984 described clinical experiments indicating a severe asthmatic reaction to the inhalation of pollen particles and the consensus view that it is certain weather events that will replicate that result, the precise mechanism is not entirely clear and it is not clear which particular storms during pollen season will lead to a TA event. Certainly, not every thunderstorm during pollen season will lead to a TA event. It is noteworthy in this regard that, while there are on average four to six thunderstorms in or around November to December each year in Melbourne, recent history suggests there a TA event occurs only once every two to five

²¹⁹ Transcript page 121.

²²⁰ Transcript pages 104-105. Exhibit B, “*Thunderstorm-associated asthma in an inland town in south-eastern Australia. Who is at risk?*” Girgis, Marks, Downs and Ors. *European Respiratory Journal* 2000 at pages 3-8.

²²¹ Transcript page 135.

²²² Ms Smith on behalf of ESTA confirmed that the ESTA received 1108 calls for ambulance services over a 12 hour period from 9.00am to 9.00pm on 25 November 2010 and there were no consequential impacts on the ESTA’s service. See transcript pages 259 and coronial brief page 425.

²²³ Transcript pages 105, 123-124.

years. Little is known about the specific meteorological, biological and aerobiological variables that predispose or combine to bring about a TA event.²²⁴

158. Nevertheless, there appears to be some predictability in the Melbourne TA season with TA events having been observed to occur mostly in the second half of November (although there were two events in 1984 and 1987 that occurred in the first half of November) and to occur approximately six weeks after preceding rains which create a spike in pollen counts.²²⁵
159. Arising from the prevailing weather patterns, there is the suggestion of a potential early warning system for TA, as opposed to a predictor as such. As Melbourne's weather generally comes from the west, tracking west or south-westerly through Victoria and Geelong before reaching Melbourne, a surge in demand for ambulance or a spike in ED presentations in the west, if recognised and communicated in a timely way to other hospitals or the relevant health authorities 'would have perhaps predicated what would have happened in the rest of the State and then opportunities to intervene both in warning people...to manage themselves inside...[and for] hospitals to become prepared'.²²⁶
160. In order to understand the significance of those features shared by the cohort of deceased, there is a need to understand something of the asthma disease process and its recommended (or optimal) clinical management. Asthma is fundamentally a disease of narrowing of the lung's airways due to either airway swelling (which has an inflammatory component) or to airway narrowing secondary to intrinsic compression or constriction of muscles located in the airway wall.²²⁷
161. Reliever medications (beta-2 agonist) which relax those muscles but do not relieve inflammation are nevertheless useful as a cornerstone of treatment for patients with mild asthma who experience minimal airway inflammation.²²⁸ Reliever medication are far less potent in moderate or severe asthma and there is a concern about their overuse as they can render patients

²²⁴ Transcript pages 120-121 and 133.

²²⁵ Transcript page 137.

²²⁶ Transcript page 138-9. Prof Douglass agreed that even an hour or two can make a difference to a hospital to be better prepared to respond to such a TA event. Moreover, she expressed her understanding that the updrafts of pollen are actually minutes of really high exposure over a very short period of time, and in that case it is a matter of staying inside and out of that updraft. That is something that might be usefully employed in community warnings.

²²⁷ Transcript page 99.

²²⁸ For something like 40 years in Australia, salbutamol (available as Ventolin) is available over-the-counter. Prof Douglass noted that Australia is unique in this respect. In most countries, a prescription is required, thereby requiring some medical monitoring. Transcript pages 42-43.

more prone to severe attacks. The use of reliever medication more than twice weekly (except in exercise-induced asthma) indicates the need for preventer medication.²²⁹

