IN THE CORONERS COURT OF VICTORIA AT MELBOURNE	**COR 2021 005523**

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Nick Panagiotopoulos

Delivered On:	30 April 2026
Delivered At:	Coroners Court of Victoria at Melbourne
Hearing Dates:	11 December 2023 25, 26 and 27 March 2024
Findings of:	Coroner Catherine Fitzgerald

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INTRODUCTION

1. On 16 October 2021, Nick Panagiotopoulos was 47 years old when died from a heart attack at his home in Preston.

2. Prior to his death, Nick was experiencing symptoms which indicated he needed an ambulance. Five phone calls were made to Triple Zero in relation to Nick's emergency. Whilst all these calls were answered by a Telstra Triple Zero call-taker, there were extensive delays in connecting the calls to an ambulance call-taker at the Emergency Services Telecommunications Authority.[1] It was ultimately more than 16 minutes before one of the calls was connected and an ambulance could be requested and dispatched. By that time, Nick had suffered a cardiac arrest. When emergency services ultimately arrived, resuscitation efforts were not successful and Nick had passed away.

THE CORONIAL INVESTIGATION

The role of the coroner

3. Nick's death was reported to the coroner as a 'reportable death' pursuant to section 4 of the *Coroners Act 2008* (**the Act**) and a coronial investigation was commenced. His death was unexpected and satisfied the criteria in section 4(1) of the Act.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the medical cause of death, and the circumstances in which the death occurred. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. The findings from coronial investigations help to contribute to the reduction of the number of preventable deaths and coroners may make comments or recommendations about any matter connected to the death under investigation, including matters relating to public health and safety or the administration of justice.

[1] ESTA is now known as Triple Zero Victoria. For ease of reference, these findings will refer to ESTA, as it was known at the time the death occurred.

6. The focus of any coronial investigation must necessarily be the identity of the deceased, the cause of death, and the circumstances in which the death occurred.[2] These findings state those facts and discuss them in detail. They cannot account for the devastating impact that Nick's sudden loss has had on his family and friends. Nick is survived by his wife, Belinda, and their daughters, and it is evident from the information gathered during the coronial investigation that he was greatly loved by them. It is also evident that the circumstances of Nick's death, which involved delayed access to emergency services, were highly distressing for his family, and for the people who were present at his home and providing assistance as best they could. I offer my sincere condolences to all of Nick's family and friends for their loss.

Issues investigated

7. A member of Victoria Police was nominated to be the coronial investigator for the investigation into Nick's death. The coronial investigator conducted inquiries on the coroner's behalf and submitted a coronial brief of evidence.

8. Following review of the police coronial brief, further investigations were undertaken to explore the following issues:

    a. Why there was a delay in connecting the 000 calls to an ESTA ambulance call-taker;

    b. Whether Nick's passing may have been prevented with earlier attendance by emergency services; and

    c. Any potential prevention opportunities.

9. An inquest hearing was held and proceeded over four days in total. Five witnesses were called to give evidence, and the coronial brief and other exhibits were tendered. The scope of the inquest was as follows:

    1. The management of calls made to 000 in relation to Mr Panagiotopoulos.
    2. Whether the management of calls made to 000 in relation to Mr Panagiotopoulos contributed to his death.
    3. Whether the death of Mr Panagiotopoulos was preventable.

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[2] Pursuant to s 67 of the *Coroners Act 2008* (**the Act**).

4. Prevention opportunities.

10. Following the conclusion of the inquest, it was necessary to obtain additional evidence to supplement the inquest brief having regard to issues which arose during the proceedings. It also became necessary to allow additional interested parties, who were not called to give evidence or represented at the inquest, an opportunity to file written submissions.

11. I have considered the extensive written submissions filed by several interested parties[3] following the inquest. I have carefully considered submissions made which contest the submissions of Counsel Assisting, submissions regarding the extent of the jurisdiction of the coronial investigation, submissions regarding procedural fairness and submissions regarding the statutory roles and responsibilities of the entities involved.

12. This finding draws on the totality of the coronial investigation into the death of Nick Panagiotopoulos, including the coronial brief, all exhibits, and the evidence given by the witnesses at the inquest. I have reviewed all the evidence but will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Standard of proof

13. In the coronial jurisdiction, facts must be established on the balance of probabilities.[4] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[5]

14. Coroners should not make adverse comments or findings about individuals or entities unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts

[3] Submissions of Counsel Assisting the Coroner dated 28 May 2024; Submissions on behalf of Triple Zero Victoria dated 26 June 2024; Submissions on behalf of the Inspector-General for Emergency Management dated 22 July 2024; Submissions on behalf of Emergency Management Victoria dated 22 July 2024.

[4] 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.

[5] See *Briginshaw v Briginshaw* (1938) 60 CLR 336, 361-363 per Dixon J; *Adamczak v Alsco Pty Ltd (No 4)* [2019] FCCA 7 at [80]: *Chief Commissioner of Police (Vic) v Hallenstein* [1996] 2 VR 1, [19-20]. Also see *Wyong Shire Council v Shirt* (1980) 146 CLR 40 at [47] with regard to risk, reasonableness and foreseeability.

sought to be proved. Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences.

15. Adverse findings or comments against individuals in their professional capacity, or against 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.

PART 1: THE EVENTS OF 16 OCTOBER 2021

The circumstances in which the death occurred

16. On 16 October 2021, Nick woke at about 7:00 am and had breakfast with his wife, Belinda. He appeared to her to be in good health. At about 7:30 am, he went to his office in Thomastown and completed some work for his business. He then helped neighbours with concreting work in their backyard from about 10:00 am. Belinda saw Nick at the neighbour's house at about 11:00 am and he seemed "his usual cheerful self". She then left to attend to some chores.

17. Nick returned to his home at [redacted], Preston at about 12:20 pm.[6] He made a phone call to one of his daughters asking her to open the back roller door at the house, not realising that she was with Belinda travelling in the car, and not at home. Nick then called his daughter who was at home, and she opened the back roller door for him.[7]

18. About five minutes later, Belinda made a phone call to Nick to ask if he wanted her to get him a coffee. He mentioned to Belinda that he thought he may have injured his back, and she suggested that he use some "rapid gel" on it.[8]

19. At about 12:32 pm, Nick called Belinda asking how far away she was. She asked Nick how he was feeling and he told her that he was "sweaty and clammy". She told him to call an ambulance and said she was coming home. At that time, Belinda was on High

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[6] Statement of Belinda Panagiotopoulos, Coronial Brief Version 9 (**CB**) 25 [4]–[6].
[7] Statement of Belinda Panagiotopoulos, CB 25 [8].
[8] Statement of Belinda Panagiotopoulos, CB 25 [9]

Street in Thornbury, and she immediately changed direction and headed home to Preston.[9]

20. At 12:34:05 pm, Nick made a phone call to Triple Zero (**000**) from his mobile phone (**call 1**).[10] The call was answered by a Telstra Triple Zero call-taker (**Telstra agent**) within 8 seconds. Nick was asked which emergency services organisation (**ESO**) he required and he asked for an ambulance.[11]

21. At 12:34:26 pm, the Telstra agent tried to transfer Nick's call to an Emergency Services Telecommunications Authority (**ESTA**) ambulance call-taker (**ACT**). As the Telstra agent waited in the ESTA emergency ambulance call queue (**call queue**),[12] Nick was told that the call was still connecting and to stay on the line as the "[n]ext available operator will answer soon". As the wait continued, the Telstra agent told Nick, "I'll stay on the line with you till we connect".[13]

22. After several minutes waiting in the call queue there was still no answer by an ACT. The Telstra agent repeatedly told Nick, "we will get through" and reassured him, "I'll stay on the line with you". Nick was told that the call was "[S]till connecting".[14]

23. At 12:36:26 pm, Nick can be heard in the call recording to be groaning. At 12:36:41 and 12:37:54 pm he coughs and speaks briefly. At 12:38:02 pm he says, "Oh my God" and sounds distressed.

24. At 12:38:26 pm, call 1 disconnected on the caller end.[15] It is not clear if Nick intentionally or accidentally disconnected the call. By that time, Nick had been waiting for 4 minutes and 12 seconds without being able to request an ambulance. The last statements made by the Telstra agent to Nick before the call disconnected on his end

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[9] Statement of Belinda Panagiotopoulos, CB 25 [10]-[11].

[10] All the 000 calls answered by Telstra and the calls to ESTA are recorded. The recordings of all the 000 calls in relation to Nick's emergency formed part of the coronial brief.

[11] Telstra 000 recording (ESAP job 2105017); Transcript of Telstra 000 calls, CB 948; Notification to IGEM of adverse event, CB 56 (call 1); ESTA Final Investigation Report, CB 78 (call 1); Annexure 4 of the statement of Christopher Mercovich, CB 1018.

[12] ESTA Final Investigation report, CB 78. ESTA refers to this as "presenting the call to the ESTA ambulance emergency call queue (**queue**)". When the call is not answered by an ACT, it is "re-presented" by the agent to the queue.

[13] Transcript of Telstra 000 calls, CB 948.

[14] Transcript of Telstra 000 calls, CB 948.

[15] Telstra 000 recording (ESAP job 2105017) at 4:12.

were "We will get you some help", "Just stay on the line with me", "Trying another number", and "Ambulance will answer soon."[16]

25. Even though Nick had disconnected from call 1, the Telstra agent remained in the call queue waiting for the call to be answered by ESTA, in accordance with Telstra procedure. However, after 4 minutes and 19 seconds, the Telstra agent's call had not been answered by ESTA, and at 12:38:33 pm, the agent terminated the call, which was in accordance with the "4-minute rule". This policy directed Telstra agents to end the call after 4 minutes where the caller had disconnected and there was still no answer by ESTA.[17]

26. At 12:38:34 pm, a second call was made from Nick's mobile phone to 000 (**call A**). It was answered by a Telstra agent who asked the standard question of the caller, "Police, fire or ambulance?" but there was no verbal response received. At 12:38:55 pm, this call disconnected on the caller end. There is no direct evidence about how the call came to be made from Nick's phone or why the call disconnected.[18] However, it is evident that the mobile phone was in his possession at that time, and no other voice or background noise is heard in the audio recording with the exception of a dog barking. After approximately 23 seconds, the agent terminated the call. As there was no verbal response by the caller, call A was not presented by the Telstra agent for answer by ESTA.[19]

27. Whilst in the car, Belinda made a mobile phone call to her daughter who was at home. She told her to open the front door and front gate and asked what Nick was doing. Her daughter said Nick was "making funny noises" and Belinda could hear him in the background of the call moaning in pain. She reassured her daughter she would be home soon.[20]

28. Belinda also told her eldest daughter, who was in the car with her, to call 000. At 12:38:37 pm, a call was placed to 000 (**call 2**) which was answered by a Telstra agent

[16] Transcript of Telstra 000 calls, CB 948.
[17] Transcript of Telstra 000 calls, CB 948.
[18] Telstra 000 recording (ESAP job 2065753); Transcript of Telstra 000 calls, CB 949; Statement of Nicole Ashworth, CB 620.
[19] Telstra 000 recording (ESAP job 2065753); Transcript of Telstra 000 calls, CB 949; Statement of Belinda Panagiotopoulos, CB 26 [14].
[20] Statement of Belinda Panagiotopoulos, CB 25-26.

within 17 seconds at 12:38:54 pm, and at 12:39:07 pm the Telstra agent presented the call to the call queue for answer by ESTA.[21]

29. It appears that Belinda arrived home before 12:40 pm, not long after call 2 was made. She ran into the house and found Nick lying on his side on the lounge room floor. Her daughter who was home with Nick told her he had initially been sitting on the couch but had slumped to the floor.[22] At some point, a male neighbour also arrived at the home to assist.

30. At this time, call 2 was still connected with a Telstra operator waiting for answer by ESTA and the audio recording captures a chaotic and emotional scene. As minutes continued to elapse with no answer by ESTA, Belinda is heard attempting to comfort her children whilst speaking reassuringly to her dying husband. During call 2, the Telstra agent repeatedly stated variations of "Still connecting", "We will get you through", and "Bear with us", whilst acknowledging there were delays.[23]

31. At 12:40:24 pm, whilst the Telstra agent on call 2 was still waiting in the call queue, Nick's mobile phone was used to place another call to 000 (**call 3**).[24] It was answered by a Telstra agent within 39 seconds at 12:41:03. The call was presented to the call queue at 12:41:14 pm, waiting for answer by ESTA. During call 3, the Telstra agent stated repeatedly "I will get you through" and "still connecting".[25]

32. The recordings for call 2 and call 3, which overlap in time, capture various observations about Nick's breathing. At about 12:41:06, in call 2, Belinda says that Nick is breathing, but this is quickly followed by a statement that he is not breathing at about 12:41:25.[26] At about 12:41:30, call 3 records a statement that "He's stopped breathing".[27] At about 12:42:48, it is stated in call 2 that Nick is breathing, but also that he is not breathing.[28]

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[21] Annexure 4 of the statement of Christopher Mercovich, CB 1018; ESTA Final Investigation Report, CB 78.
[22] Belinda Panagiotopoulos statement, CB 26 [20]–[26].
[23] Telstra 000 recording (ESAP Job 2144732); Transcript of Telstra 000 calls, CB 950.
[24] ESTA Final Investigation Report, CB 79; Annexure 4 of the statement of Christopher Mercovich, CB 1018.
[25] Telstra 000 recording (ESAP Job 3137311); Transcript of Telstra 000 calls, CB 958; ESTA final report, CB 79 (call 3); Statement of Belinda Panagiotopoulos, CB 26 [14]; Annexure 4 of the statement of Christopher Mercovich, CB 1018.
[26] Transcript of Telstra 000 calls, CB 951.
[27] Transcript of Telstra 000 calls, CB 958.
[28] Telstra 000 recording (ESAP Job 2144732) at 3:58; Transcript of Telstra 000 calls, CB 952.

The recordings also evidence Belinda's increasing distress at being unable to request an ambulance for her husband and the panic of those present with her.[29]

33. Shortly after a third presentation to ESTA at 12:45:06, call 3 disconnected on the caller end.[30] At 12:45:50 pm, call 3 was terminated by the Telstra agent pursuant to the "4-minute rule" as it had not been answered by an ACT and the caller had disconnected.[31] Call 2 still remained waiting in the call queue for answer by ESTA.

34. At about 12:45:51, 6 minutes and 57 seconds into call 2, it is stated that cardiopulmonary resuscitation (**CPR**) had been commenced.[32] The male neighbour (a former health practitioner) was attending to compressions and Belinda was administering breaths. At some point, several more neighbours arrived, including a female neighbour who was a nurse, and she took over CPR.[33]

35. Throughout the incident, Nick and Belinda's daughters were highly distressed and were being comforted by Belinda and various neighbours. At some point, Belinda told one of her daughters to call her aunty (Belinda's sister-in-law) who lived in the next street to come and help. When her sister-in-law arrived at the house a short time later, she called 000 (**call 4**) at 12:45:45 pm.[34] A Telstra agent answered the call within 14 seconds at 12:45:49 pm and presented the call to the call queue at 12:46:10 pm.[35] At the time call 4 was made, call 2 was still in the call queue waiting to be answered by ESTA.

36. At 12:48:33 pm, the male neighbour stated that Nick had stopped breathing.[36]

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[29] Telstra 000 recording (ESAP Job 3137311) at 0:23; Transcript of Telstra 000 calls, CB 958; Telstra 000 recording (ESAP Job 2144732) at 2:30; Transcript of Telstra 000 calls, CB 951.

[30] ESTA Final Investigation Report, CB 79; Statement of Nicole Ashworth, CB 621.

[31] Telstra 000 recording (ESAP Job 3137311) at 4:50; Transcript of Telstra 000 calls, CB 959; Telstra data, CB 822; ESTA Final Investigation Report, CB 79-80; Statement of Belinda Panagiotopoulos, CB 26 [14]; Annexure 4 of the statement of Christopher Mercovich, CB 1018.

[32] Telstra 000 recording (ESAP Job 2144732) at 6:30; Transcript of Telstra 000 calls, CB 954.

[33] Statement of Belinda Panagiotopoulos, CB 26-27.

[34] Statement of Belinda Panagiotopoulos, CB 26 [37]–[38]; Annexure 4 of the statement of Christopher Mercovich, CB 1018.

[35] Telstra 000 recording (ESAP job 8054348); Transcript of Telstra 000 calls, CB 960; Notification to IGEM of adverse event, CB 56-57 (call 3); ESTA Final Report, CB 79 (call 4); Annexure 4 of the statement of Christopher Mercovich, CB 1018.

[36] Telstra 000 recording (ESAP Job 2144732) at 9:39; Transcript of Telstra 000 calls, CB 956.

37. At 12:48:08 pm, yet another call was made to 000 by one of the people at the house (**call 5**). A Telstra agent answered the call within 67 seconds, at 12:49:15 pm. The call was presented to the call queue at 12:49:32 pm.[37]

38. At 12:50:31 pm, call 4 was answered by an ACT.[38] This was the first of the five 000 calls presented to the call queue that was answered by ESTA. It was answered 4 minutes and 21 seconds after it was first presented by the Telstra agent, and before call 2. The Telstra agent in call 2 was still waiting in the call queue, despite call 2 being made more than 7 minutes earlier than call 4.[39]

39. By the time that call 4 was answered by an ACT, it had been *16 minutes and 5 seconds* since call 1 from Nick was presented by the Telstra agent for answer by an ESTA ACT.[40] It had been *7 minutes and 3 seconds* since call 2 had been presented to the call queue, being the only other ongoing call that was still waiting to be answered.[41]

40. Call 4 resulted in an "event"[42] being created in the Computer Aided Dispatch (**CAD**) system by an ESTA ambulance call-taker (**ACT1**). During call 4, the speaker confirmed that a neighbour, a nurse, was performing CPR and that Nick was not awake and not breathing.[43]

41. At 12:51:21, call 2 was answered by a different ambulance call-taker (**ACT2**). This was *more than 12 minutes* after it was first presented by the Telstra operator to the call queue.[44] During triage of the call by ACT2, they identified that an event for the same emergency had already been created in CAD by ACT1.[45] CPR remained in progress throughout this time.[46]

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[37] Transcript of Telstra 000 calls, CB 963; Statement of Nicole Ashworth, CB 622; Notification to IGEM of adverse event, CB 57 (call 4); ESTA Final Report, CB 79-80 (call 5); Annexure 11 to statement of Nicole Ashworth, CB 832.

[38] Telstra 000 recording (ESAP job 8054348) at 4:37; Transcript of Telstra 000 calls, CB 960; ESTA recording, call 4; Transcript of ESTA call 4, CB 965; Notification to IGEM of adverse event, CB 56-57 (call 3); ESTA Final Report, CB 79 (call 4).

[39] Notification to IGEM, CB 57.

[40] ESTA Final Investigation Report, CB 81.

[41] Ibid.

[42] Ibid. Event number E21101610699.

[43] ESTA recording, call 4; Transcript of ESTA calls, CB 966.

