IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004385

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sara Dennis
Deceased:	Giuseppe Antonio Iera
Date of birth:	13 June 1948
Date of death:	31 July 2024
Cause of death:	1a: Ischaemic heart disease 1b: Coronary artery atherosclerosis
Place of death:	Dalton Road Lalor Victoria 3075
Keywords:	Ischaemic heart disease, cardiac arrest, Ambulance Victoria, ambulance delays

INTRODUCTION

1. On 31 July 2024, Giuseppe Antonio Iera was 76 years old when he died en route to hospital. At the time of his death, Giuseppe lived in Lalor with his wife, Maria.

2. Giuseppe had a history of non-ST elevation myocardial infarction with a right coronary artery stent in 2012 and left anterior descending coronary artery stent in 2013, hypertension, type 2 diabetes mellitus, dyslipidaemia and benign prostatic hyperplasia.

3. Giuseppe had last seen his cardiologist in September 2023. They did not note any concerns and planned to review him again in 18 months' time.

4. Proximate to his death, Giuseppe had experienced blood in his urine and urinary difficulties, which were being investigated by urologist Dr Daniel Steiner. He had an appointment booked for 12 August 2024 for a cystoscopy.

THE CORONIAL INVESTIGATION

5. Giuseppe's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).[1] The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death.

7. Coroner Audrey Jamieson (as her Honour then was) originally held carriage of this investigation prior to her retirement in April 2026. I assumed carriage of this investigation on 27 April 2026.

8. This finding draws on the totality of the coronial investigation into the death of Giuseppe Antonio Iera. Whilst I have reviewed all the material, I will only refer to that which is directly

[1] Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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

Circumstances in which the death occurred

9. At around 9:07am on 29 July 2024, Giuseppe presented to the Epworth Hospital Emergency Department with urinary retention and increasing abdominal pain. A bladder scan demonstrated more than 1000mls of urine in the bladder. An indwelling catheter was inserted, resulting in the drainage of urine, after which his pain resolved. Giuseppe was provided with a leg bag and an overnight drainage bag for the indwelling catheter and advised to re-present to the Emergency Department if it stopped draining. He was discharged home at 1:50pm.

10. At around 12:26pm the following day, 30 July 2024, Giuseppe attended at the Epworth Hospital Emergency Department for a catheter blockage. The blockage was flushed, and he left hospital at around 4pm.

11. That night, Giuseppe had little appetite, struggled to sleep and was restless, which appeared to be due to his breathing.

12. At around 12:40am on 31 July 2024, Maria called for an ambulance as Giuseppe was experiencing shortness of breath. He was breathing heavily and was clammy with cold sweats but was alert and responding normally. Maria advised the call-taker that Giuseppe had emphysema and had used his prescribed medication as directed by his doctor.

13. The call-taker advised Maria to have Giuseppe rest in a comfortable position and to continue to use medication as needed. The call-taker advised that a Triage Practitioner would call back within 60 minutes to assess Giuseppe's condition and determine the assistance necessary, and for Maria to call back if he deteriorated further. An ambulance was not dispatched at this time.

14. At 1:07am, the Triage Practitioner called Maria. The Triage Practitioner spoke with Giuseppe, who described that he was breathing heavier than usual and this had started around 5pm the

[2] Subject to the principles enunciated in Briginshaw v Briginshaw (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

previous day. Giuseppe sounded as if he was struggling to speak and asked that the Triage Practitioner speak with Maria.

15. At 1:08am, the Triage Practitioner requested that an ambulance be dispatched priority 2 (within 25 minutes).

16. The Triage Practitioner continued to triage Giuseppe by speaking to Maria. Maria thought that Giuseppe looked pale and had a bit of a wheeze and told the Triage Practitioner that he had a history of acute myocardial infarction and congestive cardiac failure.

17. Giuseppe had access to a blood pressure machine and pulse oximeter which were used during the assessment at the request of Triage Practitioner. The blood pressure machine reported a blood pressure of 94/68 and a heart rate of 197bpm. The pulse oximeter reading showed an oxygen saturation of 98% and heart rate of 197 – 200bpm.

18. The Triage Practitioner was unable to verify the readings, so asked that Giuseppe's son, Donnie, measure his pulse, which was *"too fast to count."*

19. The Triage Practitioner advised that Ambulance Victoria were experiencing ambulance delays. Maria told the Triage Practitioner that Donnie was able to drive Giuseppe to hospital and that it was the preference of Giuseppe's family that he attend the Epworth Hospital given he was already under the care of a specialist there for his prostate condition.

20. The Triage Practitioner initially advised that it was best to wait for an ambulance as paramedics would be able to assess Giuseppe but, after speaking with Donnie, advised that he would be able to get Giuseppe to a hospital faster than an ambulance would. They advised Donnie to stop and call Triple Zero if Giuseppe's condition deteriorated en route. Ambulance Victoria records indicate that an ambulance was recorded as 'not required' at 1:30am.