162. Preventer treatments contain an anti-inflammatory component (a modified corticosteroid) and when inhaled actually suppress the airway inflammation associated with asthma. Preventers are one of the few effective treatments for moderate and severe asthma and are highly recommended as a preventative strategy for all but the mildest forms of asthma. Most currently prescribed preventers are a combination of inhaled corticosteroid and long-acting bronchodilators which relax the airway and are generally designed to be used regularly.²³⁰ Systemic corticosteroid medication would likely be protective for a severe episode of asthma.
163. There is an issue of patient non-compliance with preventer medication, possibly due to patients feeling it is intuitively unreasonable to keep using a drug when they feel well and to concerns about the long-term use of inhaled corticosteroids. Prof Douglass advised that the evidence indicates that the routine use of preventers at the prescribed dose is very safe and certainly safer than risking an asthma exacerbation. She suggested that there was scope for further patient education, improved health literacy and marketing to improve patient outcomes in this regard, especially for those with moderate to severe asthma.²³¹
164. Unopposed, frequent reliever use appears to increase air hyper-responsiveness to non-specific stimuli.²³² In a TA event, this means that those asthmatics who do not have the use of a preventer or inhaled corticosteroid are at a greater risk of significant bronchoconstriction in a TA event if they are frequently relying solely on salbutamol (Ventolin).²³³
165. There is a distinction that needs to be made between those patients who suffer from severe asthma and those who experience a severe asthma response.²³⁴ A patient with severe asthma is one who fails to obtain control of their asthma or who suffers from exacerbations despite maximum doses of inhaled combination preventer therapy. On the other hand, the cohort of deceased suffered a very profound severe asthma attack.²³⁵ Prof Douglass gave anecdotal

²²⁹ Transcript page 100. Prof Douglass explained that spacers assist in delivering more of the inhaled medication into the lungs. It is considered that using the puffer alone delivers less than 20% of the dose to the lungs. Also, the use of a puffer alone requires co-ordination and can be difficult when a patient is short of breath. A spacer creates a reservoir of medication and improves medication delivery to the lungs. Transcript page 101. See also transcript pages 48-49 where Prof Douglass discusses the relative merits of Formoterol and Salmeterol which is in Seretide.

²³⁰ Transcript pages 98-99.

²³¹ Transcript page 99.

²³² Transcript pages 124-125. Prof Douglass explained that airway hyper-responsiveness is (defined in a strict clinical sense) a response to agonists that cause airway muscle constriction that is greater than what you find in people who don't have asthma, and it can be measured, classically by using methacholine (or mannitol or hypertonic saline).

²³³ Transcript pages 125-126.

²³⁴ Transcript page 128.

²³⁵ Transcript pages 128-129.

evidence from the TA event that patients known to have severe asthma who she and her colleagues might have predicted would be vulnerable in a TA event apparently did not experience difficulties on 21 November 2016.²³⁶

166. Also available over the counter and therefore accessible without monitoring by any medical practitioner are antihistamine medications, inhaled nasal corticosteroids and topical eye medications for the treatment of the symptoms of seasonal allergic rhinitis or “hay fever”, as it is commonly known. This places pharmacists in a position to educate their customers and to influence their choices. Relevantly, although oral antihistamines appear more popular, studies provide evidence that topical nasal corticosteroids are more effective in head to head studies compared to oral antihistamines and are also associated with reduced asthma exacerbation rates (and so may be protective of hay fever sufferers in a TA event).²³⁷
167. Asthma management plans are recommended for and should do two things. They need to help a person recognise when they are sicker, when to call for help, when they are more significantly unwell and need to call for emergency assistance, and what treatment to institute at both of those times.²³⁸ Prof Douglass said that if one has hours available in a situation of worsening asthma, then oral corticosteroid medication can be lifesaving. If people had been better informed about their asthma and better able to recognise earlier symptoms of deterioration, they might have had more time to respond accordingly. It follows, that where appropriate, family members and carers should also be familiar with asthma management plans and able to enact them.²³⁹
168. Prof Douglass commented that it was not apparent from the available material whether any of the deceased were aware of the utility of high dose reliever medication or resorted to the ‘four by four by four’ asthma first aid paradigm recommended by Asthma Australia.²⁴⁰
- (a) take one puff into a spacer device;
 - (b) take four breaths from the spacer;
 - (c) repeat until four puffs have been taken;

²³⁶ Transcript page 129.

²³⁷ Transcript page 88.

²³⁸ Transcript page 85.

²³⁹ Ibid.

²⁴⁰ Ibid and <https://www.asthmaaustralia.org.au/act/home>.

(d) wait four minutes and if there has been no improvement, give four more separate reliever puffs; and

(e) if there is still no improvement, call '000'.²⁴¹

169. Prof Douglass was hopeful that with the benefit of people having good asthma plans, which included simple strategies such as staying indoors, shutting windows and taking their preventer medications on days/times when there is a forecasted risk of TA, that it would be less likely that they would require the assistance of AV or hospitals in a TA event.