[44] Telstra 000 recording (ESAP job 8054348); Transcript of ESTA calls, CB 973; ESTA Final Investigation Report, CB 79, 81; Notification to IGEM, CB 56-57 (call 3); Annexure 4 of the statement of Christopher Mercovich, CB 1018, Statement of Nicole Ashworth, CB 620.

[45] Notification to IGEM, CB 57.

[46] ESTA recording, call 4 at 1:23; Transcript of ESTA calls, CB 965.

42. At 12:51:42, ACT1 accepted an event for call 4 into CAD: "9E1 – CARDIAC OR RESP ARREST/DEATH: ? WORKABLE ARREST, NOT BREATHING AT ALL". This event type is pre-assigned a Priority 0 (Code 1) response, the most urgent response category, and automatically generated a multi-agency event for Ambulance Victoria[47] and Fire Rescue Victoria[48] to attend.[49]

43. At 12:51:51, the ESTA Fire Turnout Dispatcher dispatched unit P12 (**FRV unit**) from the Preston Fire Station for an Emergency Medical Response.[50]

44. At 12:51:54 pm the first ambulance unit (PR6798) (**first ambulance**) was dispatched by an ESTA Ambulance Dispatcher (**AD1**). The first ambulance was 1.9 km from Nick's address.[51]

45. At 12:52 pm, AD1 also dispatched three MICA single-responder paramedics to Nick's house. Unit ZR28 was 7.2 km from the house but was subsequently cancelled as units closer to the house were available. Unit ZR4 was 3.5 km from the house and unit ZR22 was 3.6 km from the house.[52]

46. At 12:53:23 pm, the ACT for call 4 provided instructions regarding CPR to those present with Nick and assisted them with compression counting for the first time.[53] This was the first time that any advice regarding first aid was provided to any of the 000 callers.

47. At 12:54:29, call 5 was terminated by the Telstra agent pursuant to the "4-minute rule" as there was no answer by an ACT and the caller had disconnected. This was 5 minutes and 14 seconds after that call was first answered by an agent.[54]

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[47] Event E21101610699.
[48] Event F211012555.
[49] Statement of Nicole Ashworth, CB 622; ESTA Final Investigation Report, CB 81; Statement of A/Prof David Anderson, CB 373.
[50] Statement of Nicole Ashworth, CB 623; Notification to IGEM, CB 57; ESTA Final Investigation Report, CB 81.
[51] Statement of A/Prof David Anderson, CB 374; Statement of Nicole Ashworth, CB 623; Notification to IGEM, CB 57; ESTA Final Investigation Report, CB 81.
[52] Statement of A/Prof David Anderson, CB 374; ESTA Final Investigation Report, CB 81- 82.
[53] ESTA recording, call 4 at 2:54; Transcript of ESTA calls, CB 969.
[54] ESTA Final Investigation Report, CB 79-80; Statement of Nicole Ashworth, CB 622.

48. At 12:55:23, call 2 was terminated by ACT2 as assistance was being provided in call 4, which had been answered earlier in time.[55] Between 12:55:57 and 12:56:27, ACT2 updated the event remarks on CAD with the information provided.[56]

49. The first ambulance and the FRV unit both arrived at the house at 12:55 pm, within 4 minutes of dispatch.[57] At 12:56:55, the FRV unit can be heard on the call recordings confirming that they had taken over CPR and ambulance were right behind them.[58]

50. Ambulance unit ZR 22 arrived at the house 12:58:06 pm.[59]

51. When paramedics assessed Nick at 12:59 pm, he was unresponsive, not breathing, with no circulation or palpable pulse.[60] It was confirmed that Nick was in asystolic cardiac arrest[61] and paramedics commenced medical management in accordance with the Clinical Practice Guideline for Adult Medical Cardiac Arrest.[62]

52. At 1:01 pm, ambulance unit ZR4 arrived at the house. An Ambulance Victoria Team Manager (TM1407) also self-responded to the event at 1:08 pm and arrived at the house shortly after.[63]

53. Despite extensive resuscitation efforts by the attending paramedics, Nick remained in asystole and could not be revived. He was declared deceased at 1:45 pm.[64] Police attended the scene and the death was reported to the Coroner.

54. As the event was unfolding, ESTA received email notifications from Telstra of the three calls where the caller disconnected and the "4-minute rule" operated (calls 1, 3 and 5). The emails were received at 12:54, 12:53, and 13:07 respectively, and an ambulance call-taker (**ACT3**) attempted to call the mobile numbers. In each case, the return call attempt went unanswered at 12:57:30 (calls 1 and 3) and 13:18:44 (call 5 – which was

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[55] ESTA recording call 2 at 4:02; Transcript of ESTA calls, CB 975.
[56] ESTA Final Investigation Report, CB 81.
[57] ESTA Final Investigation Report, CB 82; Statement of A/Prof David Anderson, CB 374; Notification to IGEM, CB 57; ESTA chronology report, CB 49.
[58] ESTA recording, call 4 at 6:24; Transcript of ESTA call 4, CB 972.
[59] Ambulance Victoria electronic patient care record, CB 40; ESTA chronology report, CB 49; ESTA Final Investigation Report, 82; Notification to IGEM, CB 56; ERTCOMM Event Register, CB 382.
[60] Ambulance Victoria electronic patient care record, CB 37.
[61] Notification to IGEM, CB 57.
[62] Statement of A/Prof David Anderson, CB 374; Ambulance Victoria electronic patient care record, CB 37; ESTA chronology report, CB 49; ESTA Final Investigation Report, CB 82.
[63] Statement of A/Prof David Anderson, CB 374; CB 81- 82: QIT report.
[64] Verification of Death Form CB 385

made to the incorrect number).[65] Having regard to the time that this call back procedure took to occur, it provided no hope of initiating a timely ambulance response which could have assisted in Nick's case.

Identity of the deceased

55. On 16 October 2021, Nick Panagiotopoulos, born 24 April 1974, was visually identified by Michael Nicolazzo, his brother-in-law. Identity is not in dispute and required no further investigation.

Medical cause of death

56. Nick had a medical history of moderate, chronic hypercholesterolaemia; hypertriglyceridaemia; moderate, chronic hypertension; and obesity. He received medical management for these conditions from General Practitioners and was prescribed Rosuvastatin (5mg daily), Irbesartan (75mg daily) and Atenolol (50mg daily), and he was recommended to take fish oil (3g daily).[66]

57. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 19 October 2021 and provided a written report of his findings dated 7 December 2021. In providing the report, Dr de Boer also considered initial information about the death provided in the Victoria Police Report of Death to the Coroner (Form 83), the Post-Mortem CT scan, and medical records provided by a medical practice that Nick attended. Dr de Boer noted that the medical history included hypertension and smoking (which had reportedly been ceased for 7 months).

58. The post-mortem examination revealed moderate atherosclerosis of the coronary arteries, with rupture of an atherosclerotic plaque in the posterior descending coronary artery with thrombotic occlusion. Histology did not show histological signs of acute infarction. Dr de Boer noted that the heart was enlarged (cardiac hypertrophy).

59. Toxicological analysis of post-mortem samples identified the presence of the inactive cocaine metabolite benzoylecgonine in blood and urine, and the inactive cocaine metabolite ecgonine methyl ester in urine only. Irbesartan and quinine were also detected in urine.

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[65] ESTA Final Investigation Report, CB 82-83.

[66] Statement of Dr Imogen Denton, CB 30-31.

60. Dr de Boer provided an opinion that the medical cause of death was "1(a) Acute myocardial infarction; 1(b) thrombotic occlusion of the right coronary artery; 1(c) coronary artery atherosclerosis" and that the death was due to natural causes.

61. Dr de Boer's report explained that the death was caused by a "heart attack", meaning "damage to the heart muscle due to an insufficient supply of oxygen, caused by thrombotic occlusion of one of the coronary arteries (the right coronary artery)." He further explained that the absence of sufficient oxygen caused the heart muscle cells to "die off', triggering a (potentially fatal) cardiac arrhythmia". Dr de Boer noted that in Nick's case, "[a]ll three coronary arteries showed a moderate degree of atherosclerosis" and [t]hrombotic occlusions are usually the result of atherosclerosis".[67]

62. At the inquest, Dr de Boer was called to give evidence and expanded upon the findings in his report. He explained that what is colloquially referred to as a "heart attack" is an acute myocardial infarction. In Nick's case, this was caused by the thrombotic occlusion of one of the three coronary arteries which supply the heart with blood. The thrombus (blood clot) occluded the entire coronary artery, meaning that no blood could flow through it.[68]

63. The blood clot in Nick's case was due to coronary artery atherosclerosis, a condition where there is a build-up of fat, cholesterol and other substances in the wall of the arteries, called "plaques". When plaques "rupture" and come into contact with the bloodstream, the blood clots, preventing blood from flowing through the artery. This in turn prevents oxygen supply to the heart muscles and the heart cells die off, causing the electrical activity in the heart to become unstable. The heart then pumps in an uncoordinated manner. As explained by Dr de Boer, when the heart doesn't pump blood, no oxygen is transported to the rest of the body and this causes circulatory collapse.[69]

64. Dr de Boer also explained that whilst the autopsy and related investigations did not directly show acute infarction, this was due to the timing of the event. He explained that to be able to see the structural changes caused by an infarct at autopsy, the person needs to have survived for a particular period of time, "at least a couple of hours", after the

[67] Autopsy report of Dr Hans de Boer, CB 7.
[68] Inquest transcript (**T**), 11 December 2023, 16:5-8
[69] T 11 December 2023, 15:3 - 16:4.

acute event. In Nick's case, because the acute infarction occurred "directly prior to death", the infarct was inferred (rather than demonstrated) from the presence of a thrombus in the coronary artery.[70]

65. Dr de Boer noted that other than the increased size of the heart, the heart was structurally normal.[71] He did not know whether the chances of survival differed for persons with an enlarged heart.[72]

66. Regarding the toxicology results, Dr de Boer confirmed that post-mortem blood and urine samples obtained at the time of the autopsy showed the presence of benzoylecgonine and ecgonine methyl ester, which are inactive cocaine metabolites, and that no cocaine was detected. He opined that Nick was therefore not under the influence of cocaine at the time of his death, but the results indicated cocaine use, likely within two days of death, but very likely not within the 12 hours prior to death.[73] Dr de Boer didn't think this could have had any impact on the chance of survival, as Nick was not under the influence of cocaine at the time of his death. The caveat to his evidence on this issue was that it was a clinical question. However, he did not think that the presence of cocaine metabolites had any impact on the utility of the first aid and medical treatment.[74]

67. Dr de Boer is an expert in his field of forensic pathology, and his evidence was not the subject of any dispute. I accept his evidence and I am satisfied that the medical cause of death is clear. Nick died from an acute myocardial infarction caused by a thrombotic occlusion of the right coronary artery and coronary artery atherosclerosis.

Circumstances in which the death occurred - the effect of delay

ESTA and the performance benchmark for ambulance call answer speed

68. At the time of Nick's death, ESTA had statutory responsibility for delivering Victoria's emergency call-taking and dispatch services on behalf of emergency services organisations including Ambulance Victoria (**AV**), the Country Fire Authority (**CFA**),

[70] T 11 December 2023, 16:9-21.
[71] T 11 December 2023, 19:19-23.
[72] T 11 December 2023, 21:14-24.
[73] T 11 December 2023, 17:2 - 19:3, 20:16-23.
[74] T 11 December 2023, 20:24 - 21:11.

Fire Rescue Victoria (**FRV**), Victoria Police and the Victoria State Emergency Service. This responsibility included ambulance call-taking and dispatch.[75]

69. ESTA's emergency ambulance call answer performance was evaluated against performance standards set by the Inspector-General for Emergency Management (**IGEM**).[76] At the relevant time, the primary benchmark was that 90 per cent of emergency ambulance calls were answered at or within five seconds within a calendar month. A secondary benchmark was that 95 per cent of calls were answered at or within 30 seconds. The standards reflected that not every call could be answered within 5 seconds.[77]

70. Whilst the standards acknowledged that not all calls could be answered in that time, it is not controversial that the delays which occurred in Nick's case were completely unacceptable and occurred at a time when ESTA had not met the performance standard for ambulance call answer speed since November 2020.[78] A key issue considered as part of the coronial investigation was whether these delays, and the failure by ESTA to meet the performance standard, contributed to Nick's death, and whether his death was preventable.

Expert medical evidence

71. An expert medical report was obtained from a Cardiologist, Associate Professor Nicholas Cox. The expertise of A/Prof Cox is in Cardiology, and I note that this was not a matter of any dispute. During his evidence at the Inquest, A/Prof Cox expanded on the contents of his report.

72. The evidence of A/Prof Cox addressed the circumstances of Nick's case, including the nature of the cardiac arrhythmia which led to cardiac arrest, the timing of the clinical events and the prospects of survival throughout the period leading up to death. I am satisfied that these matters are within the specialised knowledge which A/Prof Cox has as a Cardiologist. I understood that his evidence as it pertained to Nick's specific circumstances was based on the application of his expertise (which was inclusive of

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[75] IGEM review, CB 209,228. Statutory responsibility for this service is now with Triple Zero Victoria following the rebadging of ESTA in 2023

[76] Ashton review, CB 172.

[77] IGEM review, CB 233. The standards applied to the metropolitan area, but IGEM utilised these to assess Statewide performance, although the secondary benchmark was effectively not utilised by IGEM to measure performance, CB 323.

[78] IGEM review, CB 203. As acknowledged by the Inspector-General for Emergency Management

knowledge based upon his own clinical experience) to the particular facts of Nick's case, as known through the findings of Dr de Boer, and the available evidence regarding observations made of Nick and the timing of events, which was reviewed by A/Prof Cox.

The "chain of survival"

73. A/Prof Cox regarded Nick's death as "consistent with a cardiac arrhythmia leading to circulatory collapse caused by an acute myocardial infarction due to rupture of an atherosclerotic plaque leading to thrombotic occlusion of the posterior descending branch of the right coronary artery".[79] I note that this accords with the cause of death formulated by Dr de Boer.

74. A/Prof Cox explained the concept of a "chain of survival"[80] for patients in acute cardiac arrest as follows:

- Early symptoms recognition and activation of medical services by the patient or bystanders.
- Skilled recognition and rapid dispatch of emergency medical services by emergency call taker.
- Early CPR and early Defibrillation by emergency medical services responding within as short a time as possible to activation.[81]

75. Generally, he noted figures for survival to hospital discharge of an unwitnessed, out-of-hospital cardiac arrest reported at 13%, and 20% for those witnessed by emergency medical responders. However, A/Prof Cox also explained that such figures are for "large population groups including elderly patients and patients with significant comorbidities". He opined that in relation to Nick's specific case, "I would expect a more favourable outcome given his young age, absence of significant comorbidities and small infarct size as demonstrated by the autopsy report". A/Prof Cox opined that the size of the myocardial infarct in Nick's case was "likely to have been small, because it was in the distal right artery".[82]

[79] Statement of A/Prof Nicholas Cox, CB 61.
[80] The "chain of survival" is a series of critical actions that, when performed sequentially and in a timely manner, maximise a patient's chances of survival following a cardiac arrest.
[81] Statement of A/Prof Nicholas Cox, CB 66.
[82] T 11 December 2023, 36:29 - 37:1.

76. A/Prof Cox explained his opinion by reference to his clinical experience, noting that a large part of his daily clinical experience as a Cardiologist was working in "cath labs" (cardiac catheterization laboratories), where he is treating heart attacks "all the time".[83] He described his knowledge from that experience as follows:

> When we see a thrombus in the distal right coronary artery, it's almost always causing a small heart attack, but it just so happens that infarcts in the distal right coronary artery appear to be more commonly associated with abnormal heart rhythms. So the patient usually doesn't die from a pump failure, but dies from a rhythm which had it been treated appropriately, would've meant that the patient would've survived with minimal long term comorbidities or other problems.[84]

77. A/Prof Cox regarded Nick's medical condition as "similar to arrests that I see in the cath lab", which involved "a very controlled situation due to a blockage". Hence, he was "reasonably optimistic about his chances of survival with treatment early".[85]

78. According to A/Prof Cox, the evidence that there was a small infarct was significant because Nick was therefore likely to have had a treatable event and likely to recover as his heart was "less likely to be damaged by the event that's occurring".[86] If Nick had been treated and survived, A/Prof Cox expected he "could've had a high – a normal quality of life and indeed probably a long life, with appropriate care and follow up".[87]

79. A/Prof Cox opined that a patient suffering a witnessed cardiac arrest involving ventricular tachycardia or ventricular fibrillation in a hospital setting had in the order of a 99% chance of survival.[88] He considered this to be a similar scenario to a patient suffering the same type of witnessed arrest "in the field" if they had appropriately trained individuals present. He estimated that this cohort of patients have a 95 to 97 per cent chance of survival. He generally characterised the chance of survival in Nick's circumstances as "quite high to start with", meaning from the outset of the emergency.[89]

[83] T 11 December 2023, 36:8-10.
[84] T 11 December 2023, 26:14-22.
[85] T 11 December 2023, 44:3-9.
[86] T 11 December 2023, 36:4-7.
[87] T 11 December 2023, 37:2-6.
[88] T 11 December 2023, 43:1-8.
[89] T 11 December 2023, 43:10-16.

80. Having regard to the evidence of A/Prof Cox, I am satisfied that in assessing Nick's chance of survival, the starting point is that his condition was treatable and he could have survived.