21. The phone call with the Triage Practitioner was approximately 21 minutes long.

22. At 1:43am, Donnie called for an ambulance while driving on Dalton Road in Thomastown as Giuseppe had *"taken a turn"* and was unconscious and not breathing. Donnie commenced cardiopulmonary resuscitation on the instruction of the call-taker. Fire Rescue Victoria arrived around 8 minutes later and took over resuscitation efforts, followed by Ambulance Victoria.

23. Giuseppe was unable to be resuscitated and was declared deceased at 2:43am.

Identity of the deceased

24. On 31 July 2024, Giuseppe Antonio Iera, born 13 June 1948, was visually identified by his son, Donnie Iera, who completed a Statement of Identification.

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

Medical cause of death

26. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine conducted an autopsy on the body of Giuseppe Iera on 6 August 2024. Dr Young considered materials including the Victoria Police Report of Death (Form 83), post-mortem computed tomography scan and medical records and provided a written report of his findings dated 29 August 2024.

27. The autopsy showed features of ischaemic heart disease, including cardiac hypertrophy, remote and subacute myocardial infarction and severe triple vessel coronary artery atherosclerosis. A poorly differentiated urothelial carcinoma was seen in the bladder. Rib fractures and pulmonary intravascular fat emboli were identified, attributable to CPR.

28. Toxicological analysis of post-mortem blood samples identified the presence of bisoprolol and paracetamol.

29. Dr Young provided an opinion that the medical cause of death was *1(a) ischaemic heart disease, 1(b) coronary artery atherosclerosis*. I accept Dr Young's opinion.

FAMILY CONCERNS

30. Donnie Iera wrote to the Court explaining the events of the night of Giuseppe's death, as well as providing background on his prostate concerns and attendances at Epworth Richmond on 29 and 30 July 2024. He concluded:

> I guess what is unknown to me is what checks the Epworth made upon returning to ER Tuesday afternoon. And why couldn't the ambulance attend my parents' home as requested and why were we advised to drive him ourselves.

FURTHER INVESTIGATION

Ambulance Victoria

31. Having considered Donnie's concerns and the circumstances of Giuseppe's death, I sought a statement from Ambulance Victoria explaining:

    a) the reason/s for not dispatching an ambulance following Maria's initial call to Triple Zero; and

    b) the reason/s for the delay in ambulance attendance after the triage practitioner determined one should be dispatched, and the rationale for the advice that it would be quicker for Giuseppe's family to drive him to hospital.

32. In response, Ambulance Victoria provided a statement under the hand of Diana Zimmermann, Director of Operational Triage Services.

<u>The reason/s for not dispatching an ambulance following Maria's initial call to Triple Zero</u>

33. Ms Zimmermann advised that Triple Zero Victoria call takers use ProQA software in their call taking, which provides scripted questions to identify the nature of the emergency. Based on the answers, ProQA creates an event and assigns an event type.

34. In Giuseppe's case, an event type of *64DE – Breathing Problems: Clammy or Cold Sweats (COPD)* was created based on Maria's answers. This was a secondary triage suitable event.

35. Ms Zimmerman explained that *triage suitable* events are low acuity and unlikely to require emergency ambulance response, with a high likelihood of referral to an alternative service provider. Giuseppe's case was referred to an Ambulance Victoria Triage Practitioner.

<u>The reason/s for the delay in ambulance attendance after the triage practitioner determined one should be dispatched</u>

36. Ms Zimmermann advised that the role of a Triage Practitioner is to undertake triage and to provide an appropriate care pathway to patients, and to provide health advice where appropriate. Ambulance Victoria Triage Practitioners are registered division 1 nurses or qualified ambulance paramedics with a minimum of four years post qualification experience.

37. At 1:08am, when the Triage Practitioner requested an ambulance be dispatched priority 2, there were no available ambulances to be dispatched.

38. A Code Green had been called by Ambulance Victoria at 3:46pm on 30 July 2024 and remained in place at the time an ambulance was requested for Giuseppe. Ms Zimmermann described a Code Green:

> A Code Green is called when there is escalating patient care and demand in a region which has resulted in a medium impact on service delivery of ambulance services in the region. A Code Green is called in circumstances where 15 or more cases in total are delayed (a resource has not been allocated within designated timeframes) and/or there is a 20-30% reduction in fleet availability. Practically, it means there are actual or anticipated delays between 1-2 hours past target response timeframes for the region.