170. Having appraised the clinical management and care provided to each of the ten deceased, Prof Douglass was able to inform the inquest about features they had in common that might assist in the identification of patients most at risk in a TA event and/or might suggest protective factors. As a general observation, the demographic features of the deceased were that they were relatively young, resided in the northern and western suburbs of Melbourne,²⁴² with a disproportionately high representation of males²⁴³ and of people from Asian backgrounds, many of whom had immigrated to Australia relatively recently.²⁴⁴

171. All ten of the cohort of deceased were known to suffer from asthma. Another standout feature of the cohort was that they suffered from hay fever and/or, historically, experienced seasonal exacerbations of asthma. Investigations post-mortem indicate they were all sensitised or even highly sensitised or allergic to ryegrass pollen and, in general, their use of preventer medications to control their known asthma symptoms was sub-optimal. Four out of ten of the deceased appear to have been prescribed oral corticosteroid medication, indicating that this was treatment for a flare up of severe asthma.²⁴⁵

172. There was evidence of an asthma action and asthma emergency plans in respect of only three of the ten deceased, a proportion consistent with community levels whereby only about 30% of

²⁴¹ <https://www.asthmaaustralia.org.au/act/about-asthma/asthma-emergency> accessed 5 September. Prof Douglass explained that very high doses of reliever medications are used in hospitals and are considered quite safe in an acute or emergency setting. Transcript pages 85-86.

²⁴² Transcript pages 80-81. Prof Douglass explained that this distribution may indicate the direction of the storm from the west, or other sociodemographic factors that need to be identified.

²⁴³ Prof Douglass notes that seven out of the 10 deceased were male, which was consistent with the hospital presentation demographic. She noted that the prevalence of asthma in general is predominantly middle-aged women. See transcript page 83 for a discussion of a Lancet Planetary Health article that looked at 1,400 presentations, 44% of which were women. Exhibit A. This article entitled 'The Melbourne epidemic thunderstorm asthma event 2016: an investigation of environmental triggers, effect on health services, and patient risk factors.' Thien, Beggs, Csutoros and Others e255-e263 is a succinct and accessible summary of the TA event.

²⁴⁴ Ibid. Prof Douglass spoke of a hypothesis that, as a group, people who immigrate to Australia from Asia are well known to develop quite severe hay fever, after some three to four years for reasons that are not yet well understood. The same group was also over-represented in emergency department presentations during the TA event.

²⁴⁵ Transcript page 102 and table at coronial brief page 908.

asthmatics have asthma management plans. Prof Douglass noted that epidemiological studies demonstrate that asthma management plans facilitate improved control of asthma symptoms and protect from adverse outcomes, including death. Prof Douglass bemoaned ‘banging on’ about asthma management plans for 30 years and finding they continue to be under-utilised, despite strong recommendations for their use.²⁴⁶ In any event, it is unclear how many of the deceased in fact followed their asthma management plans (or asthma emergency plans) during the TA event.²⁴⁷

173. Other features of optimal clinical management generally conspicuously absent were the objective measurement of lung function. Prof Douglass noted that there appeared to be very few lung function tests²⁴⁸ or peak flow measurements documented for the cohort of deceased.²⁴⁹ She gave evidence that studies have also demonstrated that lung function testing provides an objective measure of the severity of asthma and is associated with protection against adverse outcomes for asthmatics.²⁵⁰
174. Prof Douglass gave evidence that there was an argument to be made for particular targeting prevention strategies at those Melbournians with hay fever²⁵¹ as the evidence would suggest that ‘seasonal asthma’ is not well dealt with nor recognised in current asthma treatment guidelines, either in Australia or globally. She therefore suggested that the use of asthma preventer medication in episodic fashion in individuals who suffer hay fever or seasonal exacerbation of their asthma, is something that should be strongly considered.²⁵²
175. As regards possible triggers for TA, Prof Douglass noted that the testing of post-mortem samples indicated that three of the cohort of deceased were sensitised to *Alternaria* mould, know to trigger asthma but usually in the autumn months. It may be significant that the three deceased were among the first four to die on the night.²⁵³ According to Prof Douglass,

²⁴⁶ Transcript page 87.

²⁴⁷ Transcript page 85.

²⁴⁸ Prof Douglass explained that this assessment is a gold standard for asthma treatment and measures a person’s maximum expiration. Where there is an impairment noted in this measurement that improves following treatment with a beta-2-agonist (for example salbutamol) there is support for a diagnosis of asthma. Transcript pages 89-90.