Assessing 'the chain of survival' in Nick's case

a. The type of cardiac arrhythmia

81. According to A/Prof Cox, the symptoms described by Nick when he first became unwell were likely due to acute coronary ischaemia,[90] and Nick called for ambulance assistance after he experienced symptoms of myocardial infarction due to coronary occlusion. A/Prof Cox explained that a patient will often have symptoms of chest pain, be alert, and able to articulate their symptoms when they are having a myocardial infarction, and he noted that if a person is awake, they have not yet had a cardiac arrest.[91] He described Nick as being "dangerously unwell" at the time of his first call to 000, and requiring urgent medical attention as soon as possible.[92]

82. As explained by A/Prof Cox, there are three ways in which a person dies following a heart attack. One of these is "pump failure" and he opined that it was not likely that this occurred in Nick's case.[93] He regarded it as "much more likely" that he died from one of two other causes,[94] namely, "tachyarrhythmia, a ventricular tachycardia or a ventricular fibrillation" (a very fast heart rhythm), describing this as the "the most common outcome",[95] or a "bradycardic event, a slow heartbeat", which is associated with right coronary thrombosis, noting that this was the location of thrombosis in Nick's case.[96]

83. A/Prof Cox assessed that at the time Nick called 000, the main risk was that he would experience "sudden onset of a ventricular arrhythmia requiring defibrillation".[97] The effect of A/Prof Cox's evidence was that this risk of ventricular arrhythmia ultimately materialised, and it was during Nick's call to 000 or shortly after that he had "a cardiac

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[90] Statement of A/Prof Nicholas Cox, CB 61. Coronary ischaemia is when blood flow to the heart muscle is suddenly reduced. This causes severe oxygen starvation (ischaemia) to the heart muscle.
[91] T 11 December 2023, 30:2-7.
[92] Statement of A/Prof Nicholas Cox, CB 64.
[93] T 11 December 2023, 23:21-27, 24:11-19.
[94] T 11 December 2023, 24:19-21.
[95] T 11 December 2023, 23:28-31.
[96] T 11 December 2023, 24:24-27.
[97] Statement of A/Prof Nicholas Cox, CB 64.

arrest secondary to a cardiac arrhythmia, which was likely to be ventricular fibrillation or ventricular tachycardia".[98]

84. A/Prof Cox explained that when the heart rhythm changes (tachyarrhythmia or bradyarrhythmia), that is the point of cardiac arrest. He added:

> So, that's the point where the heartrate changes […] the heart output drops, because the heart no longer is generating a pulse and the blood pressure drops. At that point that the cardiac arrest occurs, that is when the patient falls unconscious and that is the clear difference. So, if they are awake, then they haven't had a cardiac arrest, but if they are unresponsive or unconscious, then it is likely that the cardiac arrest has occurred.[99]

85. Having listened to the 000 call recordings, A/Prof Cox opined that whilst Nick was heard talking and was awake, he was pre-cardiac arrest.[100]

86. A/Prof Cox's evidence regarding the type of cardiac arrhythmia that Nick experienced is relevant to assessing his survival prospects because it is determinative of the appropriate medical treatment. Tachyarrhythmia (tachycardia) are known as "shockable rhythms" as they "are amenable to defibrillation and cardioversion". In contrast, bradycardia is usually not a shockable rhythm and, if diagnosed at the time of arrest, is "amenable to treatment by emergency medical services" using intravenous medications.[101]

87. Whilst the appropriate medical treatment is ultimately different, the treatment pathway for either tachycardia or bradycardia required commencement of CPR and application of a defibrillator to identify the rhythm and administer the appropriate emergency treatment, being cardioversion[102] for a shockable rhythm, or intravenous medication for a non-shockable rhythm.[103] In this regard, A/Prof Cox opined that the combination of the response time of the first medical responders, commencement of CPR and defibrillation was the "key determinant to an improved outcome" in Nick's case.[104]

[98] Statement of A/Prof Nicholas Cox, CB 63.
[99] T 11 December 2023, 30:8-20.
[100] T 11 December 2023, 30:21-30.
[101] T 11 December 2023, 24:30-25:13.
[102] Use of a defibrillator.
[103] T 11 December 2023, 27:22-31.
[104] Statement of A/Prof Nicholas Cox, CB 65.

88. Based upon his assessment that Nick's cardiac arrest was most likely due to a tachycardia, which is a shockable rhythm, the "key intervention" which was required to save Nick's life after his cardiac arrest was "the presence of an individual trained in CPR with access to a defibrillator".[105] A/Prof Cox opined that this could have been either the ambulance, or fire services.[106] He therefore expected the same outcome whether it was an FRV unit or paramedics who were the first to attend, as FRV are equipped with defibrillators and trained in CPR.[107]

89. A/Prof Cox noted that Nick had a good chance of survival if a first responder had been dispatched within 60 seconds of his first 000 call, and that it was likely he would have survived without significant long-term morbidity.[108] This is because if Nick received medical intervention before he had a cardiac arrhythmia, or if it had been rapidly treated, the size of the infarct would likely have been small, and "would not have led to significant myocardial dysfunction".[109] Furthermore, "his likelihood of survival with appropriate treatment of his myocardial infarct would have been high".[110]

90. A/Prof Cox described Nick's chance of survival as "good" if paramedics arrived after the cardiac arrhythmia occurred but before the cardiac arrest occurred, noting they could have immediately commenced CPR and performed defibrillation within 1 or 2 minutes of loss of cardiac output. In such circumstances, his opinion was that there was a high likelihood that defibrillation would have been successful.[111]

91. By way of overview regarding Nick's chances of survival, A/Prof Cox opined as follows:

> So had emergency responders arrived before he had his cardiac arrest, I think his chance of survival would have been exceptionally high, over 90 per cent for sure. Had they arrived shortly after his cardiac arrest, I think his chances of survival would also have been high, [because] he has no other comorbidities. He's never had a heart attack before. He was otherwise a young, healthy individual and in that circumstance, early CPR and early cardioversion is usually successful.[112]

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[105] Ibid, CB 65-66.
[106] T 11 December 2023, 37:11-16.
[107] Statement of A/Prof Nicholas Cox, CB 65-66.
[108] Ibid, CB 66.
[109] Ibid, CB 64.
[110] Ibid, CB 64.
[111] Ibid, CB 65.
[112] T 11 December 2023, 31:2-12

92. At other points in his evidence. A/Prof Cox described Nick's chance of survival as being "almost a hundred per cent" if emergency services arrived prior to cardiac arrest occurring, and "good" if they arrived within 7-10 minutes.[113] Overall, A/Prof Cox regarded the delay in call answer as "contributory" to Nick's death as it "eliminated his chances of survival".[114]

b. The effect of timing of CPR and defibrillation/intravenous medication

93. During the evidence of A/Prof Cox there was a focus on the timing of CPR and the nature of it, as it pertained to Nick's chances of survival. A/Prof Cox's evidence was that CPR required chest compressions, by either a trained or untrained person, noting that a trained person is "more likely to do it effectively", but in either case the aim is for 120 chest compressions per minute. This is to maintain perfusion to the brain and other organs to keep the person alive until a defibrillator can be used and treatment given for the cause of the cardiac arrest.[115] A/Prof Cox explained that the purpose of CPR is to maintain cerebral perfusion which helps stop brain death. It also provides some blood flow to the heart, which increases the likelihood of success of cardioversion and defibrillation.[116]

94. A/Prof Cox noted that delayed commencement of CPR after the patient collapses decreases the chances of survival. The sooner it commences, the more likely a good outcome is.[117] He also gave evidence that CPR by someone who is untrained, but who is being guided to give CPR by a trained individual over the telephone "is better than someone who has … no guidance". This is because whilst any compression of the chest is good, compressions at the right speed in the right spot "increases the likelihood of sustaining someone until further treatments can be delivered".[118]

95. The success of defibrillation also depends on the time it is commenced from the point of cardiac arrest, assuming that the patient has a shockable rhythm. The longer the delay from the commencement of CPR to defibrillation, the less likely the defibrillation will be successful.[119] As explained by A/Prof Cox,

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[113] T 11 December 2023, 37:31 - 38:6.
[114] T 11 December 2023, 37:31 - 38:9.
[115] T 11 December 2023, 28:7-19.
[116] T 11 December 2023, 46:26 - 47:3.
[117] T 11 December 2023, 32:5-17.
[118] T 11 December 2023, 32:13-24.
[119] T 11 December 2023, 28:27 - 29:8.

> [E]arly defibrillation within a minute or two is very likely to be successful. Defibrillation after a period of CPR is a bit less likely to be successful, but still reasonably likely to be successful. Defibrillation after a prolonged arrest with neither CPR, or any other support, becomes less and less likely to be successful.[120]

96. A/Prof Cox specifically disagreed with the proposition that a patient needs to be defibrillated within “a couple of minutes” of arrest, explaining that the “key intervention” needed was commencement of quality CPR as soon as possible after arrest, and noting that in “many cases” patients have survived with 30-40 minutes of CPR prior to being defibrillated.[121] When questioned about the reference in his report to survival rates for ventricular arrythmia with cardiac arrest decreasing approximately 10 per cent with every minute that defibrillation is delayed, he qualified that the presence or absence of CPR is also critically important.[122] He explained that this was a statistic reported in relevant literature, but he could not state whether it referred to cases with or without effective CPR, and noted a lot of the literature was a “mixture of all sorts of events”.[123]

97. A/Prof Cox also classified the chances of survival with intravenous medication (which is necessary where there is a non-shockable bradycardia) as being the same as with defibrillation where CPR has been given.[124]

c. The time breathing stopped and the time of cardiac arrest

98. Another focus of questioning during the evidence of A/Prof Cox was the significance of the observations about the time when Nick stopped breathing.

99. According to A/Prof Cox, breathing will stop after a cardiac arrest has occurred.[125] However, a person who has stopped breathing can have a shockable rhythm, and a person who has stopped breathing who has a non-shockable rhythm, can still be amenable to medication. [126]

100. He agreed that the observations made by bystanders that Nick was breathing, then not breathing, then breathing again, were consistent with “agonal breathing” – a disturbed

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[120] Inquest transcript, 11 December 2023, 29:9-15.
[121] Inquest transcript, 11 December 2023, 41:2-12, 28:21-26.
[122] Inquest transcript, 11 December 2023, 42:9-17.
[123] Inquest transcript, 11 December 2023, 43:24-31.
[124] Inquest transcript, 11 December 2023, 29:9-20.
[125] Inquest transcript, 11 December 2023, 34:29-31.
[126] Inquest transcript, 11 December 2023, 44:20-28.

breathing pattern which occurs "post-arrest".[127] However, he considered that the descriptions of Nick as "not breathing" were unclear, and noted that even with agonal breathing there will be some oxygenation. He regarded bystanders' descriptions of the time at which Nick stopped breathing as not very useful in his assessment of the chances of survival, as what was more relevant was the point in time at which the cardiac arrest occurred.[128] He agreed that if the first bystander report that Nick was not breathing was at 12:41 pm, even with the subsequent observations that Nick *was* breathing, it was likely Nick had arrested by 12:41 pm and would have benefitted from CPR from that point.[129]

101. Regarding the time at which cardiac arrest occurred, A/Prof Cox commented that, based upon the information he had available,

> [T]he one thing I was confident of was that he was – he had not arrested at that point where he vocalised on the call that he made to Emergency Services. So I think we can assume he's definitely pre-arrest at that point and up until the end of the call. I had trouble determining at other points, whether he was pre or post arrest.[130]

Asystolic arrest

102. By the time that paramedics arrived at the house and applied a defibrillator, Nick was in asystolic arrest, which is a non-shockable rhythm.

103. I note that evidence regarding survival rates following cardiac arrest was included in a statement by Associate Professor David Anderson from Ambulance Victoria, which referred to annual reports of the "Victorian Ambulance Cardiac Arrest Registry". This information indicated survival from asystolic cardiac arrest in Victoria is 0.3%, which is consistent with information gathered by other ambulance services around the world.[131]

104. A/Prof Cox also gave evidence that once Nick's condition deteriorated into asystole, "the chances of the emergency responders resuscitating him became very small".[132] He opined that Nick's condition degenerated into asystolic arrest over time in the setting

[127] T 11 December 2023, 39:17-31.
[128] T 11 December 2023, 44:30 - 45:11.
[129] T 11 December 2023, 38:24 - 39:15.
[130] T 11 December 2023, 40:11-17.
[131] CB 376.
[132] T 11 December 2023, 46:10-15.

of a myocardial infarct, and it was several minutes after Nick arrested that he would have been in asystole.[133] By that time Nick was (unsurprisingly) unable to be resuscitated despite appropriate measures being utilised by paramedics.[134]

Chance of survival

105. Having regard to the evidence of A/Prof Cox, out-of-hospital cardiac arrest is survivable but time is a critical factor for the success of treatment. Having reviewed the circumstances of Nick's particular case, including the length of delay in ESTA call answer, A/Prof Cox was of the opinion that the "delays encountered in transferring the call from the Telstra operator to the emergency services responder [were] contributory to [Nick's] death".[135]

106. A/Prof Cox specifically noted the more than 4-minute delay during which Nick's own call to 000 was not able to be connected to an ambulance call-taker by the Telstra operator, and that the delays in connection to an ambulance call-taker in subsequent calls "further exacerbated the delay to emergency treatment".[136] He opined that these delays were "a significant contributor to the inability to resuscitate Mr Panagiotopoulos after his cardiac arrest" and that all other steps in the required "chain of survival" had occurred in a "timely manner".[137] A/Prof Cox specifically identified the delay in connection to emergency services in Nick's case as the issue in the well-known "chain of survival" which "resulted in survival not occurring".[138]

107. Regarding whether or not such delays were acceptable, A/Prof Cox stated his professional view that,

> [T]here is an expectation from those involved in resuscitation care, as well as an expectation from the community that a call made to 000 would be connected to a skilled ambulance dispatcher within seconds."[139]

108. In assessing Nick's chances of survival, I am satisfied that at the outset of his heart attack his chance of survival was high, and that this deteriorated over time due to delay

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[133] T 11 December 2023, 45:27 - 46:13.
[134] T 11 December 2023, 35:7-12; statement of A/Prof Nicholas Cox, CB 63.
[135] Statement of A/Prof Nicholas Cox, CB 66.
[136] Ibid, CB 66.
[137] Ibid, CB 67.
[138] T 11 December 2023, 47:10-30.
[139] Statement of A/Prof Nicholas Cox, CB 67.

in commencement of guided CPR and defibrillation/cardioversion. Nick's condition then deteriorated into asystolic arrest over several minutes. It is unclear how long prior to paramedic attendance this occurred, but from the moment he was in asystolic arrest his chances of survival were negligible, even with appropriate medical intervention by paramedics. Considering that emergency services did not arrive until after he was in asystolic arrest, it is unsurprising that Nick did not survive.

Whether the death was preventable

109. The risks associated with delayed emergency ambulance call answer include "delayed clinical triage, provision of first aid advice, and delayed dispatch of ambulance resources."[140] It is apparent that all of these risks materialised in Nick's case.

110. Having regard to the evidence of A/Prof Cox, Nick first began experiencing symptoms of myocardial infarction at about 12:25 pm when he told his wife Belinda he thought he may have injured his back. From this time, Nick was experiencing a heart attack. His symptoms progressed to feeling sweaty and clammy by 12:32 pm. When Nick first called 000 at 12:34:05, he was experiencing a medical emergency and he required urgent medical assessment and treatment.

111. Nick was still conscious and speaking four minutes later at 12:38:02, when he was last heard speaking to the Telstra operator before the call disconnected. At that point in time, he was not in cardiac arrest.

112. Call 1, made by Nick, disconnected on his end at 12:38:26 and it remains unclear why the call disconnected. From 12:34 pm, Nick was aware he was suffering symptoms and he called 000 to request an ambulance. I infer that he knew he was experiencing a medical emergency, and this awareness would have increased throughout the call as he is heard groaning and in some degree of distress/discomfort. Having regard to the recording of his call with the Telstra operator, Nick was aware that no ambulance had been requested as the Telstra operator was still trying to connect him when the call disconnected. There is therefore no rational explanation as to why he would not have remained on the call with the Telstra operator if he was able to do so.

[140] Statement of Christopher Mercovich, CB 366.

113. There is no direct evidence explaining how the next call from Nick's mobile phone (call A) at 12:38:34 pm was made. This call was made from Nick's mobile phone immediately after his first call disconnected. There was no verbal response to the Telstra operator by the caller during call A, and no background noise can be heard in the call recording except for a dog barking. It is apparent that Belinda had not yet arrived home. It is not possible to know if call A was deliberately made or accidentally dialled, but whilst those details remain unclear, Nick's mobile phone remained in his possession throughout this period. I infer that if Nick was conscious and physically able to have intentionally made call A from his mobile phone, he was by that time unable to verbalise any response to the Telstra operator's questions. After call A ended, there was no further call made from Nick's phone prior to Belinda arriving home. Having regard to the evidence of A/Prof Cox, it is likely that Nick had experienced a cardiac arrest by the time call A was made.

114. The first direct evidence that Nick was non-responsive, and in cardiac arrest, is Belinda's arrival at the house at about 12:40 pm.

115. I am satisfied that the likely explanation for call 1 disconnecting, and there being no response in call A, is that Nick suffered a cardiac arrest during that short period of time. Nick therefore experienced a cardiac arrest at some point after he is last heard verbalising at 12:38:02, and before he was found non-responsive by Belinda at about 12:40 pm. Consequently, even though the cardiac arrest was not witnessed, Belinda was likely present with Nick within a minute (possibly less) or two (at most) of it occurring. At that time, call 2 was connected with a Telstra operator, waiting in the call queue for answer by ESTA.

116. The first indication in the evidence about Nick's breathing is Belinda's description of the male neighbour arriving at the home and stating that he thought Nick was breathing. The first confirmation in the 000 call recordings that Nick is not breathing is at 12:41 pm, after which time he is described as both breathing and not breathing. At about 12:45:50 pm, the male neighbour states he is sure Nick is not breathing, and he and Belinda commence CPR.

117. Having regard to the evidence of A/Prof Cox, I am satisfied that the varying descriptions of Nick's breathing are likely attributable to agonal breathing, consistent with Nick having already suffered a cardiac arrest. Nick's chances of survival would have been

maximised if CPR was commenced when it was first observed that he was not breathing. By the time CPR was commenced at about 12:45 pm, Nick had likely been in cardiac arrest since approximately 12:38 - 12:39 pm. During that period of 6 to 7 minutes before CPR was commenced, there may have been some limited agonal breathing occurring, meaning there was some oxygenation. Regardless of the agonal breathing, Nick needed effective CPR as close in time to his cardiac arrest as possible to have the best chance of survival. Belinda was present with him from about 12:40 pm and could have commenced CPR if she was given first aid advice and instruction to do so by an ESTA ambulance call-taker, but at that time call 2 was still waiting to be connected to ESTA.

118. At some point, CPR was taken over by a trained nurse who was at the house. This occurred no later than about 12:51:54, when it is mentioned in the call recording. That was approximately 13 minutes after the cardiac arrest occurred.

119. It was not until 12:53:23 that an ESTA ambulance call-taker gave instructions on how to perform high quality CPR with compression counting to assist the people present with Nick. This was more than 13 minutes after Belinda arrived at the house. During that period, those trying to assist Nick were left waiting on hold with a Telstra operator, not knowing whether CPR should occur and with no assistance as to how to perform it effectively.

120. Other than the absence of agonal breathing, Nick's presentation when call 4 was finally answered by ACT1 was no different to what it had been when he was first found unresponsive by Belinda. Having regard to the manner in which the information in call 4 was assessed and triaged by ACT1 as a cardiac arrest, I am satisfied that the assessment and actions taken by the ACT would have been identical if the call had been answered when Belinda first arrived, namely: recognition of the emergency as a cardiac arrest, with dispatch of ambulance resources with a Priority 0 response and associated dispatch of an FRV unit, prompt instructions given to commence CPR and assistance with compression counting.

121. The fact that ACT1 gave instructions to commence CPR demonstrates that an essential part of the 000 call taking process includes provision of life saving first aid advice to callers who are not medically trained, and this is done to increase the patient's chance of survival prior to paramedics arriving. This is consistent with the evidence of

A/Prof Cox, which explained that timely CPR is a critical component of the response to a cardiac arrest.

122. Call 2 was connected to the Telstra operator and waiting for ESTA to answer when Belinda arrived home. If the call had been answered by ESTA within seconds, as it should have been, I am satisfied that an ACT would have provided CPR instructions to Belinda as Nick was non-responsive and had suffered a cardiac arrest by the time she arrived. This would have been just after Nick went into cardiac arrest. If CPR commenced at that early stage, it would have been with an ACT providing compression counting assistance to those present with Nick until paramedics arrived.