39. Despite the delays, the Triage Practitioner continued to triage Giuseppe while reviewing the status of the requested ambulance. They determined that he needed to be assessed in hospital and considered that private transport would be the fastest option to get him the required care. This advice was given in circumstances where:

    a) an ambulance had been requested but had yet to be dispatched and it was unclear when an ambulance would be available;

    b) the Triage Practitioner had conducted a thorough assessment over the phone;

    c) Donnie was able and willing to drive Giuseppe to hospital; and

    d) Giuseppe's family expressed a strong desire for him to be treated at Epworth Hospital.

CORONERS PREVENTION UNIT REVIEW

40. I requested the Coroners Prevention Unit[3] consider the management of, and advice provided to, Giuseppe proximate to his death, in the context of his son's concerns.

Presentations to Epworth

41. The Coroners Prevention Unit noted that Giuseppe attended the Epworth Emergency Department on 29 and 30 July because of urinary difficulties, passing blood in his urine and

[3] The Coroners Prevention Unit was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The Coroners Prevention Unit is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

abdominal pain. These were addressed appropriately by medical staff at the Epworth and Giuseppe was referred for ongoing specialist care.

42. The Coroners Prevention Unit advised that there was no indication that Giuseppe was experiencing other symptoms or concerns that could be relatable to his pre-existing cardiac condition and therefore there was no indication for Epworth medical staff to undertake cardiac checks. An electrocardiogram would not be routinely required for a patient complaining of urinary difficulty.

Ambulance Victoria

Referral to Triage Practitioner

43. The Coroners Prevention Unit opined that, based upon the Maria's initial responses to questions regarding Giuseppe's condition where it was apparent that he was feeling clammy and experiencing some breathing problems, but without concerning symptoms or signs such as chest pain, collapse or turning blue, it was appropriate to initially assign the case as secondary triage suitable and to refer him to a Triage Practitioner for further assessment.

44. The subsequent discussion between the Triage Practitioner and Giuseppe's family was detailed and did not reveal any additional concerns. The Triage Practitioner was made aware of Giuseppe's diagnoses of coronary artery disease and diabetes.

45. When the Triage Practitioner became aware of the presence of a pulse oximeter and blood pressure machine at Giuseppe's home, they requested his family check his blood pressure and heart rate. The resulting readings were described by the Coroners Prevention Unit as *"significantly abnormal"*. The Triage Practitioner appeared to have been doubtful as to the accuracy of the readings, stating they could hear the beeping from the equipment in the background of the call and these *"did not correspond with the reported results"*.

46. Despite the Triage Practitioner appearing to discount the readings, they nonetheless considered that Giuseppe needed to have a heart monitor applied and that an ambulance should be sent, and they requested an ambulance be dispatched priority 2 (within 25 minutes).

Advice for Giuseppe's family to drive him to hospital

47. No ambulance was available to attend at Giuseppe's home due to the Code Green in place.

48. The Triage Practitioner initially advised Giuseppe's family to wait for an ambulance to attend and place Giuseppe on a heart monitor. In the following discussion, Maria said there was no point in sending an ambulance if Giuseppe would not be conveyed to the Epworth, as Giuseppe was already under specialist (urology) care there. It appears that Giuseppe's family agreed to drive him there themselves, and this was supported by the Triage Practitioner who advised that, if the family took Giuseppe, it would ensure that he went to the Epworth and that they would be able to get Mr Iera to hospital a *"lot sooner"* as there were current delays in ambulances and that there was not one currently assigned.

49. The Coroners Prevention Unit noted that the closest emergency department to Giuseppe's home was the Northern Hospital, a 4.4km drive away. Epworth Richmond was 18km away. The location where Ambulance Victoria subsequently attended Giuseppe in cardiac arrest was approximately 3km from his address and in the opposite direction to the Northern Hospital.

Could Giuseppe's death have been prevented had he been seen to sooner?

50. The Coroners Prevention Unit advised that a patient such as Giuseppe, with known heart disease who develops a severe and sustained 'tachyarrhythmia'[4] of 200 is likely to deteriorate, potentially into cardiac arrest, if this is untreated. They opined that the type of heart rhythm initially experienced by Giuseppe was likely amenable to treatment with either drugs, or electrical cardioversion, or both, provided by paramedics and/or emergency department medical staff and may have prevented his cardiac arrest. Early defibrillation if Giuseppe had further deteriorated to ventricular fibrillation in their presence would have had a high likelihood of a good outcome.