²⁴⁹ Prof Douglass explained that this merely involves getting the patient to perform an expiration/puff into a peak flow device a number of times, to gauge their maximum measurement. There is a predicated normal range, according to a patient’s age and size. Transcript page 90.

²⁵⁰ Transcript pages 90 and 94. Prof Douglass mentioned the lack of lung function testing, including peak flow measurement particularly with reference to Mr Min Guo (COR 2016 5824). If this measurement had been taken and, hypothetically, had been low, it arguably would have been factored into the decision to discharge him. Prof Douglass explained that it is a good way to assess asthma severity and better than a stethoscope as patients can otherwise present deceptively - they can ‘sit there with poor lung function and you just don’t know’.

²⁵¹ Hay fever is also known as seasonal allergic rhinitis.

²⁵² Transcript pages 87-88.

²⁵³ Mr Leo, Ms Carnevali (Marsh) and Mr Papadopoulos, most highly sensitised of all. Coronial brief page 908.

sensitisation to *Alternaria* is unusual in individuals who have lived in Melbourne most of their lives and is more common in those who have spent time in arid, inland Australia. The presence of mould sensitisation is an indicator for severe asthma, referred to as severe asthma with fungal sensitisation or SAFS.²⁵⁴

176. Prof Douglass stated that while it is currently unknown whether *Alternaria* was present in the air on 21 November 2016, it was her understanding that air sample slides from pollen monitoring activities have been preserved. She suggested that the presence and extent of moulds in the air on 21 November 2016 is an active research question which could potentially elucidate the mechanisms of TA, or at least on those operating on 21 November 2016.²⁵⁵ Prof Douglass thought that mould may be an important or additional co-factor in TA, in addition to pollen. She referred to the relatively recent discovery of pathways by which mould can indirectly stimulate airway inflammation and the notion of a ‘two-hit’ phenomenon which might account for the severity of the reaction in so many individuals on 21 November 2016.²⁵⁶
177. Another aspect of the circumstances that is common among the cohort of deceased is that that were either outdoors or by a window and therefore exposed to the air when the thunderstorm struck. Prof Douglass’ evidence was that consistent with this fact and experience from previous TA events, remaining indoors was considered ‘somewhat protective’. Her suggestion was that remaining indoors with windows shut during future TA events could be a simple future preventative strategy on high pollen days with predicted thunderstorms. For similar reasons, advice to turn off evaporative cooling or other mechanisms which draw in air from outside might be usefully researched in future.²⁵⁷

²⁵⁴ Prof Douglass’ report dated 17 October 2017 coronial brief page 888 and transcript pages 53-54 where her evidence was ‘[t]his is quite remarkable [be]cause you wouldn’t – in clinical practice it’s quite uncommon to see so many people sensitised – it’s an unusual event to see three...out of 10 is certainly higher than – well, far higher than community expectations for a Melbourne dwelling cohort’. The most common mould allergy in Melbourne is to *Cladosporium herbarium*, which was also tested for, and is a domestic mould commonly found in bathrooms. Transcript page 40.

²⁵⁵ Transcript at pages 39, 94-96. I note that this was the first time I was informed of this situation. Professor Douglass indicated that she believed the slides were kept at the University of Melbourne’s Department of Botany, with a suggested contact of Associate Professor Ed Newbiggin. The Court subsequently corresponded with Melbourne and Deakin Universities, and corresponded further with Professor Douglas and Dr Iles in relation to *Alternaria*. A copy of these correspondences were distributed to the legal representatives of Interested Parties and tendered in evidence (Exhibit Q), which includes the following advice from Associate Professor Ed Newbiggin from the University of Melbourne ‘...the thunderstorm asthma event occurred before the peak of Melbourne’s 2016-2017 alternaria season in mid-late summer. At the time...the dominant *Alternaria* types in the air were species from *Alternaria* section *Infectoriae*. Species from *Alternaria* section *Alternata* were also present but were not an abundant component in the air. *Alternaria alternata* is one of the 60 species in *Alternaria* section *Alternata*. The exact identity of the species in *Alternaria* section *Alternata* present at around the time of the thunderstorm asthma event cannot be determined from the available data’.

²⁵⁶ Transcript pages 126-127.

²⁵⁷ Transcript pages 82-83, 131.