123. Within 1 to 2 minutes of Nick's cardiac arrest, Belinda and others were present with Nick and in a position to have performed effective CPR if instructed to do so by an ACT. Instead, they were left waiting on hold with Telstra operators who could not offer any such advice or assistance. Having regard to the evidence of A/Prof Cox, the timing of the commencement of CPR following cardiac arrest was an essential determinant in Nick's chances of survival. Members of the community present at a medical emergency where CPR is needed rely upon ESTA call-takers to provide that assistance to them in a timely manner, and lives may depend upon this occurring. Therefore, the first consequence of the delay in ESTA call answer was that CPR was not commenced as soon as it could have been. This delay in the provision of first aid advice has adversely impacted Nick's chances of survival and contributed to his death.

124. I am also satisfied that if the 000 calls had been answered by ESTA at an earlier time, an ambulance and FRV unit would have been available and promptly dispatched. I note that within one and a half minutes of ACT1 answering call 4,[141] an ambulance and FRV unit were dispatched, with two further single-responder MICA units dispatched within another minute. The first ambulance unit and FRV unit arrived at the house within 4 minutes of dispatch, and the two additional MICA single-responder paramedics arrived at the house 3 and 6 minutes respectively after the first ambulance and FRV unit arrived.

125. Whilst it cannot now be found that these exact response times would have occurred if the 000 call connected earlier, the evidence suggests that there would have been a

[141] ESTA call answer at 12:50:31 with dispatch of FRV and ambulance and resources at 12:51:51 and 12:51:54 respectively.

similar response time from 12:34 pm when Nick first called 000. At that point in time, he was still responsive and breathing and may have been classified as requiring a Priority 1 response, rather than a Priority 0 response. However, by the time Belinda arrived at the home, Nick was non-responsive and would have been assessed as requiring a Priority 0 response. The response times which did ultimately occur demonstrate the speed of dispatch and attendance which can and should occur for a Priority 0 case. The number of FRV and ambulance units dispatched within quick succession also demonstrates that there were no emergency services resourcing issues in Nick's locality at the time he was experiencing a cardiac arrest. I am therefore satisfied that if there had been earlier connection to an ACT at any time from 12:34 pm, similar if not identical resourcing and response times would have occurred.

126. The evidence establishes that Nick and his wife recognised very quickly that he was seriously unwell and in need of an ambulance, and a call to 000 was made immediately by Nick. The medical emergency he experienced was very serious in nature from the outset, but it was also treatable and survivable. His type of cardiac arrest, whether it was a ventricular arrhythmia (most likely) or a bradycardia, required prompt attendance by paramedics, and Nick had an excellent chance of survival with appropriate and timely first aid and medical intervention.

127. Therefore, if Nick's 000 call been connected to an ACT within the performance benchmark times, or within seconds, as expected by A/Prof Cox, it is likely that paramedics would have been promptly dispatched. If prompt dispatch had occurred when Nick initially called 000, it is possible that paramedics would have been in attendance at the home within seconds or minutes when Nick suffered a cardiac arrest 4 minutes later. Having regard to the evidence of A/Prof Cox, it is likely that Nick would have survived if this response occurred. Even if paramedics were not dispatched during Nick's call, a prompt answer of call 2, when Belinda was present with Nick, would have led to a Priority 0 dispatch and effective CPR instructions until paramedics arrived, all of which would have increased Nick's chance of survival. I am therefore satisfied that the delay in call answer by ESTA has also adversely impacted Nick's chance of survival and contributed to his death.

128. Having regard to the chain of survival, the only deficiency with regard to the response to Nick's circumstances was the delay in call answer speed by ESTA. This not only delayed timely dispatch of available ambulance and FRV resources, it also delayed

timely advice regarding the commencement of CPR by those present with Nick. As articulated by A/Prof Cox, these delays extinguished Nick's chance of survival. In my view, on the balance of probabilities, Nick's death could have been prevented.

PART 2: COVID-19 AND EMERGENCY AMBULANCE CALL ANSWER DELAYS

OVERVIEW

000 and requests for emergency ambulance

129. Telstra is the Emergency Call Service for nationwide calls to 000. It is responsible for initially answering all emergency calls to 000 and ensuring they are transferred to the requested emergency services organisation (**ESO**), namely Police, Fire or Ambulance in the relevant state or territory.

130. Performance benchmarks for Telstra require that on any day, 85 per cent of calls are answered by a Telstra agent within 5 seconds, and 95 per cent of calls are answered by within 10 seconds. This is referred to as the Grade of Service.[142]

131. Telstra agents identify which ESO the caller requires. The Telstra agent then remains on the line with the 000 caller until the call is transferred to the relevant ESO by way of a "warm transfer". This requires an ESO operator to answer the call and thereby establish a three-way conference call in which the Telstra agent ensures they can hear the ESO operator in conversation with the 000 caller before releasing the call to the ESO operator, which ends the Telstra agent's involvement. This releases the Telstra agent to answer other incoming 000 calls nationwide.

132. Ordinarily, this entire process takes less than 50 seconds.[143] Where the caller disconnects prior to an ESO call-taker answering the call, the Telstra agent stays on the line and provides the known information from the caller to the ESO when they answer.[144]

133. Telstra agents are unable to provide any medical or first aid advice and they cannot dispatch any emergency services for callers. Delays in ESO call-takers answering the 000 call from the Telstra agent therefore results in the 000 caller receiving delayed

[142] Annexure to statement of Jane Elkington, CB 389.
[143] Ibid.
[144] Ibid, CB 390.

access to the help they need and no medical or first aid advice. Delays in ESO answer times may also impact Telstra agents' capacity to answer other incoming 000 calls, as they result in new calls sitting behind existing calls, creating a "funnelling effect" for Telstra, increasing the time it takes for Telstra operators to answer other 000 calls.[145]

134. Having regard to this system, the most critical factor for ensuring an emergency caller receives timely assistance is the ability of the ESOs in each state and territory to quickly accept the transferred call from Telstra, triage the call, and then dispatch the emergency assistance required.[146]

135. In accordance with this procedure, all Victorian calls to 000 are initially accepted by Telstra's national E000 service. The caller is asked by the Telstra agent whether they require the services of Police, Fire or Ambulance and, based on the caller's response, the Telstra operator will transfer the call to an ESTA call-taker trained in answering the call for the relevant ESO which is required.[147]

136. ESTA (now Triple Zero Victoria) is unique within Australia as it is the sole statutory authority with responsibility for the call-taking and dispatch (**CTD**) functions for all ESOs for the state. Telstra must direct the 000 calls received for Victoria to the relevant ESTA call-taking line, which is staffed by call-takers who are trained for that specific emergency service.

137. ESTA's call-taking staff have specific skills and training that are developed in conjunction with the relevant emergency service provider. There are substantial differences between ambulance call-taking and dispatch, and police or fire call-taking and dispatch. The training for Ambulance Call-Takers (**ACTs**) is specific and more complex. Prior to the pandemic, that training took seven weeks.

138. When a Victorian caller requests the ambulance service, the Telstra operator can only transfer the call to an ACT. If the ESTA line for the ambulance service is busy, Telstra cannot transfer the call to a different emergency service line at ESTA. The Telstra operator must remain on the line until the call is answered by an ACT.

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[145] Ibid.
[146] Ibid, CB 390.
[147] Victoria Police, Fire Rescue Victoria, Ambulance Victoria or Victoria State Emergency Service.

139. As an additional resource, ESTA also has "multi-skilled call-takers" available. These staff are trained in call-taking procedure for the other ESOs and are also fully trained and accredited in ambulance call-taking. Training to become a multi-skilled call-taker generally takes 2½ to 3 months. During the pandemic there was a very limited number of these multi-skilled call-takers, and likely only one or two were available on any given shift.

140. When a call is answered and "warm-transferred" by the Telstra operator to the ACT, the ACT proceeds with a "structured call-taking process", which involves asking the caller scripted "key questions" that are designed to obtain relevant information to assess the resourcing needed for their stated emergency. Based on the answers given, the call is assigned an "event type", which in turn determines the priority which is assigned to dispatching an ambulance. An ambulance cannot be dispatched until this call-taking process has been completed and an event is created in the Computer Aided Dispatch (**CAD**) system by the ACT.

141. At the time of Nick's emergency, the standard emergency ambulance event priorities were as follows:

   a) Priority 0 – Most critical events requiring an immediate response (lights and sirens);

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

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

   d) Priority 3 – Non-urgent events, referred to AV's Secondary Triage service for further assessment; and

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

142. By reference to the priority categories, it is apparent that the triage process undertaken by the ACT is crucial in determining the urgency of ambulance attendance in any given case. Ambulance resources are then allocated by ESTA Ambulance Dispatchers to emergencies, dependent upon the criticality of the medical event, as reflected by the priority level assigned to the event.

143. In Victoria, there is no means by which the community can access emergency ambulance assistance other than by calling 000 and being transferred to ESTA in this manner. ESTA, and now Triple Zero Victoria, is the critical link between Victorians and emergency ambulance services.

144. If callers are unable to be transferred from the Telstra operator to an ESTA call-taker, there is no prospect of an ambulance being sent to them, and if there are delays in this process, the caller has no option but to stay on the line and wait for an ESTA ambulance call-taker to answer the call being transferred by Telstra, as occurred in Nick's case.

145. While the caller is waiting, the Telstra operator has no alternative means of requesting an ambulance for them and cannot offer pre-arrival first aid instructions or any advice to the caller. Nor does the Telstra operator have any knowledge about how long it will take for the call to be answered by ESTA.

146. The transfer of calls from Telstra to an ACT should happen very quickly, within seconds, as reflected by the performance standard for ambulance call answer speed which was applicable to ESTA at the time of Nick's emergency. However, in Nick's case there were significant delays which led to completely unacceptable call answer times.

The ambulance call-taking crisis

147. The delays experienced in Nick's case were not an anomaly. Rather, they were the product of a large-scale crisis in ESTA emergency ambulance call-answer performance caused by factors attributable to the COVID-19 pandemic. Not only were the delays not an anomaly, but they were also known to be occurring on a large scale, and on an ongoing basis, at the time of Nick's death.

148. The delays were known and appreciated by ESTA in real time due to data it collected and analysed regarding its own performance. This data collection and monitoring was part of its business-as-usual operational model, and necessary for ESTA to acquit its statutory functions under the *Emergency Services Telecommunications Authority Act 2004* (**ESTA Act**). It was through this routine data collection and monitoring that the delays in ambulance call-taking became apparent, and because ESTA was required to assess its performance by reference to the IGEM performance standards for its call-taking and dispatch services.

149. At all relevant times, ESTA was subject to performance standards for its call-taking and dispatch (**CTD**) functions in relation to emergency ambulance calls, which required that 90 per cent of emergency ambulance calls in any calendar month be answered within 5 seconds.[148] ESTA had complied with this benchmark between January 2016 and November 2020. However, commencing in December 2020, during the COVID-19 pandemic, ESTA experienced a significant and ongoing decline in its emergency ambulance call answer times, dropping below this 90 per cent compliance standard. It would not achieve compliance again until August 2022.

150. During that time, ESTA faced an unprecedented increase in demand for ambulance services in Victoria attributable to factors arising from the COVID-19 pandemic and related public health measures. ESTA's available workforce was also negatively impacted, and its resources were simply unable to service the increased demand over a prolonged period of time. This resulted in a significant and unprecedented decline in ESTA's ability to meet its performance benchmark for emergency ambulance call answer speed for 18 months. During this period, which encompassed Nick's emergency, the system of emergency ambulance call taking in Victoria effectively failed.

151. The impact of this system failure was not just statistics on a page. Members of the Victorian community were left waiting on hold with Telstra operators in highly distressing emergency situations, unable to be transferred to an ACT to request timely ambulance assistance. Throughout the crisis, large numbers of callers were on hold for completely unacceptable lengths of time.[149] The fact of the crisis was known and acknowledged by ESTA and the Victorian Government at the time, and it received extensive media scrutiny just prior to, and following, Nick's death.[150]

152. It is extraordinary that there was an 18-month period during which ESTA simply could not meet its monthly performance benchmark for ambulance call answer speed, even accounting for the COVID-19 context. The implication is that throughout this period, ESTA was failing to satisfactorily delivery its CTD functions.[151]

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[148] The performance standard for the metropolitan area.

[149] Inspector-General for Emergency Management, *Review of Victoria's emergency ambulance call answer performance* (September 2022), CB 203. (**IGEM review**)

[150] Statement of Christopher Mercovich, CB 370-371; ESTA, *Capability and service review: Final Report* (2022), CB 109. (**Ashton review**)

[151] Section 7, *Emergency Services Telecommunications Authority Act 2004* (**ESTA Act**).

153. The crisis was also unusual for several other reasons. Unlike natural or law enforcement emergencies which have been known to periodically overwhelm or challenge the ESTA CTD system[152] and cause call answering delays for various ESOs, this crisis was limited only to ambulance services. Also, it was not the result of an unforeseen natural or law enforcement event, and the period of crisis was not of short duration or self-limiting. It was, in many regards, unprecedented.

154. Throughout this period, ESTA did not perform its functions in a silo. The ongoing non-compliance with the ambulance call-answer speed performance benchmark was known and appreciated not only by ESTA, but also by the Inspector-General for Emergency Management (**IGEM**) who monitored ESTA's performance.

155. IGEM is a legislated assurance and oversight entity for the emergency management sector.[153] As an independent statutory body, IGEM had a key role in assuring ESTA's performance in accordance with the *Emergency Management Act 2013* (**Emergency Management Act**). This included a statutory responsibility for both setting and monitoring ESTA's compliance with performance standards.[154] Relevantly, this included the benchmark of answering 90 per cent of calls for emergency ambulance in a calendar month within 5 seconds. In addition to IGEM, Emergency Management Victoria, the Emergency Management Commissioner, ESOs, government departments and the Minister of Emergency Services also became aware of ESTA's performance issues through various means and to varying degrees.

156. Due to the critical nature of the ambulance call answer service provided by ESTA, it cannot be a matter of controversy that the scale and extent of the delays for emergency ambulance call answer which occurred during this period were wholly unacceptable and constituted a crisis.[155] The critical nature of the service ESTA provided has been described by IGEM as follows:

> In any emergency, seeking help from professionals is instinctual. Emergency communications – comprising call-taking and dispatch – are critical steps in responding emergency services. For many emergencies, especially those involving serious illness or injury, time is critical and timely response from emergency

[152] For example, the world's largest epidemic thunderstorm asthma event which hit Melbourne on 21 November 2016 and the 2009 Black Saturday bushfires.
[153] Statement of Christopher Mercovich, CB 364.
[154] Ibid, CB 364, 368.
[155] IGEM review, CB 203.

services may improve patients' chances of survival and can reduce the risk of further harm.

Victorians expect that when they call triple zero (000), their call will be answered promptly. […]

Emergency ambulance call-taking presents a particular set of challenges, given the nature of the events involved. Many 000 calls concern people who are acutely ill or seriously injured and in need of urgent assistance – the provision of which may literally be a matter of life and death.[156]

REVIEWS OF THE CALL-TAKING CRISIS AND RELEVANCE TO THE CORONIAL INVESTIGATION

157. The extent of the ambulance call-taking crisis and the factors which led to it have been the subject of extensive analysis. In 2022, IGEM completed a *Review of Victoria's emergency ambulance call answer performance: COVID-19 pandemic-related 000 demand surge* (**IGEM review**).[157] This review was undertaken by IGEM in its capacity as an independent statutory body with responsibilities under the Emergency Management Act regarding emergency management arrangements in Victoria.[158] The Victorian Government also commissioned a review by Graham Ashton AM APM, resulting in the *Emergency Services Telecommunications Authority Capability and Service Review: Final Report* (**Ashton review**).[159] Additionally, there was an internal ESTA investigation report into the specific circumstances of Nick's death.[160] These reviews were highly relevant to the coronial investigation for the reasons which follow.

158. Pursuant to section 67 of the *Coroners Act 2008*, coroners investigating reportable deaths must make findings regarding the identity of the deceased, the cause of death and the circumstances in which the death occurred.[161] Coroners also have the power to make recommendations[162] or comment[163] on any matter connected with the death, including matters relating to public health and safety or the administration of justice.

[156] IGEM review, CB 203.
[157] CB 199.
[158] Statement of Christopher Mercovich, CB 365-366.
[159] CB 104.
[160] ESTA Quality Improvement & Investigations Team, Final Investigation Report, *Call answer delays for a patient in cardiac arrest in Preston on 16 October 2021* (31 October 2023), CB 71. This was provided to IGEM by ESTA on 31 October 2023: Statement of Christopher Mercovich, CB 367.
[161] Noting the exceptions in s 17 and s 67(2) where no inquest is held and the death is not subject to the requirement for a mandatory inquest hearing.
[162] Section 72(2) of the Act.
[163] Section 67(3) of the Act.

The obligation on a coroner to make findings under section 67 is mandatory,[164] whereas the power to make comments or recommendations is discretionary. These mandatory and discretionary provisions inform the parameters and character of all coronial investigations.

159. Coronial investigations are therefore not limited to only discovering the "primary facts" of the death, but also serve a broader public interest function. This is evidenced in the preamble to the Act which is in the following terms:

> The coronial system of Victoria plays an important role in Victorian society. That role involves the independent investigation of deaths and fires for the purpose of finding the causes of those deaths and fires and to contribute to the reduction of the number of preventable deaths and fires and the promotion of public health and safety and the administration of justice.

160. This broader public interest function is served by utilising the power to make comments and recommendations arising from a coroner's investigation of a reportable death. Those powers are informed by the stated objectives and purposes of the Act, which include contributing to the reduction of the number of preventable deaths and fires through the making of findings and recommendations by coroners. This is generally acknowledged as the coroner's "prevention role".[165]

161. A coroner's powers to make findings is limited by jurisdiction pursuant to the Act. As such, findings about circumstances are limited to those that are sufficiently proximate and casually related to the death being investigated.[166] A coroner's powers to make comments or recommendations are similarly limited as they are ancillary to the primary duty to make findings about a death. Comments or recommendations must have a sufficient connection to the death being investigated, which includes broader issues of public health and safety. The connection between the death being investigated and the comments or recommendations a coroner chooses to make may therefore be broad in nature,[167] and the scope of a coronial investigation may include the broader

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[164] Where an inquest has been held and subject to certain exemptions in s 17 and s 67(2) of the Act.
[165] *Runacres v The Coroners Court of Victoria* [2024] VSC 304 at [9].
[166] *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17 August 1994, Supreme Court of Victoria, per Harper J).
[167] *Doomadgee v Clements* [2005] QSC 357, 360*; Thales Australia Limited v The Coroners Court & Ors [2011] VSC 133).*

circumstances surrounding the event. A coronial investigation is not, however, akin to a roving Royal Commission and must not expand to that level of enquiry.

162. In the circumstances of Nick's death, ascertaining the reasons for the delays which occurred in his case, and which potentially contributed to his death, was a reasonable line of enquiry. This was necessary to make the required statutory findings and, having regard to the preventative function of the coroner, to consider the utility of any comments or recommendations.