51. The Coroners Prevention Unit explained that survival from out-of- hospital ventricular fibrillation cardiac arrest is predominantly determined by the interval from collapse to defibrillation. In witnessed arrests with rapid defibrillation, survival to hospital discharge is commonly in the range of 30–40% and may be higher in optimal systems of care. Where defibrillation is delayed or the arrest is unwitnessed, survival falls markedly. In the Victorian

[4] A cardiac rhythm disturbance characterised by an abnormally rapid heart rate, generally exceeding 100 beats per minute in adults, resulting from abnormal electrical impulse generation, conduction, or both. Tachyarrhythmias may originate from the atria, atrioventricular junction, or ventricles and include conditions such as sinus tachycardia, supraventricular tachycardia (SVT), atrial fibrillation with rapid ventricular response, atrial flutter, and ventricular tachycardia (VT). Depending on the rate, rhythm, and underlying cardiac function, tachyarrhythmias may reduce ventricular filling time and cardiac output, leading to symptoms such as palpitations, chest pain, dyspnoea, dizziness, weakness, syncope, hypotension, or cardiovascular collapse

Ambulance Cardiac Arrest Registry 2023/24 Annual Report,[5] Victoria reported a 41% survival to hospital discharge for all out-of-hospital cardiac arrest cases where the arrest was witnessed by a bystander and the presenting rhythm was shockable.

ASSESSMENT OF CONTRIBUTING FACTORS

52. The availability of an ambulance within the recommended response time of 25 minutes following the initial call to Triple Zero would have markedly improved Giuseppe's chances of survival. However, on the night in question, the community demand for ambulance services clearly exceeded the available resources.

53. The problem of poor ambulance availability in the face of increasing demand is multifactorial and complex and beyond the scope of this investigation. Additional and sporadic surges in demand, as were occurring on the evening of Giuseppe's death, make consistent improvement difficult, reflecting ongoing structural challenges in balancing demand, workforce capacity, and system flow within metropolitan emergency health services.

54. That said, I have, identified two instances where alternative advice may have improved Giuseppe's outcome, and on which I will make recommendations:

    a) If the Triage Practitioner had relied upon the readings of the blood pressure machine and pulse oximeter, supported by Donnie's inability to count his father's pulse because it was *"too fast"*, they may have assigned a priority 1 response rather than priority 2, which may have resulted in the earlier arrival of an ambulance.

    b) Once Giuseppe's family had decided to drive him to hospital, the Triage Practitioner could have strongly advised him to travel directly to the nearest appropriate emergency department (being the Northern Hospital), rather than travelling a much longer distance to the Epworth.

55. In keeping with the principles of natural justice, Ambulance Victoria was notified of my intention to make recommendations and given the opportunity to respond.

56. As to the issue of home monitoring devices, Ambulance Victoria noted that these can vary significantly in quality, validation and reliability but, whilst readings can sometimes be inaccurate, they can nevertheless provide important clinical information to assist in the triage

[5] https://www.ambulance.vic.gov.au/sites/default/files/2025-04/VACAR-Annual-Report-2023-2024.pdf

process. They said that aberrant vital signs on home monitoring devices should raise strong suspicion of an acutely unwell patient, and timely dispatch should be strongly considered by the Triage Practitioner.

57. Ambulance Victoria advised that, following Giuseppe's death, further education has been provided to Triage Practitioners regarding the interpretation of home monitoring devices. The circumstances of Giuseppe's death were used in a deidentified case study in a Triage Services Clinical Newsletter.

58. On the issue of directing patients to the nearest emergency department, Ambulance Victoria advised that its secondary triage procedures do not specifically prescribe advice directing attendance at the nearest emergency department in circumstances where a patient elects to self-present. In practice, Triage Practitioners do identify and advise patients of their nearest appropriate emergency department to support informed decision-making.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Giuseppe Antonio Iera, born 13 June 1948;

    b) the death occurred on 31 July 2024 at Dalton Road, Lalor, Victoria 3075;

    c) the cause of Giuseppe's death was ischaemic heart disease and coronary artery atherosclerosis; and

    d) the death occurred in the circumstances described above.

60. I find that Giuseppe's chances of survival would have markedly improved had an ambulance been available to attend upon him following the initial call to Triple Zero at around 12:40am on 31 July 2024.

61. However, I accept the information provided by Ambulance Victoria that a Code Green was in place and there was no ambulance available to attend, and I find that the Triage Practitioner acted within Ambulance Victoria guidelines in providing the advice they did.

RECOMMENDATIONS

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

i. I recommend that Ambulance Victoria review their current guidelines and/or develop a guideline regarding the use of, or reliance upon, medical devices at the caller's home to inform triage decisions, with particular reference to the interpretation of observations obtained from such equipment.

ii. I recommend that Ambulance Victoria review their current guideline and/or develop a guideline regarding advice when patients and/or their families wish to transport themselves to hospital to ensure that, where appropriate, the advice provided is to attend the nearest appropriate hospital emergency department.

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

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

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

Maria Iera, Senior Next of Kin

Ambulance Victoria

Senior Constable Abdul-Rahman Masri, Coronial Investigator

Signature:





Coroner Sara Dennis

Date: 17 November 2026

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.