178. Speaking of all ten individuals whose deaths were the subject of the inquest, Prof Douglass characterised their underlying diagnoses as severe allergic asthma with an allergen-induced exacerbation which led to respiratory arrest and their demise.²⁵⁸ She noted that the average time from complaint or flare up to respiratory arrest was very short, as little as 15 minutes in some cases, rendering any emergency response very time critical. It therefore behoves clinicians to be aware of the warning signs of severe asthma and of unstable asthma in the hours that may precede a severe attack and to treat the patient accordingly.²⁵⁹ Prof Douglass noted that an out of hospital respiratory arrest from asthma is something from which very few, if any, people would survive. Moreover, even though in a hospital setting, survival is not assured, getting people to hospital remains a major ambition of treatment.²⁶⁰
179. Drawing on the common features of the cohort of deceased, Prof Douglass opined that the risk factors for fatal TA are pre-existing asthma, hay fever, and severe sensitisation to ryegrass pollen. Beyond these, more needs to be known about the precise risk factors in order to target patient populations and therapies accordingly.²⁶¹
180. As regards the observation that many people who had never had asthma previously reported experiencing asthma symptoms following the 21 November 2016 TA event, Prof Douglass suggested that it was possible that there was an under appreciation of symptoms in these people previously, that is that they may have indeed suffered from asthma but never been formally diagnosed.²⁶²
181. Also under appreciated is the link between hay fever, asthma and consequently TA. Prof Douglass referred in evidence to the old mantra ‘hay fever never kills anyone’ that may need to be re-visited as a result of the TA event. Lessons learned in the aftermath of 21 November 2016 include a need to reconsider the clinical management of hay fever sufferers, among medical as well as community allied health professionals, who are often the first point of contact for people with allergic disease.²⁶³

²⁵⁸ Transcript page 84.

²⁵⁹ Ibid.

²⁶⁰ Transcript page 87.

²⁶¹ Transcript page 103.

²⁶² Transcript pages 112-113.

²⁶³ Transcript pages 122-123.

BUREAU OF METEOROLOGY (BOM)

182. The BOM is Australia's national weather, climate and water agency, operating pursuant to the *Meteorological Act 1995 (Cth)* and the *Water Act 2007 (Cth)*. The BOM provides regular forecasts, warnings, monitoring and advice across Australia,²⁶⁴ including issuing TA forecasts to the DHHS for dissemination.²⁶⁵
183. The BOM was generally aware of TA as a health issue associated with previous weather events. Prior to the 21 November 2016 TA event in Melbourne, the only Australian TA warning system operated in NSW, where the BOM provides NSW Health with thunderstorm advice in support of this service.²⁶⁶
184. In the lead up to spring 2016, Victoria's temperatures had been generally close to average. Spring 2016 was Victoria's 10th wettest spring on record, with western areas received above average rainfalls.²⁶⁷
185. During the week before 21 November 2016, the weather transitioned from a cool, moderate to strong south-westerly wind flow, to warmer conditions by 17 November as a high pressure system moved eastwards across Victoria. A mainly dry trough with an associated weak wind change moved across the State on 18 November, bringing cooler south-westerly winds to the south. Maximum temperatures in the north reached the low 30's. A high pressure system moved across Victoria on 19 November, resulting in light winds, no rainfall, and temperatures in the low to mid 20's in the south and high 20s to low 30s in the north. Northerly winds developed on 20 November, with maximum temperatures generally in the high 20s to mid-30s throughout Victoria. Thunderstorm and shower activity developed during the afternoon, but no significant rainfall was recorded.²⁶⁸
186. On 21 November, Victoria experienced its first hot day since the previous summer as a fresh and gusty northerly wind flow developed ahead of an approaching cold front. Temperatures generally reached the mid to high-30s. A cool change entered the southwest during the early afternoon, bringing a west to south-westerly wind shift. Storms also developed across western and central Victoria during the afternoon, particularly near the change. Damaging wind gusts

²⁶⁴ Statement of Dr Andrew Tupper dated 7 May 2018 coronial brief page 974.

²⁶⁵ Statement of Dr Andrew Tupper dated 7 May 2018 coronial brief page 982.

²⁶⁶ Ibid.

²⁶⁷ Ibid.

²⁶⁸ Statement of Dr Andrew Tupper dated 7 May 2018 coronial brief pages 976-977.