163. In pursuing this line of enquiry, it was relevant to consider other inquiries or investigations relating to the ESTA ambulance call-answer delays in this period. These investigations could potentially shed light on why the delays in Nick's case occurred, Additionally, pursuant to section 7 of the Act, a coroner should liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of inquiries and investigations.

164. However, whilst a coroner is directed by the Act to make enquiries to avoid unnecessary duplication, and thus efficiently use public resources in the investigation of reportable deaths, a coroner does so in their capacity as an independent judicial officer. There are important differences between the character of an independent judicial investigation of a specific death and other non-judicial investigations and reviews, which are limited by terms of reference set by government and other legislative mandates. A coroner is not bound by the investigations and conclusions of other authorities, bodies or officers, and determination of the relevance of such reviews is a matter for the coroner.

165. Having regard to their subject matter, it was apparent that the IGEM, Ashton and ESTA reviews were relevant to the issues arising from the coronial investigation into Nick's death, and the review reports were therefore included in the coronial brief. This relevance was explicitly acknowledged by IGEM, who provided both the IGEM review[168] and a confidential Addendum Report[169] directly to the State Coroner pursuant to section 71(1)(c) of the Emergency Management Act, which authorised release to the coroner in the public interest.[170] As the IGEM review was intended to be complementary to the Ashton review (which considered the adequacy of the

[168] Provided in August 2022, prior to its the public release by government in September 2022.
[169] Provided in January 2023.
[170] Statement of Christopher Mercovich, CB 363.

organisational and governance structures of ESTA), both had obvious relevance to the coronial investigation. Similarly, considering that the ESTA review directly addressed the events which occurred in Nick's case, it was also of clear utility to the coronial investigation.

166. An assessment of these other reviews was necessary to understand whether the primary factors which led to the crisis in emergency ambulance call-taking at the time of Nick's death were sufficiently identified. Similarly, consideration of the extensive recommendations made in the reviews (which were accepted by government) was necessary to assess whether there were any remaining prevention opportunities arising from the coronial investigation into Nick's death. This assessment entailed consideration of whether the reviews "covered the field" in relation to the issue of the ESTA emergency ambulance call-taking delays.

The Ashton Review

a. Overview

167. On 8 October 2021, eight days before Nick's death, the Victorian Government commissioned an independent review into how ESTA delivered its 000 services, to be led by former Victorian Chief Commissioner of Police Graham Ashton AM APM. The need for the review arose from the government's acknowledgement of the ambulance call-taking crisis.

168. According to the government media release at the time, it was acknowledged that ESTA provided "the critical link between the Victorian community and the state's emergency services agencies" and the purpose of the review was to enable ESTA to "continue to keep the community safe and provide its vital service". It was envisaged that Mr Ashton would review ESTA's capability and services, and provide advice on how to improve ESTA's capability. The findings and recommendations were expected to be delivered by Mr Ashton in early 2022.[171]

169. The remit of the Ashton review was dictated by the Terms of Reference approved by the Minister for Emergency Services. Although the commissioning of the Ashton review clearly arose from the context of a crisis in delays in ESTA ambulance call-

[171] https://www.premier.vic.gov.au/former-police-chief-head-review-esta-capabilities.

taking, it was predicated on assertions that ESTA was failing more broadly in its delivery of Victoria's emergency operational communications services, and the Terms of Reference reflected those broader concerns.[172]

170. The Ashton review was publicly released by the Victorian Government on 18 May 2022. This was in tandem with the official government response to the review, which accepted all twenty recommendations made in principle. The Ashton review focused on identifying systemic issues within ESTA which contributed to its inability to meet increasing call volumes. It recommended broad structural reform of ESTA and led to the subsequent rebadging of ESTA as Triple Zero Victoria, with major governance changes and reforms in relation to its performance standards, management structure, and oversight within the emergency management sector.

171. The Ashton review acknowledged that ESTA played a central role in Victoria's emergency management response model, and noted that when calls were not answered or resources not dispatched, "the fragility of Victoria's emergency management system becomes apparent".[173] It was observed that the number of times when the system had failed was growing and that these incidents, which were well documented by the media, had the potential to cause "dire outcomes".[174] The report acknowledged that factors such as the increasing frequency of complex major emergencies and the impact of the COVID-19 pandemic were pushing ESTA's workforce to its limits. It was also noted that ESTA was part of a broader sector and that the ESTA workforce alone could not "sustain this continual barrage of stress, criticism, and heartbreak, and it should not be left to ESTA to resolve these issues alone".[175] The Ashton review acknowledged as its starting point "that the current system is not delivering the expected services, nor is it sustainable in its current form" and was largely directed towards conclusions about ESTA's "optimal future state".[176]

172. The Ashton review also acknowledged the ongoing challenges for some of ESTA's CTD services arising from the ongoing COVID-19 pandemic operating environment, including unprecedented demand on ESTA call-taking services. However, it specifically excluded consideration of these issues in the report, noting the thematic

[172] Ashton review, CB 110.
[173] Ashton review, CB 109.
[174] Ashton review, CB 109.
[175] Ashton review, CB 109.
[176] Ashton review, CB 112.

review which was by then being undertaken by IGEM regarding emergency ambulance call answer performance during the pandemic-related 2021 call surge. It was explicitly stated that the IGEM review was not anticipated to replicate the Ashton review.[177]

173. As such, the Ashton review gave no specific consideration to the issue of delays in ESTA call answer speed for emergency ambulance, nor did it consider individual deaths or other adverse events suspected of being attributable to ESTA call answer delays. These exclusions were reflected in the distinction drawn in the Ashton review between the "current state" of ESTA's capability and service delivery as it existed prior to October 2021, and the program of work across ESTA that commenced from October 2021 "to deliver an immediate uplift to CTD services",[178] which was not assessed or critiqued by the Ashton review.[179]

174. Whilst not considering the specific factual matrix of the emergency ambulance call answer delays, the Ashton review findings and its recommendations remained highly relevant to the coronial investigation. It identified the need for significant reform of ESTA and made a variety of observations about its shortcomings and challenges prior to October 2021, being the time period the coronial investigation was concerned with. These not only had the potential to further elucidate the causes of the call answer delays, but were pertinent in considering whether any prevention opportunities still arose.

b. Summary of relevant findings and recommendations from the Ashton review

175. The Ashton review acknowledged that ESTA was the entity within the emergency management sector which receives and triages calls via 000 whenever there is an emergency, and it therefore provided a "critical service" to the Victorian community. It described call-taking and dispatch as ESTA's core function and noted that this service should be ESTA's main focus.[180]

176. The review identified that there were broader issues with ESTA's role within the emergency management sector[181] as it was disconnected from government,[182] had split Ministerial oversight, and its governance arrangements were deficient and not working

[177] Ashton review, CB 109.
[178] Ashton review, CB 111.
[179] Ashton review, CB 114.
[180] Ashton review, CB 135-6.
[181] Ashton review, CB 118.
[182] Ashton review, CB 120.

efficiently.[183] This meant that ESTA found it difficult to engage with government, to obtain sufficient support in the delivery of operational and corporate services, and importantly, to make a convincing case to government for investment. Yet funding of ESTA was identified as one if its key challenges.[184]

177. The Ashton review also identified cultural issues with ESTA, stating that it "operated more as a corporate entity than an organisation delivering a critical emergency management service".[185] ESTA was characterised as being highly reactive, with a lack of agility in responding to emergencies and a need to be more proactive in future.[186] Moreover, internal committees designed to provide ESTA with strategic device had become diluted.[187]

178. Key issues with the CTD service were also identified. It was noted that the ESOs which ESTA provided services for had difficulty engaging with ESTA.[188] Also, that due to long-term challenges with recruitment and retention of CTD staff, including funding issues, ESTA's CTD service was being driven by workforce availability, rather than by the Victorian community's demand for its services.[189]

179. It also referred to ESTA's inability to manage call volumes during significant storm events and the COVID-19 pandemic, and attributed this in part to the inability to quickly interchange call-takers and dispatchers across the different ESO disciplines.[190] While noting that the pandemic situation was unprecedented, the review commented that "these are the types of surge events where ESTA's aggregated model should have delivered an exceptional and coordinated emergency response".[191] It was acknowledged that such surges can be difficult to predict, but also that surge events could be planned for, and that doing so provided an opportunity to mitigate potential risks.[192]

180. Whilst ESTA had intelligence services which informed forecasting and performance measurement, and it possessed advanced data and analytics capabilities, the review

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[183] Ashton review, CB 118-9, 128.
[184] Ashton review, CB 118.
[185] Ashton review, CB 120.
[186] Ashton review, CB 120.
[187] Ashton review, CB 129.
[188] Ashton review, CB 129.
[189] Ashton review, CB 138.
[190] Ashton review, CB 140.
[191] Ashton review, CB 140.
[192] Ashton review, CB 139.

found that ESTA did not fully utilise them in operational decision making and forward planning.[193] Data was also siloed and not utilised as effectively as it could be.[194]

181. The review concluded that there had been continued and systematic underperformance by ESTA over a period of time[195] and made 20 significant recommendations[196] to rectify the issues identified. These included a recommendation that ESTA undergo a re-brand to become "Triple Zero Victoria" to "better reflect its core CTD function and ensure its enabling role within the emergency services sector is well understood by the community".[197]

c. Performance standards set by IGEM

182. The most relevant part of the Ashton review findings related to the ESTA performance standards set by IGEM. The Ashton review noted that under the ESTA Act, IGEM determined the non-financial performance standards for ESTA's delivery of CTD services, and the Emergency Management Act required IGEM to monitor and investigate ESTA's performance and report any related issues to the Minister for Emergency Services.[198]

183. Referring specifically to the performance standard requiring 90 per cent of emergency ambulance calls to be answered within 5 seconds, the review concluded that such time-based measures were not outcome-based and did not always deliver the best community outcomes. Nor did they always provide an accurate picture of ESTA's operational performance,[199] as poor compliance during peak hours could be masked by high performance in off-peak hours.[200] The review considered that the standards did not "materially take into consideration the end-to-end customer experience and [were] output rather than outcome focused".[201] It further concluded that ESTA's performance

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193 Ashton review, CB 168.
194 Ashton review, CB 119.
195 Ashton review, CB 107.
196 Ashton review, CB 179.
197 Ashton review, CB 135.
198 Ashton review, CB 124: By reference to the IGEM *Assurance Framework for Emergency Management: Performance monitoring*.
199 Ashton review, CB 124.
200 Ashton review, CB 172.
201 Ashton review, CB 172.

standards promoted “a particularly inflexible CTD model in which meeting time-based targets is the primary goal”.[202]

184. The review ultimately found that ESTA’s performance standards were a key area of concern, “not fit for purpose”[203] and “not centred around health and safety measures, such as patient outcomes for ambulance events”.[204] Specific recommendations were made as follows:

> **Recommendation 18**
> ESTA, in partnership with [the Department of Justice and Community Safety], ESOs, and in consultation with IGEM and [Safer Care Victoria], must develop and implement outcome-based performance standards that properly reflect the end-to-end process of incident management.
>
> **Recommendation 19**
> Responsibility for approving the outcome-based performance standards should sit with the Emergency Management Commissioner and the Minister for Emergency Services to ensure IGEM, with the support of [Safer Care Victoria], can maintain independent monitoring and reporting of ESTA’s performance.
>
> **Recommendation 20**
> A formal consultation mechanism must be established between [Safer Care Victoria] and IGEM in the monitoring and investigation of ESTA’s performance against outcome-based performance standards for AV.

185. Although the Ashton review recommended that there be outcome-based performance measures, these were intended to be additional and complementary to the existing time-based performance standards for ESTA’s call taking and dispatch services.[205]

The IGEM review

186. Separate to the Ashton review, the IGEM review was completed in July 2022, which was provided to the Minister for Emergency Services on 5 August 2022. The Victorian Government publicly released the report on 3 September 2022, with an official response accepting the findings and supporting the review’s recommendations in principle.

187. Unlike the Ashton review, the IGEM review was not commissioned by government. The Inspector-General of Emergency Management is an independent statutory role with

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[202] Ashton review, CB 172.
[203] Ashton review, CB 120.
[204] Ashton review, CB 172.
[205] Ashton review, CB 173.

designated responsibilities under the Emergency Management Act. IGEM is tasked with providing assurance to government and the community with respect to emergency management arrangements in Victoria, and with fostering continuous improvement in emergency management in Victoria.[206]

188. As noted earlier, IGEM's role includes routine monitoring of ESTA's non-financial performance, which encompasses call answer speed performance. The need for the IGEM review was said to have been identified by IGEM as part of this routine monitoring of ESTA, and was completed pursuant to its statutory functions under section 64(1)(b) of the Emergency Management Act.[207]

189. The content of the IGEM review was distinct from Mr Ashton's review of ESTA because it specifically focused on the delays in emergency ambulance call-taking which occurred during the COVID-19 pandemic. The scope of the IGEM review included:

    a. the planning and preparedness for a major surge in emergency ambulance calls due to the COVID-19 pandemic by both ESTA and the broader emergency management sector;

    b. the effect of the increased call volumes during the COVID-19 pandemic on ESTA's service delivery and the 000 service nationally;

    c. ESTA's capacity to manage surges in the context of its governance and financial arrangements; and

    d. highlighting the potential effects of call answer delays on the Victorian community.[208]

190. Significantly, the IGEM review identified 40 potential adverse events involving seriously ill and injured patients between 1 December 2020 and 31 May 2022, many of which involved delayed call answer or dispatch.

191. The IGEM review explicitly aimed not to replicate any aspect of the Ashton review. Its timing was therefore delayed to accommodate the completion of the Ashton review and to enable IGEM to consider the recommendations made. This was done with a view to

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[206] IGEM review, CB 228
[207] IGEM review, CB 228; statement of Christopher Mercovich, CB 364.
[208] IGEM review, CB 229.

avoiding unnecessary duplication and streamlining the implementation of any recommended changes.[209] Thus, although the reviews were distinct in nature, a complementary reading of them both is necessary to fully understand the specific and systemic issues which led to the emergency ambulance call answer delays attributable to the COVID-19 pandemic, and the breadth of recommendations which were made to prevent a reoccurrence of a similar crisis in the future.

192. Read together, the IGEM and Ashton reviews reveal that the causes of the emergency ambulance call answer delays in this period are well understood. Primarily, they were caused by an increase in call volume which couldn't be serviced by ESTA's existing workforce.[210] As described by the IGEM review,

> Since December 2020 – and more specifically since October 2021, when its call answer speed performance dropped below 70 per cent of 000 calls answered in five seconds, ESTA simply did not have sufficient ambulance call-takers to meet incredible demand.[211]

193. The IGEM review runs to 153 pages. It made 42 findings, eight recommendations and nine observations. The review cites voluminous data and figures regarding the severity of the decline in performance and the delays experienced by the Victorian community. Even a limited sample of the figures it cited demonstrates the severity of the ambulance call-taking crisis:

    a. From December 2020, ESTA's performance in the first six months of 2021 was consistently under the 90 per cent benchmark, ranging from the mid-70s to the high 80s.[212]

    b. From September 2021, call answer speed performance declined significantly, to 67.8 per cent of calls answered within 5 seconds within the calendar month.[213]

    c. From October 2021 to March 2022, ESTA reported the lowest emergency ambulance call answer performance in its history. Thousands of callers each

[209] IGEM review, CB 229.
[210] IGEM review CB 204.
[211] IGEM review, CB 204.
[212] IGEM review, CB 209.
[213] IGEM review, CB 209.

month waited for more than one minute for ESTA to answer their emergency call.

d. By late 2021, ESTA was failing to answer most ambulance calls within 5 seconds, with many examples of callers waiting more than 10 minutes.[214]

e. By January 2022, only 39 per cent of calls were answered within 5 seconds for the calendar month.[215]

194. IGEM observed that the extent of the delays experienced was "damaging the public's confidence in the system and placing the community at risk".[216]

195. IGEM reported that ESTA's emergency ambulance call activity increased significantly following the first COVID-19 infections in Australia in 2020, and that 2021-22 was the busiest year ever for emergency ambulance calls to 000. IGEM attributed the unprecedented surge in community demand for ambulance call-taking to factors arising from the COVID-19 pandemic. There were simply too many calls for ESTA's available workforce to answer for over an 18-month period. The main driver for the IGEM review was the observed decline in call answer speed and the associated reporting of potential adverse events.[217]

196. The IGEM review noted that pursuant to the ESTA Act, the Board of ESTA was ultimately accountable for ensuring that its people and systems met government and community expectations.[218] It detailed the various strategies that ESTA employed to service the demand and address its staffing issues, but without success. The account of how the crisis was ultimately resolved and resourced demonstrates that ESTA's performance issues were well beyond the capability and resources of ESTA, and that there was no prospect that it would be able resolve the crisis on its own.

197. It was only once it was recognised in October 2021 that ESTA could not resolve the issue without assistance, that effective mitigation strategies were put in place. This involved broad government intervention and additional funding.

[214] IGEM review, CB 209.
[215] IGEM review, CB 210.
[216] IGEM review, CB 209.
[217] IGEM review, CB 211.
[218] IGEM review, CB 211.

198. The IGEM review detailed the enormous scale of work and resources that were ultimately needed to end the crisis, including $333 million committed by the Victorian Government over five years to support ESTA.[219] A significant degree of inter-agency assistance across the emergency management sector was also required to rectify the situation, led by Emergency Management Victoria. Specifically, from October 2021, the Emergency Management Commissioner was engaged to provide assistance and "ensure that ESTA had the support it needed to manage the call-taking crisis." Interestingly, IGEM observed that "[t]his intervention may have been different had ESTA been better integrated into the emergency management arrangements".[220]

199. The IGEM report described those arrangements as follows:

> Emergency management in Victoria works to a shared goal across all agencies expressed as 'we work as one'. This simple statement underpins the need for effective coordination and collaboration to achieve the EM Act 2013 objective of fostering a sustainable and efficient emergency management system that minimises the likelihood, impact and consequences of emergencies.[221]

200. So, whilst ESTA was in the first instance responsible for its own performance, it was also entitled to expect assistance from the emergency management sector when it was faced with circumstances beyond its own resourcing and organisational capability.

201. By the time ESTA sought the assistance of the emergency management sector, there had been no minimising of the likelihood of the emergency facing ESTA ambulance call-takings services, or its impact and consequences. By that time the crisis was so entrenched that it took until August 2022 for ESTA to return to compliance with its ambulance call answer speed performance standards.

202. The IGEM review identified long-term inadequate funding as one of the key issues leading to the call-taking crisis, describing how ESTA was in a "precarious financial position" prior to the COVID-19 pandemic, and that this was known to the Victorian Government from as early as 2015. Since that time, ESTA had been dependent on ad hoc annual supplementary funding via the State Budget. IGEM regarded the funding issues as having had a detrimental effect on ESTA's ability to recruit to meet demand, particularly by limiting its ability to plan and improve service delivery not only during

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[219] IGEM review, CB 215.
[220] IGEM review, CB 214.
[221] IGEM review, CB 214.