(greater than 90kph) were recorded with the storms in the west. A north-south line of storms developed ahead of a mid-afternoon change to Melbourne's west.²⁶⁹

187. The wind gusts associated with individual thunderstorms developed into a gust front (the boundary between these wind gusts and the surrounding air) along a north-south line to the east of the thunderstorms.²⁷⁰ The thunderstorms dissipated in the western suburbs of Melbourne, however the gust front progressed eastwards through greater Melbourne between 5.00pm and 6.30pm. Relative humidity was approximately 40% in the late morning, dropping to 20-30% by the mid-afternoon. These conditions persisted with the passage of the gust front.²⁷¹
188. The passage of the gust front was spatially and temporally coincident with the onset of the TA event. A thunderstorm gust front is an example of a 'convergence line' (a line of converging air masses).²⁷² The gust front generally acts as an atmospheric 'broom' in concentrating loose particulates swept up from the ground (e.g. dust and pollen). The gust front persisted and tracked in a coherent fashion across all of Melbourne.²⁷³
189. The combination of a warm to hot day with a late afternoon line of thunderstorms (a squall line)²⁷⁴ is a relatively common Melbourne occurrence, particularly in November. BOM State Manager, Victorian Office, Dr Andrew Tupper,²⁷⁵ noted that Melbourne's maximum temperature on 21 November 2016 was not considered exceptionally hot. He stated that meteorological circumstances alone are insufficient to explain the gravity of the TA event, noting that the physical mechanisms of the interaction of pollen with the weather are not well known.
190. Dr Tupper advised that two theories exist:

²⁶⁹ Statement of Dr Andrew Tupper dated 7 May 2018 coronial brief pages 977-978.

²⁷⁰ Dr Tupper explained that the strong and geographically large and continuous gust front is a very powerful mechanism, which can occur very close to a thunderstorm/convergence line (a few kilometres) or can travel hundreds of kilometres ahead. Also, when a thunderstorm dissipates. That is, the gust front can be physically separate from the storms that generated it, the gust front continues. Transcript, pages 615 and 625-626.

²⁷¹ Statement of Dr Andrew Tupper dated 7 May 2018 coronial brief page 978.

²⁷² Dr Tupper explained that a recent study that looked at 12 of the highest Melbourne asthma presentation days strongly suggested that visible convergence lines may be important in concentrating pollen, and that on four of the 12 days, there was no associated thunderstorm. Exhibit P, transcript pages 613-614.

²⁷³ Statement of Dr Andrew Tupper dated 7 May 2018 coronial brief page 978 and transcript page 592.

²⁷⁴ Transcript pages 589-590. Dr Tupper explained that thunderstorm cells that form a squall line create a self-sustaining system where the strength of the gust front is maintained or even increases over time, depending on the development of the storms. On 21 November 2016, there was a single essentially coherent line from north to south covering all of Melbourne and Geelong, which had the effect of running a very large broom along the landscape, creating a collection of small objects in that [g]ust front.

²⁷⁵ Transcript page 582.

- (a) allergenic pollen fragments inhaled by people during the passage of the gust front could have been blown along near the ground and concentrated in the gust front; and/or
- (b) pollen grains are lifted in the developing thunderstorms where they rupture secondary to ‘osmotic shock’ in the presence of moisture, then returned to the surface by the storm circulation where they concentrate in the gust front.²⁷⁶

191. Dr Tupper stated that the mechanism by which larger pollen particles fracture is “an important...unresolved problem”.²⁷⁷

192. In March 2018, the BOM hosted a workshop that evaluated the results of the 2017 TA forecasting efforts, and made recommendations for improvement in 2018 and beyond, including noting the importance of:

- (a) routine monitoring of pollen concentrations;
- (b) moving towards automated pollen monitoring;²⁷⁸
- (c) developing a software platform and online portal for analysing pollen data; and
- (d) gaining a better understanding of the weather and pollen conditions responsible for epidemic TA events.²⁷⁹

193. Dr Tupper stated that in his experience, warning systems for emerging hazards such as TA take decades to fully mature from a global perspective, particularly as the science develops. As such, the response to TA is in its early stages. The science is not well understood, and evaluation of the effectiveness of the TA forecast system is ongoing.²⁸⁰ Despite the forecast system being in its relative infancy, international engagement and national information-sharing is already occurring.²⁸¹

²⁷⁶ Statement of Dr Andrew Tupper dated 7 May 2018 coronial brief page 980. Dr Tupper explained that the two theories are not necessarily mutually exclusive. Transcript page 605.

²⁷⁷ Transcript page 606.

²⁷⁸ Dr Tupper explained that currently, pollen monitoring is quite a labour-intensive process. He also explained that pollen monitoring is done on a daily basis, and as illustrated by the TA event, understanding what is occurring in terms of pollen as a gust front comes through could better improve TA understanding. Transcript page 623.

²⁷⁹ Statement of Dr Andrew Tupper dated 7 May 2018 coronial brief page 983.

²⁸⁰ Statement of Dr Andrew Tupper dated 7 May 2018 coronial brief page 984.

²⁸¹ Transcript page 584.

FINDINGS/CONCLUSIONS

194. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.²⁸²
195. Adverse findings or comments against individuals or institutions are not to be made with the benefit of hindsight, but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession, and in so doing, caused or contributed to the death under investigation.
196. Having applied the applicable standard of proof to the available evidence, I find that:
- (1) Mr Guo died as a result of the thunderstorm asthma event occurring in Melbourne on 21-22 November 2016.
 - (2) Mr Guo was known to suffer from asthma with seasonal exacerbations at times necessitating Emergency Department presentations, and from hay fever, but his allergy status had not been investigated.
 - (3) Mr Guo became acutely unwell at around 6.30pm on 21 November 2016, attended the Ballarat Base Hospital, was treated according to the asthma protocol, considered fit for discharge and departed the hospital later that night.
 - (4) Mr Guo again experienced an onset of shortness of breath on the morning of 8 December 2016. He re-presented to the Ballarat Hospital ED, was treated in accordance with their asthma protocol, and following medical review, was discharged at about 4.00pm.
 - (5) Mr Guo again experienced shortness of breath in the early hours of 9 December 2016, and arrived at Ballarat Base Hospital ED for a third time shortly before 2.00am *in extremis*.
 - (6) Despite advance life-saving measures, Mr Guo could not be revived and was pronounced deceased at 2.43am.

²⁸² *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363; ‘*The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters “reasonable satisfaction” should not be produced by inexact proofs, indefinite testimony, or indirect inferences...*’.

- (7) While Thunderstorm Asthma was a known phenomenon, described in the literature since the 1980s, and recognised by meteorologists, some public health researchers and respiratory physicians, prior to 21 November 2016, the potential for epidemic health impacts was not appreciated by first line emergency responders and the public health system.
- (8) The scale of the Thunderstorm Asthma event experienced in Melbourne on 21-22 November 2016, and to a lesser extent the rest of Victoria, can be fairly described as unprecedented globally, both in terms of the demands placed on first line emergency responders and the public health system, and the nature and extent of health impacts on individuals.
- (9) That said, it is important to acknowledge the enormous efforts made by those working at the coal face on the evening of 21 November 2016 and into the next day – the ESTA call-takers, dispatchers and managers, AV clinicians, paramedics and managers, the MFB members providing first responder assistance and Victoria Police members who assisted on an as needs basis, and the public health system, all of whom went above and beyond to deliver emergency services to the public in extremely challenging circumstances.
- (10) In keeping with the reasonable expectations of the Victorian community of its public institutions and entities, the ESTA, AV and the DHHS have engaged in appropriate professional reflection and reviewed their performance in response to the Thunderstorm Asthma event, as well as cooperating with the IGEM review and assisting this coronial investigation.
- (11) Significant effort has gone into these reviews and significant learnings were derived. More importantly, improvement have been made across the ESTA, AV and the DHHS which should see Victoria better prepared for any future Thunderstorm Asthma events and for any future surge in demand for emergency services, irrespective of the cause, or even where the cause of the surge is unknown.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments on matters connected with the deaths I have investigated, including matters relating to public health and safety or the administration of justice:

1. I do not propose to make any recommendations, as so many have been made, and few stones left unturned. However, I think it is appropriate to document those areas where the available evidence supports the need for further or ongoing work, and where there is potential for further improvements in public health and safety.
2. Although the specific meteorological, biological and aerobiological factors that combine to create a Thunderstorm Asthma event are not fully known and/or understood, the available evidence supports a finding that further research into these will improve our understanding of the phenomenon, our ability to predict which particular weather event has the potential to produce Thunderstorm Asthma and to issue more accurate forecasts and more meaningful public warnings.²⁸³ Similarly, further verification and development of the currently described ‘immature’ Thunderstorm Asthma forecasting system is vital in providing the Victorian community with accurate and meaningful Thunderstorm Asthma warnings.
3. Public awareness campaigns undertaken by the DHHS, asthma action plans that have been promulgated in Victoria, and publicity around the link between hay fever and Thunderstorm Asthma with the aim of escalating preventative therapy for those at increased risk, are all presumed to have contributed to increased general preparedness to deal with a future Thunderstorm Asthma event. While the efficacy of these strategies has yet to be tested, it makes sense that they be continued into the future in the interests of further improving the community’s health literacy and alleviating the impact of any future surge in demand for emergency services due to Thunderstorm Asthma.²⁸⁴
4. Similarly, there is scope for further medical, allied health and general community education encouraging hay fever sufferers to submit to allergy testing in order to better understand their susceptibility to Thunderstorm Asthma, to inform clinical management of their hay fever and to provide a specific management plan in anticipation of seasonal exacerbations or Thunderstorm Asthma.

²⁸³ Transcript page 120.

²⁸⁴ Transcript pages 122-123.

5. The circumstances in which the cohort of deceased suffered an exacerbation of their asthma to which they ultimately succumbed, provides a sound basis for recommending that when a Thunderstorm Asthma warning is issued, those at risk remain indoors, with the windows and doors shut, and any evaporative cooling or other systems which draw in air from outside turned off, and/or travel to or from work later, in an effort to minimise their risk of potentially fatal exposure to the elements.²⁸⁵
6. AV and the ESTA have been responsive to feedback and introduced the new surge script informing '000' callers that they are experiencing high demand and that they should consider alternative means of accessing medical attention/treatment. In a similar vein, they have changed the exit scripts for Priority 1 and Priority 0 calls from '*The ambulance is on its way*' to '*Help is being arranged*' which is likely to be more accurate at times of high demand for ambulance services. I accept the changes have been made in a genuine effort to be more informative and that the new scripts provide more accurate (and some additional) information.
7. However, it is not apparent that a caller hearing the new scripts is in any better position to make an informed choice about whether to wait for an ambulance or to engage in self-help. What such a caller needs is information specific to their situation, effectively an estimated time of arrival of the ambulance. As I understand it, our emergency response system is not presently configured to provide such information. I am confident that AV and the ESTA are well aware of this issue and I certainly do not intend to minimise its complexity. Rather, I consider it appropriate to highlight this as an extant issue going forward.²⁸⁶

PUBLICATION OF FINDING

This finding is to be published on the Internet in accordance with the rules of the Court pursuant to section 73(1) of the Act.

²⁸⁵ Transcript page 139.

²⁸⁶ Transcript pages 215-18.

DISTRIBUTION OF FINDING

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

Ms Yashi Fan, Senior next of kin

Ms Jess Bayley, K&L Gates, on behalf of the Emergency Services Telecommunications Authority

Ms Margaret Mann on behalf of the Department of Health and Human Services

Ms Kate Mellier, Lander and Rogers Lawyers, on behalf of Ambulance Victoria

Mr Evan Evagorou, Australian Government Solicitor's Office, on behalf of the Bureau of Meteorology

Mr Tony Pearce, Inspector-General for Emergency Management

Minister for Emergency Services

Minister for Ambulance Services

Minister for Health

Australasian Society of Clinical Immunology and Allergy

Royal Australian College of General Practitioners

Professor Jo Anne Douglass

Royal Australasian College of Physicians

Safer Care Victoria

Australasian College for Emergency Medicine

College of Emergency Nursing Australasia

Pharmacy Guild

Asthma Australia

National Asthma Council

Dr Rajesh Sannappareddy, Ballarat Base Hospital

Dr Lina Danvers, Ballarat Health Services

First Constable Michael Leger, Coroner's Investigator, Victoria Police.

Signature:



PARESA ANTONIADIS SPANOS

CORONER

Date: 9 November 2018

Cc:

Ms Ruth Bergman, Manager, Health & Medical Investigations, Coroners Prevention Unit

Leading Senior Constable Duncan McKenzie, Police Coronial Support Unit

Ms Amira Kafka, Coroner's Solicitor, Coroners Court of Victoria