"business as usual" but also during surge events.[222] Although ESTA was able to meet recruitment demands and deliver sufficient ambulance call-takers despite this funding difficulty prior to the pandemic,[223] it appears that it had no capacity in its funding model to recruit and "scale up" when met with a large surge incident such as occurred in the COVID-19 pandemic. As such, IGEM identified the need for a "sustainable funding model" which could meet the costs of increasing demand and surge events as a critical reform.[224]

203. ESTA may have been under-resourced, but it was not unaware of what its workforce requirements were. The IGEM review generally found a high level of proactive planning and forecasting by ESTA regarding the likely increase in emergency ambulance calls and the workforce that would be needed to meet that increased demand. It provided ample evidence from an early stage of the pandemic in 2020, ESTA was aware of the likelihood of increased demand and the potential detrimental impact that the pandemic would have on the availability of its current workforce. Based on the evidence referred to in the IGEM review, it appears that ESTA anticipated the impacts which would result from the COVID-19 pandemic. Whilst increased demand was unprecedented, it was not unforeseen by ESTA.

204. Significantly, the IGEM review explained the unfolding emergency by reference to data which demonstrated ESTA's ongoing decline in ambulance call answer speed performance, as represented by ESTA's failure to meet its performance benchmark for call answer speed from December 2020 into mid-2022. IGEM attributed this unarrested decline to broader systemic and governance issues, concluding that these prevented ESTA from effectively scaling up to meet the demand in emergency ambulance calls.

205. The findings, observations and recommendations made by IGEM were directed to the factors identified as being causative of the crisis. Whilst it also referred to the potential adverse events related to the crisis, it gave no consideration to whether call answer delay was a contributory factor in the death of any person, with IGEM specifically noting that this was the role of the Coroners Court of Victoria.

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[222] IGEM review, CB 213.
[223] IGEM review, CB 213.
[224] IGEM review, CB 214.

Victorian Government Response to the IGEM and Ashton Reviews

206. The Victorian Government's response to the Ashton review acknowledged the critical role played by ESTA in Victoria's emergency management sector, and specifically that "ESTA's Triple Zero service is crucial to the health and safety of the Victorian community and therefore, its services must be delivered at a consistently high standard."[225] It also acknowledged that "Victorians should have the confidence, that when they call for help in an emergency – they will get it".[226]

207. All twenty recommendations of the Ashton review were supported in principle by government, and implementation commenced by way of a reform program for ESTA. The government's response acknowledged that the successful implementation of the recommendations was not the sole responsibility of ESTA, and that it required "a strong partnership between ESTA and its board of management, emergency services organisations, industrial partners, and the Government".[227]

208. The response also outlined the government's significant financial investment in ESTA which had occurred to ease pressures attributable to the pandemic, including:

    a. $46.14 million in the 2021-22 Victorian Budget, in part for recruitment of 43 new full-time equivalent (FTE) staff to meet increased demand for services;[228]

    b. A further $27.5 million Treasurers Advance in October 2021, "to address increased pressure and demand, caused by the pandemic" coinciding with the recruitment of a new CEO and Deputy CEO with extensive emergency management experience.[229]

    c. A funding package of $115.6 million announced in March 2022 which "focused on recruiting and training more ambulance call-takers and providing them with greater and better support", with a view to achieving an "uplift in call-taking and dispatch staff capacity".[230] It was noted that a workforce recruitment campaign was underway for a further 50 positions in ambulance call-taking, and this extra capacity would result in "improving call answer speeds and ensuring patient safety remains

[225] Victorian Government's response to the ESTA Capability and Service Review, CB 188.
[226] Victorian Government's response to the ESTA Capability and Service Review, CB 192.
[227] Victorian Government's response to the ESTA Capability and Service Review, CB 198.
[228] Victorian Government's response to the ESTA Capability and Service Review, CB 189.
[229] Victorian Government's response to the ESTA Capability and Service Review, CB 189.
[230] Victorian Government's response to the ESTA Capability and Service Review, CB 190.

paramount."[231] Funding was also allocated for "community awareness campaigns to redirect non-emergency calls to other channels".[232]

d. In May 2022, the government announced that as part of the Victorian Budget 2022–23, ESTA would receive more than $333 million (which included the $115.6 million announced in March 2022) to recruit 400 new staff to increase call-taking and dispatch capacity for 000 services and to train more operators to distribute emergency calls across the state for all ESOs.[233]

209. The Government's response stated that ESTA's performance was already benefitting from the significant financial investment made and that more call-taking and dispatch staff, with streamlined training, was producing improvements in call answer speed.[234]

210. In relation to the three recommendations from the Ashton review relating to ESTA's performance standards, the Government gave the following response:

> While rigorous time-based performance standards must be retained, the Government supports complementary outcomes-based performance standards as an additional way to ensure the effectiveness of ESTA's call-taking and dispatch service and ensure ESTA maintains accountability to its emergency services organisations partners and the community it serves.[235]

211. The Victorian Government also accepted the findings made by the IGEM review and supported the recommendations in principle, noting that they would be subsumed into the broader reform plan for ESTA which had already commenced following the Ashton review.

212. As a result of the Ashton and IGEM reviews, a new legislative framework was implemented to reform ESTA, with the aim of providing stronger governance, accountability and oversight.[236] The *Triple Zero Victoria Act 2023* (**TZV Act**) received Royal Assent on 8 November 2023 and came into effect on 15 December 2023.

213. The TZV Act established Triple Zero Victoria (**TZV**) as the new statutory authority replacing ESTA, essentially re-naming ESTA and leaving its functions and role

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[231] Victorian Government's response to the ESTA Capability and Service Review, CB 190.
[232] Victorian Government's response to the ESTA Capability and Service Review, CB 190.
[233] Victorian Government's response to the ESTA Capability and Service Review, CB 189-190; IGEM review, CB 301.
[234] Victorian Government's response to the ESTA Capability and Service Review, CB 191.
[235] Victorian Government's response to the ESTA Capability and Service Review, CB 197.
[236] Statement of Nicole Ashworth, CB 634.

undisturbed. Overall, there was no change to ESTA's essential CTD function, and the services delivered by TZV are identical in nature to that of ESTA.

214. Relevantly, the new legislative provisions for TZV purport to provide stronger governance and oversight by both the Minister for Emergency Services and the Secretary of the Department of Justice and Community Safety (**DJCS**) specifically with regard to call-taking performance standards.[237] These changes appear to be directed at achieving closer monitoring of performance standards beyond the role performed by IGEM. They include routine direct reporting to the Minister for Emergency Services and the Justice Secretary regarding compliance with performance standards, managing any risks identified or reported, and intervening in concerns or risks impacting service delivery and the ability to meet performance standards. There is now specific provision for escalation by ESTA directly to the Minster regarding "significant issues of public concern, significant risks, and performance-related inquiries, concerning [TZV]".[238]

215. Pursuant to the TZV Act, the Emergency Management Commissioner (**EMC**) now sets agreed performance standards to measure the delivery of CTD services provided by TZV, whereas this function was previously performed by IGEM. The change resulted from identification in the Ashton and IGEM reviews that having IGEM setting the performance standards and monitoring them constituted a conflict of interest and diminished its independent monitoring role.[239]

216. Overall, the suite of reporting requirements under the TZV Act appears to create a new system of governance and escalation in relation to compliance with performance standards. This is significantly different to what existed at the time of the outbreak of the COVID-19 pandemic and the resulting crisis in call-taking. These legislative changes were made in addition to the earlier changes which had already occurred regarding the performance standards as follows:

    a. reporting requirements and performance monitoring that came into effect within ESTA from October 2021 in response to the call-taking crisis, including daily reporting by ESTA to IGEM and to "key government, departmental and ESO

[237] Statement of Nicole Ashworth, CB 633-636.
[238] Statement of Nicole Ashworth, CB 635
[239] Ashton review, CB 173-174; IGEM review, CB 323

stakeholders" of call-taking metrics such as the "number of daily calls answered, call wait times and numbers of scheduled staff compared to forecast";

b. a range of reporting requirements to the Department of Justice of Community Safety introduced in May 2023 to replace the previous periodic Statement of Expectations reporting function; and

c. performance reporting requirements introduced by the State Government in the 2023-24 financial year that required ESTA to report actions and mitigation strategies to DJCS if their quarterly performance was more than 5% below agreed performance standards.[240]

217. Whilst the EMC now sets the performance standards and there is a new government escalation system in place for non-compliance by ESTA, there has been no other change to IGEM's assurance functions, which still includes monitoring and reporting on ESTA's compliance with the performance standards, and it remains as the only independent body that does so.[241] IGEM therefore continues to provide assurance for the performance of Triple Zero Victoria in the same manner as it did with ESTA.

ESTA internal review

218. Soon after Nick's death, his family contacted Ambulance Victoria and expressed concerns about the delays they experienced when they called 000 on 16 October 2021. AV notified ESTA of the "adverse event" on 9 November 2021, and ESTA formally notified IGEM on 16 November 2021.[242] ESTA identified that "[t]here was an extended call wait time prior to answering all 000 calls for this event" and the following facts were noted:

a. It was 16:05 minutes from the time Nick's first call (call 1) was presented to ESTA to the time a different call (call 4) was first answered.

b. Between 12:30 pm and 1:00 pm (the window of time in which the 000 calls in in relation to Nick's emergency were made in relation to Nick), 81 calls were presented to the ESTA ambulance call queue, and none of them were answered

[240] Statement of Nicole Ashworth, CB 633.
[241] Statement of Nicole Ashworth, CB 634.
[242] Notification to IGEM of Adverse Event, CB 56.

within the IGEM performance benchmarks, being 90 per cent within 5 seconds or 95 per cent within 30 seconds.

c. Between 12:30 and 12:38 pm, the average call wait time was 5:01 minutes, with Telstra making up to six attempts to connect with an ESTA call-taker.

d. Between 12:39 and 12:39:52, six calls were presented to the ESTA ambulance call queue, four of which were presented ten times, two were presented 11 times, and the longest call wait time was 13:01 minutes.

e. The "4-minute rule" was put in place from 10:50 am that morning.

f. A Telstra Recorded Voice Announcement was activated from 10:58 that morning. [243]

219. ESTA's Quality Improvement Team subsequently conducted an internal investigation into the events relating to Nick's death and completed a Final Investigation Report (**QIT report**) dated 31 October 2023.[244]

220. The QIT report acknowledged that the delays in Nick's case occurred in the context of the COVID-19 pandemic, when Victoria's health system experienced a "persistent increased pressure on the entire health network: hospitals, doctors, nurses, allied health staff, Ambulance Victoria and ESTA". It observed that during this period, ESTA's call answer performance was degraded, as addressed in the IGEM review.[245] The QIT report outlined the specific delays experienced in Nick's case and addressed ESTA's management of the calls received. It provided no assessment of whether the delays contributed to the outcome in Nick's case, and it was not directed to explaining why the extensive delays occurred.

221. It was identified that at the time the 000 calls were made for Nick, "the ESTA emergency ambulance call queue was experiencing a significant and sustained increase in 000 call demand". This increased demand was recognised by both Telstra and ESTA prior to the day of Nick's emergency, as it was increasing the wait time for Telstra operators connecting to ESTA, and therefore affecting resourcing for 000 calls nationwide. Telstra raised this adverse impact with ESTA and this led to

[243] Notification to IGEM of Adverse Event, CB 58.
[244] CB 69-85.
[245] ESTA Quality Improvement Team Final Investigation Report, CB 83. (**QIT report**)

implementation of the "4-minute rule".[246] The QIT report identified that when the rule was utilised in Nick's case and the call-back procedure was attempted for call 5, the ACT did not correctly enter the mobile number and therefore dialled an incorrect number.[247]

222. At this time, Telstra was also playing a Recorded Voice Announcement to callers alerting them to the high call volume and advising them to stay on the line in cases of emergency.[248] This recording was heard by callers prior to connecting to the Telstra operator, and stated: "Emergency Triple Zero for ambulance in Victoria is extremely busy. If you require police, fire, or urgent ambulance attendance, please stay on the line. If your health need is not urgent, please call Nurse on Call on 1300 60 60 25".[249] Nick and other callers would have heard this before speaking to a Telstra operator.

223. The most significant finding of the QIT report related to the fact that call 4 (made at 12:45:25 pm) was answered before call 2 (made at 12:38:37 pm). This was despite call 2 being in the ambulance queue for longer, and remaining unanswered when call 4 was connected to an ACT. This was found to be due to a "technical anomaly" which was unknown at the time and was subsequently resolved by ESTA in March 2022.[250] The fix ensured that the calls with the highest number of presentations to the call queue were answered first, and that calls maintained their correct position in the queue.[251] This meant that up until March 2002, calls were unknowingly being answered by ESTA out of sequence, with callers waiting for shorter durations having their calls answered by an ACT before those waiting longer periods.

224. The QIT review generally found that the conduct of the ambulance call-takers involved was in accordance with ESTA policy and procedure. Although one attempt at call-back upon email notification from Telstra of disconnection under the "4-minute rule" was made to the wrong number, this was found to have had no impact on the outcome in Nick's case.[252] Neither the "4-minute rule" or the use of the Recorded Voice Announcments were deemed to have had any impact in Nick's case.

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[246] QIT report, CB 77-78
[247] QIT report, CB 78.
[248] QIT report, CB 84.
[249] QIT report, CB 84.
[250] QIT report, CB 78.
[251] QIT report, CB 85.
[252] QIT report, CB 85.

225. Finally, the QIT report noted that ESTA recommenced meeting its monthly call answer performance benchmark across all services, including ambulance, from August 2022,[253] indicating that the issue of delay in call answer speed had been resolved.[254]

Assessment of the issues identified by the reviews

226. The Ashton review addresses the broad systemic and cultural issues which impacted ESTA's service delivery during the COVID-19 pandemic. This is complemented by the IGEM review, which explains the specific factors that caused the emergency ambulance call answer delays. Together, these reviews largely explain why the delays experienced by the Victorian community at the time of Nick's emergency occurred.

227. The reviews and the legislative overhaul of ESTA which followed was designed to reduce the likelihood of such a degradation of emergency call answer speed recurring in the future, whatever the cause.[255] The critical importance of these changes, and the need to "future proof" Victoria's CTD service was acknowledged by the IGEM review as follows:

> The possibility remains of a new variant of COVID-19 or some other future disease that will challenge the health and emergency management sectors in similar ways. The improvements proposed here will not only strengthen ESTA's ability to better respond to future pandemics, but other emergencies and surge events of any type, some of which are predicted to increase in both severity and frequency.[256]

228. The reviews demonstrate how critical call-taking and dispatch functions are to the emergency management sector, and to the safety of the Victorian community. They also demonstrate that the demands placed on ESTA from the COVID-19 pandemic did not arrive without any warning. It was foreseeable on ESTA's own modelling and forecasting that there would be an increase in call volume, and it was anticipated that ESTA's financial, operational and strategic resources may not be sufficient to meet the increased demand created by the pandemic. Moreover, ESTA was aware in real time when its service declined, which was obvious from repeated non-compliance with its own performance standards for ambulance call-answer speed.

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[253] QIT report, CB 85.
[254] QIT report, CB 85
[255] Statement of Christopher Mercovich, CB 371.
[256] IGEM review, CB 215.

229. The clear decline in performance was recognised not only by ESTA, but also by IGEM due to its role monitoring ESTA's performance. The nature of this monitoring was extensive, and IGEM described ESTA as being "subject to the most intense monitoring against benchmarks and assurance processes that are typically higher than equivalents in other jurisdictions".[257]

230. Self-evidently, despite such stringent oversight, the call-taking crisis was not averted. Although both the IGEM and Ashton reviews identified ESTA's governance issues and its disconnection from government and the emergency management sector as factors contributing to the crisis, neither review addressed the adequacy of the oversight mechanism which was in place, which was provided by IGEM. Nor did the reviews address why, despite being the subject of such close monitoring throughout the entirety of the pandemic, the crisis could not be averted or contained. From an accountability and governance perspective, it remains largely unexplained how the crisis unfolded in the context of this oversight mechanism.

231. It is unsurprising that the reviews do not address these issues. The terms of reference for the Ashton review did not include a detailed consideration of the call answer delays and the independent oversight which was occurring in relation to it, and due to its assurance role, the IGEM review was not directed to evaluating performance of its own role and monitoring of the standards.

232. Therefore, the combination of the IGEM, Ashton and ESTA reviews do not paint a complete picture of how the crisis occurred. The balance of the coronial investigation and inquest was largely directed to exploring these issues.

ESTA'S RESPONSE TO THE COVID-19 PANDEMIC

The risk to patient safety

233. The Ashton and IGEM reviews both acknowledged the potential impacts of ESTA call answer delays on the safety of the Victorian community. Recognition of the critical safety role played by ESTA in the emergency management sector underpinned both reviews, noting that access to ESTA is the only means by which Victorians can request assistance from emergency service organisations, including ambulance.

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[257] IGEM review, CB 210.

234. The IGEM review acknowledged that during the ambulance call-taking crisis, whilst the effect of the delays varied in breadth and scale, the "response to individual calls was delayed on a regular basis".[258] Ample evidence was cited in the IGEM review which showed the ambulance call-answer delays were not isolated in nature, but were happening on a broad scale, daily, and particularly from September 2021. Accordingly, the IGEM review found that "[c]all answer delays exposed many Victorians to varying levels of risk and, in some cases, these may have resulted in adverse events".[259]

235. This is unsurprising. As a matter of common sense, timeliness is the most crucial factor in any emergency response. This must be the foundation for the structure of 000 emergency call-taking, including all measures of timeliness throughout ESTA policy and procedure. The centrality of this proposition was explicitly recognised for many years in ESTA's own branding, "ESTA 000 Saving Time Saving Lives", and there can be no dispute that ESTA's fundamental purpose was to provide the public with timely access to Victoria's emergency services in life-threatening situations. This was acknowledged in both the Ashton and IGEM reviews.

236. The consequences of delayed ambulance call answering by ESTA were well understood. As explained in the IGEM report:

> [A]ny significant call answer delay may result in a missed opportunity to reduce harm or prevent a death. This may be through bystanders giving first aid with verbal assistance from an ESTA call-taker, and then paramedics and emergency services personnel providing advanced life support and transport to the emergency department.[260]

237. The likelihood that patient safety risks of this kind would materialise because of delays in ambulance call answer speed was wholly foreseeable, both prior to and after the start of the COVID-19 pandemic. Moreover, recognition of these obvious risks to patient safety can be the only rationale for the existence and monitoring of performance benchmarks for ambulance call answer speed in the first place. Such benchmarks indicate demand on the ESTA service and reflect the time-critical nature of ambulance attendance. The fact that compliance with these benchmarks is monitored by an

[258] IGEM review, CB 245.
[259] IGEM review, CB 245.
[260] IGEM review, CB 230.

independent statutory body such as IGEM can also only be a recognition of the critical importance of timeliness to the service being provided by ESTA.

238. When the pandemic arrived in Australia in January 2020, the risk posed to patient safety from delayed answer of ambulance calls was readily apparent. So too was the utility of monitoring performance benchmarks to ensure ESTA was performing its statutory functions to an acceptable standard, and to ensure patient safety.

Planning and mitigation strategies

239. The ambulance call-taking crisis may have been unprecedented, but ESTA had planning in place prior to the pandemic which anticipated the impact that a large-scale and protracted health emergency might have on its services.[261] It was also understood that such emergencies were different in nature to single emergencies such as a severe weather event or complex motor vehicle accident.[262] According to the IGEM review, in planning for such an event, ESTA had identified "a range of tactics to help manage service delivery impacts such as surges in emergency calls and call answer performance".[263]

240. One such tactic involved management and coordination of ESTA's existing workforce through changes to rostering, breaks, overtime and recalling off duty staff, to meet forecast call demand.[264] ESTA ultimately used all these strategies to some degree during the pandemic, and particularly from July 2021 onwards.[265]

241. Another identified tactic was aimed at suppressing call demand by influencing community behaviour. This included use of Recorded Voice Announcements, surge scripting, urgent disconnect, and emergency rule disconnect. The aim of these strategies was to redirect non-emergency calls, advise the public of high demand on resources, and decrease the time call-takers spent with the caller. It was assessed that suppressing demand for emergency ambulance call-takers in this way would increase call-taker availability.[266] ESTA also used these tactics to some degree during the pandemic, but not prior to October 2021.[267] When they were used, subsequent analysis showed that

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[261] The Critical Incident Response Plan (**CIRP**) health sub-plan, CB 272.
[262] IGEM review, CB 272.
[263] IGEM review, CB 273.
[264] IGEM review, CB 273.
[265] IGEM review, CB 273.
[266] IGEM review, CB 273-274.
[267] IGEM review, CB 274-275.

they substantially reduced call volumes, particularly when combined with broader public education campaigns about reserving 000 calls for emergencies.[268]

242. Underpinning all these plans was a clear acknowledgement that higher call volumes would occur during this type of health emergency, and this would require additional call-taking resources and efforts to suppress call demand to prevent deterioration in call answer performance.

Knowledge of the risks regarding increased call demand

243. From March 2020, ESTA commenced planning for potentially significant increases in ambulance calls due to the COVID-19 pandemic. ESTA had been actively seeking information to prepare for the pandemic, and this included consideration of international experience which showed increasing ambulance call demand due to the pandemic. ESTA used this data to assess potential demand in Victoria,[269] and then devised planned responses within its funding constraints, operating environment and ESO requirements.[270]

244. By April 2020, ESTA was not only aware that call demand may increase because of the pandemic, but also that its available workforce may decline. This latter risk was specifically acknowledged in ESTA's *Pandemic loss of workforce plan*.[271] At these early stages, ESTA estimated it could manage an initial decline in its workforce within its available resources and maintain the ambulance call-taking service by reducing the number of events processed, increasing the operational workforce, and reducing handling time for calls.[272] However, ESTA also assessed that either a 10 per cent decrease in workforce, or a 10 per cent increase in call volume, would mean it would not be able to meet its performance benchmark for ambulance call-taking.[273]

245. ESTA was also armed with information from international sources about how the increased ambulance call demand could potentially be mitigated, including one of the

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[268] IGEM review CB 263-264, 275, 329-330. Such as the Australian and Victorian Government media campaigns that ran during periods of 2021 and into 2022.
[269] Inquest Transcript (**T**), 25 March 2024, 24.
[270] IGEM review (Finding 42), CB 227.
[271] IGEM review, CB 274, 285.
[272] IGEM review, CB 286.
[273] IGEM review, CB 285

largest lessons from the European experience of the pandemic, that "public messaging can change public call demand patterns".[274]

246. The breadth of ESTA's pandemic planning for management of emergency telecommunications was found by the IGEM review to be significant, and it was noted that ESTA continued to refine its planning and forecasting throughout 2020.[275]

247. These findings from the IGEM review were expanded upon during the Inquest through the evidence of Christopher Mercovich, the Senior Officer, Performance Monitoring at IGEM, who explained that from March 2020, "ESTA had good modelling and forecasting in place as to what the potential call loads could be in the future".[276] This included low, medium and worst-case scenario estimates. As such, "ESTA was aware of what it would be - what it could be facing in the future".[277]

248. The IGEM review also found that in early to mid-2020, "ESTA was aware that it had a shortfall of funding and that it would require extra funding in order to bring on a new cohort of emergency ambulance call-takers at that time".[278] Mr Mercovich gave evidence that additional funding would have been needed to meet staffing needs even for the "low" estimate of future call load.[279]

249. Despite this awareness, the IGEM review found that ESTA did not commence a recruitment pipeline in anticipation of increasing call demand.[280] By way of explanation, ESTA advised IGEM that it did not have the required budget to commence such recruitment and was not permitted to operate outside those financial constraints. Whilst ESTA could have made an urgent funding request to government to recruit additional staff, it did not, focusing instead on "non-financial initiatives" to manage the anticipated demand.[281] IGEM concluded that this was a missed opportunity by ESTA in early to mid-2020 to seek urgent funding from the Victorian Government to commence recruitment in anticipation of increasing ambulance call load.[282]

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[274] IGEM review, CB 278,
[275] IGEM review, CB 278.
[276] T 25 March 2024, 87:12-14.
[277] T25 March 2024, 87:17-18.
[278] IGEM review, CB 303; T 25 March 2024, 84:29 - 85:2.
[279] T 25 March 2024, 87:21-23.
[280] T 25 March 2024, 87:2-29.
[281] IGEM review, CB 303; T 25 March 2024, 84:10-25.
[282] IGEM review (Finding 25), CB 222.

250. By comparison, the IGEM review found that both New South Wales Ambulance and the Queensland Ambulance Service engaged in additional recruitment in 2020, and in response to similar modelling and intelligence about expected increases in ambulance call load due to the pandemic. As such, neither New South Wales nor Queensland experienced the degree of degradation in emergency ambulance call-taking which was experienced in Victoria.[283]

251. During his evidence, Mr Mercovich confirmed that those states were able to cope with the increased demand when it arrived. In fact, the early preparations made in New South Wales and Queensland enabled them to absorb an increase in emergency ambulance call demand that outstripped Victoria's "unprecedented" increase in call numbers. As noted by Mr Mercovich, whilst New South Wales has a higher population than Victoria, Queensland is comparatively much smaller in population, yet that state received more ambulance calls than Victoria and was closer to meeting, if not actually able to meet, their performance benchmarks.[284]

252. This early recruitment resulted in an initial overspend on staffing in New South Wales in early 2020 but, according to Mr Mercovich, New South Wales was willing to overspend to avoid fatiguing staff and to reduce reliance on overtime. They "saw it as more important to overspend to reduce the risk down the line when those large number of calls came in".[285]

253. Telstra also commenced preparations in response to the pandemic in early 2020 as it was aware from overseas experience that it would experience increased call volumes and potential delays. Its awareness arose from a March 2020 meeting of the National Emergency Communications Working Group Australia/New Zealand (**NECWG A/NZ**) that was convened "to discuss how Australia could prepare for the impacts of the Pandemic from a Triple Zero ECS perspective".[286]

254. The NECWG A/NZ is a representative public safety body which provides a forum for discussing cross-jurisdiction issues regarding emergency communications services. At the relevant time, ESTA was a member of the NECWG A/NZ and its Ambulance Sub-

[283] Noting that their performance benchmarks were not quite as stringent, being 90 per cent of calls answered within 10 seconds, compared to Victoria's 5-second benchmark. IGEM review, CB 303; T 25 March 2024, 88:12 - 89:26.
[284] T 25 March 2024, 89:31 -90:6.
[285] T 25 March 2024, 89:21-26.
[286] Annexure to statement of Jane Elkington, CB 395.

committee, which met monthly to discuss strategies to manage call volume from September 2021 to 31 December 2021, and on a weekly basis from 5 January 2022.[287] The NECWG A/NZ Executive also continued to meet throughout the pandemic to review and discuss, at a national level, call volume information and additional strategies that could be implemented to reduce call volumes and meet the increased call load.[288]

255. Following the March 2020 meeting of the NECWG A/NZ, Telstra adjusted its call volume forecast to align with modelling shared at the NECWG A/NZ Ambulance Sub-Committee meetings.[289] Telstra assessed that the information received about the international experience was sufficient for it to immediately implement strategies focused on increasing its available workforce.[290] Telstra also increased its available workforce through recruitment and identification of current employees who could be seconded to the Triple Zero Call Centre if required, and it formulated a revised training course to onboard new staff more quickly.[291]

256. During the inquest, evidence was given on behalf of Telstra by Jane Elkington, Principal, Triple Zero at Telstra Limited, in relation to the March 2020 meeting of the NECWG A/NZ. Ms Elkington stated that there was an awareness at that time that training of staff for the emergency services took much longer than training of Telstra staff, hence the focus of the meeting was concern about resourcing when the pandemic reached Australia, and whether the ESOs nationwide would be able to cope with the anticipated increase in calls.[292]According to Ms Elkington, the issue of resourcing was discussed at length, and all the agencies agreed to review their current resourcing and to complete modelling about what the potential impact would be for them.[293]

257. Like ESTA, Telstra did not initially see an increase in calls or delays in the early months of the COVID-19 pandemic.[294] However, Ms Elkington explained that the rationale for acting at an early stage was as follows:

[287] Annexure to statement of Jane Elkington, CB 398-399.
[288] Ibid CB 399. The NECWG A/NZ Executive included at the time members from SA Police (Chair), Queensland Fire & Emergency Service, Queensland Police, Queensland Ambulance, New South Wales Police, Wellington Free Ambulance New Zealand and Telstra.
[289] Annexure to statement of Jane Elkington, CB 394.
[290] T 27 March 2024, 197:16-31, 198:21-28.
[291] Annexure to statement of Jane Elkington, CB 392.
[292] T 27 March 2024, 194:18-29.
[293] T 27 March 2024, 196:3-9.
[294] T 27 March 2024, 198:11-15.

> One of the things that we wanted to be able to do is that in the event that we did start to see that occur quite quickly, we could respond quickly, and that was, you know, the key reason that we took these steps, so that we could actually flex up really quickly if we needed to.[295]

258. When Telstra experienced increasing absenteeism from 1 July 2021 to 28 February 2022 due to pandemic related factors, it was therefore able to manage the issue due to these earlier preparations.[296] Additionally, when Telstra again made use of additional recruitment and secondments in October 2021 in response to increasing call demand, it was adding to an already increased workforce, rather than starting from scratch.[297]

259. The inquest also heard evidence on behalf of ESTA from Nicole Ashworth, Chief Operating Officer at Triple Zero Victoria, in relation to this issue of early preparation. Ms Ashworth conceded that frontline workforce capacity was the key issue contributing to ESTA's inability to meet its ambulance call answer performance standards between December 2020 and August 2022 and the first issue that needed to be improved.[298] Ms Ashworth agreed that the need to increase staff was apparent to ESTA from March 2020, and planning for increases to staff should have been occurring at that time. Ms Ashworth also acknowledged that ESTA was aware that more staff was the mechanism needed to protect against degradation of call answer performance, and that what ESTA required was more money to achieve this.[299]

260. However, in relation to the experience of other jurisdictions, Ms Ashworth opined that the experience of the pandemic in Victoria was different to that of other jurisdictions. Whilst ESTA's forecasting teams were also looking at the overseas experience, Ms Ashworth did not think that the modelling could have predicted what occurred in Victoria.[300]

261. More generally, Ms Ashworth opined that lockdowns in Victoria masked some of the issues regarding staffing levels, and it was not until after October 2021 that the call volume really started to escalate and the "increasing impacts of the pandemic were being realised".[301] Ms Ashworth did not think that ESTA "predicted the need for such

[295] T 27 March 2024, 198:15-20.
[296] Annexure to statement of Jane Elkington, CB 394.
[297] Annexure to statement of Jane Elkington, CB 392.
[298] T 26 March 2024, 134:8-14.
[299] T 26 March 2024, 136:5-10.
[300] T 26 March 2024, 134:29 - 135:8.
[301] T 26 March 2024, 134:18-30.

a significant increase in workload". She explained that the modelling undertaken in 2020 "wouldn't have been forecasting the extreme volumes that were seen in October onwards [and was] unable to predict when Victoria would open up, and the volumes of the people that became unwell, the calls that came through, the forecast". She opined that "no emergency service could have really predicted the detail around the levels and when they would occur in a pandemic".[302]

262. With these caveats, Ms Ashworth still conceded that based on ESTA's modelling and forecasting of call demand, ESTA was aware that it needed more staff to meet the projected need.[303] Ms Ashworth also agreed that ESTA's forecasting for the period March 2021 to October 2021 was accurate,[304] but stated that although ESTA would have been aware of the potential for an increase in call volume, it would not have been aware in March of what was going to eventuate in October 2021.[305] Ms Ashworth regarded the most significant re-forecasting of expected call volumes for the end-of-2021 period as not occurring until the middle of September 2021.[306]

263. This is largely consistent with the assessment made by the IGEM review which found that "ESTA continuously updated its forecasting model inputs and assumptions, which led to forecast call volumes being consistently close to, or greater than the actual volume of calls received each month".[307] However, according to the evidence of Mr Mercovich, "ESTA's modelling, certainly between March and October 2021 was really quite accurate in terms of what they expected to get in terms of demand".[308]

264. Whether or not ESTA could specifically predict what the call volumes would be in October 2021, demand was expected to increase. In any event, ESTA's decision-making from March 2020 was not due to uncertainty about the modelling. Rather, the IGEM review concluded that there was simply a reluctance within ESTA to seek

[302] T 26 March 2024, 139:2-14.
[303] T 26 March 2024, 135:31 - 136:10.
[304] T 26 March 2024, 138:9-12.
[305] T 26 March 2024, 138:13-18. There was a clear surge of emergency ambulance calls from October 2021 while Melbourne was in its sixth lockdown (commencing 5 August and ending 21 October). In that month, Victoria recorded over 50,000 COVID-19 cases. For each day of October, an average of 2,784 emergency ambulance calls were made to ESTA each day. This significant load coincided with the COVID-19 Delta wave. On 28 October 2021, ESTA also faced increased emergency ambulance call load due to the forecast of an elevated risk of epidemic thunderstorm asthma: Ashton review, CB 242, 256.
[306] T 26 March 2024, 138:18-20.
[307] IGEM review, CB 220.
[308] T 25 March 2024, 21:13-17.

additional funding from government outside of the State budget process.[309] As Ms Ashworth was not employed by ESTA during the relevant period, she could not speak to ESTA's decision-making on that issue.[310]

265. In my view, it remains unclear why ESTA did not request urgent immediate funding to recruit more ambulance call-takers at this early stage, or at any time prior to October 2021. To date there has been no account of the individual decision-making in relation to this issue within ESTA and it remains largely unexplained. The omission is particularly perplexing when regard is had to ESTA's actions throughout 2020 and into 2021 when non-compliance with the performance standard commenced.

Forecasting and ongoing assessment of the risk in 2020

266. From its actions throughout 2020, it is evident that ESTA maintained an ongoing awareness that the evolving pandemic had the potential to significantly impact the ambulance call answer service. The executive level of ESTA was cognisant that the specific risks arising from the pandemic were an anticipated increase in call volume and a concurrent decrease in workforce availability, leading to a degradation in call answer speed. Despite this, ESTA's response remained focused only on utilising its available workforce and identifying strategies which could be used to mitigate call demand.

267. In March 2020, ESTA formed a Crisis Management Team to manage the initial pandemic response, and an ESTA COVID-19 Response Group as an advisory group to the Executive Leadership Team.[311] This indicated an awareness that the pandemic required additional resourcing and focus in response to the risks it posed to ESTA's operations.

268. In the same month, during a meeting between IGEM and ESTA conducted as part of IGEM's ongoing monitoring function, ESTA advised IGEM that the "modelling look[ed] bad" and that they were "focused on mitigating risks" arising from the pandemic.[312]

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[309] T 25 March 2024, 63:14 - 64:5.
[310] T26 March 2024, 137:3-11.
[311] Statement of Nicole Ashworth, CB 648.
[312] IGEM review, CB 278.

269. By July 2020, ESTA was advising IGEM "that it expected high COVID-19 caseloads to affect its call activity, commencing December 2020".[313]

270. In June 2020, in a draft Corporate Plan for 2020-2021, ESTA was forecasting that it expected to be compliant with call answer speeds for the remainder of the year, but only just compliant from January 2021 to June 2021.[314] This draft plan was reviewed by Ambulance Victoria (**AV**) who noted that it "was largely silent on COVID-19 despite the significant and likely ongoing impact to our respective agencies".[315] AV also noted that ESTA's forecasts for emergency call answer performance for ambulance failed to articulate the drivers of the expected decline in performance from a position of compliance in 2020, into near non-compliance into 2021. Furthermore, AV noted that the plan did not articulate what measures would be utilised by ESTA to support or improve performance.[316] Despite these reservations, the final Corporate Plan was approved by the ESTA Advisory Committee without any changes in September 2020.[317]

271. More generally, the IGEM review noted that ESTA's Corporate Plans for 2019-20 and 2020-21 "contained very limited information regarding actions to improve its resourcing situation, nor how it planned to onboard and upskill new employees. In addition, there is no information on how ESTA plans to manage its performance during surge events into the future".[318] This evidences that whilst ESTA did engage in early planning and acknowledgement of the risks posed by the pandemic, there was insufficient consideration of the detail of what was necessary to address those risks if they eventuated.

272. The IGEM review also noted that ESTA's focus on the pandemic seemed to become less acute over the course of 2020. It was the role of the ESTA Advisory Committee to present and discuss information about ESTA's performance,[319] but there was no reference to COVID-19 or the pandemic in the minutes of the September or December 2020 meetings of the Advisory Committee.[320]IGEM also found that ESTA's Advisory

[313] IGEM review, CB 278.
[314] IGEM review, CB 276.
[315] IGEM review, CB 276.
[316] IGEM review, CB 276.
[317] IGEM review, CB 276.
[318] IGEM review, CB 312.
[319] T 26 March 2024, 99:17-19.
[320] IGEM review, CB 277.

Committee was not utilised as it could have been to "assist with strategic planning for the effects of the COVID-19 pandemic on ESTA's services".[321]

273. Additionally, in December 2020, the COVID-19 Crisis Management Team which had been formed and met weekly from March 2020, was disbanded. In communicating this decision, ESTA's executive advised the ESTA Chair and Board that the organisation would be managed on a "business as usual" basis going forward, unless a third COVID-19 wave occurred. The IGEM review noted that despite ESTA's planning and forecasting, this decision appeared to be based on an assessment that the worst of the pandemic was over. IGEM also expressed concern that this coincided with the commencement of ESTA's first month of non-compliant ambulance call answer performance in many years.[322]

274. However, leading up to December 2020, there is no evidence that ESTA ever reached an organisational position of satisfaction that the anticipated risks from the pandemic had resolved and would not materialise. Moreover, there was an awareness within ESTA at that time that demand for ambulance continued to be historically high. ESTA's own modelling had forecast increases in call demand in December 2020, and although that was due to anticipated high COVID-19 caseloads[323] which may not have eventuated, ESTA should have remained prepared for potentially increasing call demand at that time in the absence of any sound basis for concluding the previously identified risks no longer existed.[324]

275. Despite ESTA's apparent lack of focus on potential impacts to its ambulance call answer service, there was paradoxically ongoing acknowledgment that more call-taking staff were needed. In December 2020, ESTA made a submission to government for additional funding in the Victorian State Budget for 43 additional full-time employees (**FTE**), the majority of whom would be call-takers. The request was made in recognition of the need for an increased workforce.[325]

276. However, there was still no urgency in ESTA's actions. This request for additional funding aligned with the annual budget process. If approved, the funds could not have

[321] IGEM review (Finding 32), CB 223.
[322] IGEM review, CB 279.
[323] IGEM review, CB 278.
[324] IGEM review CB 279.
[325] T 26 March 2024, 106:26 - 107:5.

been expected to be available until the new financial year in 2021, and no additional recruitment would occur until after that time. It is unclear whether any consideration was given in December 2020 to making an urgent request for funding, or why the long timeline for potential recruitment which would follow any approval of funds in the State Budget was regarded as acceptable. It also remains unknown what the Victorian Government understood about the need for this additional funding and whether the request was assessed with any understanding of the risks that the pandemic posed to ESTA in relation to its performance. Such matters are beyond the scope of this coronial investigation, and there is no account of them in either the IGEM or Ashton reviews.

ESTA'S NON-COMPLIANCE WITH THE PERFORMANCE BENCHMARK

Overview

277. For the month of December 2020, ESTA failed to meet its performance benchmark of answering 90 per cent of emergency ambulance calls within a calendar month within 5 seconds, when its call answer performance dropped to 88 per cent.[326] ESTA then failed to meet this benchmark for every month until August 2022.[327] The non-compliance for December 2020 was a significant event because ESTA had been consistently meeting and exceeding its ambulance call answer performance benchmark since January 2016.[328]

278. The failure to meet the benchmark could not have been unexpected considering the ongoing pandemic and the earlier ESTA forecasts regarding the risks of increased call demand and a decreased workforce. As recently as November 2020, ESTA's own planning documents had been updated, acknowledging that a pandemic was a widespread health incident which would impact the Victorian public and result in an increase in requests for ambulance attendance.[329] It was also specifically acknowledged that this would result in a surge of call activity from the public, and that the broader consequence for the public may be the occurrence of adverse events due to delay in call answer, and a consequential delay in ambulance attendance.

[326] IGEM review, CB 288.
[327] IGEM review, CB 240.
[328] IGEM review, CB 234; statement of Nicole Ashworth, CB 637.
[329] IGEM review, CB 272.

279. From December 2020, ESTA did explore and pursue several initiatives to minimise workforce impacts to manage increasing calls for ambulance. However, ESTA was very limited in what it could achieve in this regard in the absence of any additional recruitment. According to the IGEM review, this was because ESTA's workforce model was constrained by relevant industrial agreements at the time.[330]

280. ESTA had only a limited number of "multi-skilled call-takers" (especially for ambulance agency skills) who were trained in multiple ESO call-taking procedures and an inflexible rostering system. ESTA was therefore unable to rapidly and flexibly deploy its available workforce to meet additional ambulance call demand.[331] When ESTA exhausted the available numbers of ambulance call-takers, there was simply no reserve workforce that could assist with answering calls.

281. Consequently, if there were call-taking staff from other ESO lines available, such as Victoria Police or Fire Rescue Victora, they were not trained to answer ambulance calls and could not assist even if they had physical capacity to do so. It is therefore possible that whilst ambulance call-taking staff were fully occupied and overwhelmed with call volumes and unacceptable wait times, their call-taking colleagues for other ESO lines were nearby and unoccupied.

282. Inexplicably, having disbanded the COVID-19 Crisis Management Team at the beginning of December 2020, ESTA did not reinstate it when non-compliance with the performance standard occurred. IGEM identified this as a lost opportunity for better management of the ongoing risk at a strategic level, which would have enabled ESTA to better manage the increasing demand in ambulance calls and its declining performance.[332]

283. In January 2021, ESTA again failed to meet its performance benchmark, answering 89.1 per cent of calls within 5 seconds for the month.[333] In late January, it was assessed that ambulance call answer speeds were falling below performance standards due to "surging demand for triple zero services" after COVID-19 restrictions eased, resulting in a 11.6 per cent increase in calls answered when compared with the previous reporting period. This was accompanied by high levels of call-taking staff absenteeism, which

[330] IGEM review, CB 305.
[331] IGEM review (Finding 26), CB 222.
[332] IGEM review (Finding 13), CB 280.
[333] IGEM review, CB 289.

had reached a rate of 11.5 per cent.[334] This was consistent with a materialisation of the risks which were forecast at the beginning of 2020. More specifically, ESTA modelling from early 2020 had predicted that in the event of a 10 per cent increase in call volume or a 10 per cent decrease in workforce from March 2020 levels, it would be unable to meet the performance benchmark for ambulance call answer speed.[335] ESTA's non-compliance in January 2021 was therefore wholly unsurprising.

284. On 21 January 2021, the ESTA CEO wrote to the Deputy Secretary of Emergency Management at EMV, for endorsement of ESTA's *Statement of Expectation Report Q2 2020-21 and Annual Corporate Plan*, noting it had been approved by the ESTA Authority and ESTA Advisory Committee. The report recorded that ESTA expected to fulfil its statutory responsibilities. It noted the failure to meet the performance benchmark in December 2020, attributing this to surge in demand and increased employee absenteeism due to COVID-19, and WorkCover claims. It noted some strategies about workforce and the submission for ERC (Expenditure Review Committee) funding for the next financial year. Reference was made to reduced employee capacity and fatigued employees due to three previous years where its funding growth requests had not been received.[336]

285. ESTA was again non-compliant with the performance benchmark in February 2021, answering 88.4 per cent of calls within 5 seconds for the month.[337]

286. By March 2021, there was "a very high jump in call activity" which ESTA was unable to service.[338] This resulted in a fourth consecutive month of non-compliance with the performance benchmark, and ESTA answered 83.8 per cent of calls within 5 seconds for the month.[339] By this time, ambulance call demand was 14.8 per cent higher than it had been in the same period in 2020.[340] Mr Mercovich described the non-compliance in March 2021 as the first significant decline in ESTA's performance.[341]

287. It was acknowledged in discussions between ESTA and Ambulance Victoria at this time that ESTA simply did not have the required number of staff to meet the expected

[334] Statement of Nicole Ashworth, CB 638.
[335] IGEM report, CB 285.
[336] ESTA letter to EMV, CB 868.
[337] IGEM review, CB 289.
[338] IGEM review, CB 279.
[339] IGEM review, CB 289.
[340] IGEM review, CB 305.
[341] T 25 March 2025, 22:3-5.

elevated call volumes. It was also recognised that multiple calls were being made for single events.[342] Also in March 2021, minutes of the ESTA Advisory Committee meeting noted that the increasing demand was affecting call answer speed, and this was problematic.[343]

288. Between January and June 2021, even accepting that spikes in call volumes were erratic and not continuous, and that staffing was for the most part at forecast required levels,[344] the degradation in call answer performance demonstrated that surges in demand were occurring frequently, not resolving, and ESTA did not have a sufficient reserve workforce to service them. Even in the absence of a consistent pattern of demand, the detrimental effect on performance due to periods of peak demand during individual shifts was sufficient to tip ESTA into non-compliance with the performance benchmark for each month. Ongoing non-compliance with the performance benchmark therefore indicated that there was a larger issue with delay which ESTA was unable to absorb, and which was not self-correcting. It should also have been apparent to ESTA that the issue was being caused by factors arising from the pandemic, in accordance with the earlier predicted risk.

289. On 25 March 2021, the then CEO of ESTA, Marty Smyth, wrote to Sue Clifford, Chief Executive and Deputy Secretary of Emergency Management Victoria (**EMV**), copying in Andrew Crisp, the Emergency Management Commissioner.[345] Mr Smyth wrote that he wished to bring to EMV's attention "the sustained increase in year-on-year demand in emergency ambulance service call volumes that are now impacting various key performance indicators" and what ESTA was doing in response. He noted that this had recently been discussed by the ESTA Advisory Committee.[346] Mr Smyth advised that emergency ambulance call demand for the month to date in March 2021 was "sitting at 14.8% higher than same period March 2020 and 20% higher than March 2019 with no increase in resources or growth funding in recent years", and that this was "resulting in degradation of the call-answer speed and total time to dispatch key performance indicator".[347]

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[342] IGEM review, CB 251, 290.
[343] IGEM review, CB 277.
[344] IGEM review, CB 288; IGEM review (Finding 19), CB 289.
[345] Letter from ESTA to EMV dated 25 March 2021, CB 875.
[346] Letter from ESTA to EMV dated 25 March 2021, CB 875.
[347] Letter from ESTA to EMV dated 25 March 2021, CB 875.

290. Mr Smyth referenced several factors relating to the pandemic as accounting for the increase in demand.[348] He acknowledged that ESTA had a "pandemic fatigued workforce who are less engaged", evidenced by a much lower up-take of overtime and increased absenteeism,[349] and advised that ESTA would be revisiting the planning which was devised at the start of the pandemic regarding potential increased ambulance demand.[350] This was the earlier planning relating to strategies to mitigate call demand and utilise ESTA's existing workforce.

291. Mr Smyth noted that ESTA had submitted a request for "additional funding for growth" and for additional ambulance CTD staff through an Expenditure Review Committee (**ERC**) submission which was at that time being considered by the Victoria Government,[351] and that he wished to ensure EMV, the Department of Treasury and Finance, and IGEM ("the regulator") were aware of the pressures that ESTA was facing.[352] This indicates ongoing recognition by ESTA that it needed more funding and it needed more staff to address the pressures it was experiencing.

292. Mr Smyth also advised that ESTA was exploring as many strategies as possible to address the problem with call answer speed, noting "We are doing everything pragmatically possible to ensure this issue is kept front of mind as it is adversely impacting the Victorian community".[353]

293. Referring to the impact on ESTA's workforce, Mr Smyth also noted that it would be prudent to inform the Minister[354] of these issues, "as we are noticing increased union agitation in this space".[355] Implicit in that request was an acceptance that the workforce issues were expected to persist for some time.

294. Mr Smyth also emailed the CEO of Ambulance Victoria, Associate Professor Tony Walker ASM, on 25 March in almost identical terms, stating "I have brought this matter

[348] Letter from ESTA to EMV dated 25 March 2021, CB 876.
[349] Letter from ESTA to EMV dated 25 March 2021, CB 877.
[350] Letter from ESTA to EMV dated 25 March 2021, CB 879.
[351] Letter from ESTA to EMV dated 25 March 2021, CB 877.
[352] Letter from ESTA to EMV dated 25 March 2021, CB 877.
[353] Letter from ESTA to EMV dated 25 March 2021, CB 877.
[354] At that time the Minister for Police and Emergency Services.
[355] Letter from ESTA to EMV dated 25 March 2021, CB 877.

to the attention of my Board, IGEM and to EMV, for the purposes of informing the Minister".[356]

295. In response, on 14 April 2021, Ms Clifford acknowledged the correspondence and advised that Mr Smyth's concerns would be passed on to the Minister of Police and Emergency Services' office and the Department of Treasury and Finance. In relation to IGEM, she suggested "ESTA is more appropriately placed to provide this information to the Inspector-General Emergency Management (IGEM) via your existing arrangements, recognising IGEM's role as an independent authority".[357] Ms Clifford also encouraged ESTA to consider if any savings accrued during the COVID-19 restriction period when ambulance demand was lower could be reprioritised to help manage the high demand.[358]

296. There is no evidence indicating that ESTA expected any broader government intervention because of its correspondence with EMV, and it did not specifically request any. Having regard to the muted response which was received, there could have been no expectation from ESTA that any further or additional assistance was in the pipeline. The request for escalation to the Minister and broader government was limited to concern regarding industrial issues and the need to approve the funding sought as part of the State Budget.

297. Whilst EMV suggested that ESTA advise IGEM directly about the pressures it faced, ESTA had already been doing so.[359] It also appears that ESTA was already having monthly meetings with the Emergency Management Commissioner (**EMC**), EMV's CEO and IGEM where call-answer speed performance was being raised in a general sense.[360] There was therefore a diffuse awareness of the issue outside of ESTA, but ESTA remained responsible for its own performance and it was not clear that ESTA was seeking broader assistance from the emergency management sector or government at that time. It can be inferred that ESTA was content to wait for the requested funding through the State Budget process as no request for additional urgent funding was made or advocated for.

[356] Letter from ESTA to Ambulance Victoria dated 25 March 2021, CB 882.
[357] Letter from EMV to ESTA dated 14 April 2021, CB 878.
[358] Letter from EMV to ESTA dated 14 April 2021, CB 878.
[359] Statement of Nicole Ashworth, CB 639.
[360] Statement of Nicole Ashworth, CB 638.

298. ESTA was again non-compliant with the performance benchmark in April 2021, answering 81.6 per cent of calls within 5 seconds for the month.[361] By that time, ESTA had data indicating that the trend of higher call volumes would continue to track upwards into higher numbers by the end of 2021.[362]

299. On 14 April 2021, IGEM provided ESTA with an *Assessment of ESTA's non-financial performance from 1 July to 31 December 2020.* It was stated that IGEM would soon provide an update to the Acting Minister for Police and Emergency Services. Non-compliance with the ambulance call answer speed performance benchmark for December 2020 was not specifically referred to. The letter generally noted that "ESTA's performance of call-taking and dispatch services remains very high". However, the Inspector-General acknowledged the recent decline in ambulance call-taking and dispatch performance, and referred to recent correspondence from ESTA regarding increased demand impacting performance. IGEM believed that data showed a "consistent increase in call activity" from 2015, with call volume decreasing in lockdowns. However, it was noted that data "suggests the trend will continue upward or possibly trend to higher levels by the end of 2021". The Inspector-General also noted that ESTA was trying to improve performance and was in discussions with AV about this, and IGEM would continue to monitor the issue for the remainder of the financial year.[363]

300. Yet this assessment from IGEM came just weeks after ESTA was communicating data to EMV and AV that showed a substantial increase in call demand due to pandemic factors, as well as noting workforce and funding issues. It also occurred despite ESTA informing AV that the issues had been brought to the attention of IGEM to "manage expectations",[364] yet the assessment by IGEM in April appeared not to be aware of the extent of the pressures being felt by ESTA and ESTA's view of their cause.

301. As indicated in ESTA's correspondence with EMV, AV and IGEM, ESTA tried to manage the situation by utilising some of the mitigation tactics[365] identified in its pandemic planning, primarily in relation to management of its existing workforce. However, ESTA had now experienced four months of ongoing non-compliance with

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[361] IGEM review, CB 289.
[362] Statement of Nicole Ashworth, CB 638; Letter from IGEM to ESTA dated 14 April 2021, CB 874.
[363] Letter from IGEM to ESTA dated 14 April 2021, CB 873-874.
[364] Letter from ESTA to AV dated 25 March 2021, CB 882.
[365] IGEM review, CB 272-273.

the performance benchmark which it was unable to correct, and there was no sound basis for expecting that the non-compliance was going to resolve without an increase in call-taking staff numbers. Whilst it hoped for additional funding in the State Budget, ESTA should also have known the issue was not capable of any quick resolution having regard to the length of time it took to hire and train new call-takers and the pandemic context in which they were operating. Moreover, they had forecasting which expected call volumes to increase.

302. In May 2021, ESTA was again non-compliant with the performance benchmark, answering 75.4 per cent of calls within 5 seconds for the month.[366] Also in May 2021, ESTA received funding approval for 43 FTE positions as part of the 2021-22 State Budget allocation for ESTA.[367] However, this funding was not released to ESTA until August-September 2021.[368]

303. By June 2021, ESTA was still non-compliant, answering 82.3 per cent of calls within 5 seconds for the month.[369] The ESTA Advisory Committee minutes for June 2021 reflected that there was now significant discussion of ambulance call answer performance. It was acknowledged that ESTA could not absorb the large increases in call activity being seen from May 2021, and factors related to staffing levels were identified as explaining the inability to meet demand.[370]

304. Performance benchmark non-compliance continued and worsened in July 2021, when ESTA answered 77.2 per cent of calls within 5 seconds for the month. By this stage, it was evident that ESTA was "under substantial operational strain".[371] ESTA put forward proposals to AV on the introduction of Recorded Voice Announcements to deliver post-dispatch instructions to callers, a strategy identified in its early planning. However, this was initially not supported by AV without further review and was ultimately not implemented until October 2021.[372]

305. In August 2021, ESTA was again non-compliant with the benchmark, answering 81.2 per cent of calls within 5 seconds for the month.[373] This was a slight improvement,

[366] IGEM review, CB 289.
[367] Statement of Nicole Ashworth, CB 639.
[368] Statement of Nicole Ashworth, CB 668.
[369] Statement of Nicole Ashworth, CB 668..
[370] IGEM review, CB 277.
[371] Statement of Nicole Ashworth, CB 649.
[372] Statement of Nicole Ashworth, CB 639.
[373] IGEM review, CB 291.

but by that time ESTA recognised that COVID-19 numbers would likely increase and brought forward its reforecast for ambulance demand, which was otherwise due to occur in October 2021.[374]

306. In September 2021, ESTA was again non-compliant with the benchmark, answering 67.8 per cent of calls within 5 seconds for the month, a new low.[375] That month, the CEO of ESTA advised AV that in the absence of additional operational resources, ESTA would continue to struggle to meet the performance benchmarks. It was also acknowledged that whilst there was additional funding announced in the State Budget, it would take six months for additional call-takers to be operational and proficient in call-taking, and no additional call-takers had yet been employed. Meanwhile, ESTA's existing workforce was fatigued and experiencing increasing pressure, leading to compounding mental health and wellbeing issues and increasing unplanned leave.[376] At this stage, ESTA activated its Crisis Management Plan and reinstated the Crisis Management Team in response to the reforecast figures[377] and contacted AV to discuss the expected imminent increase in call volume due to the Delta strain of COVID-19.[378]

307. In September 2021, the "significant operational impacts of the pandemic started to materialise".[379] From that time, ESTA's focus "shifted and multiple business units across the organisation were attempting to implement a vast range of activities to scale ESTA's ambulance workforce, increase call-taking efficiency and reduce call volume demand". However, by early October 2021, those measures were still only in progress or not yet activated.[380]

308. ESTA took unprecedented steps, attempting to obtain resources from the South Australian Ambulance Service, but this was not viable. Other interstate ambulance services were also approached but were unable to assist.[381] Additionally, ESTA was meeting with the NECWG A/NZ Ambulance Sub-committee to discuss the high volume of calls and seeking advice to help rectify the crisis.[382]

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[374] Statement of Nicole Ashworth, CB 639.
[375] IGEM review, CB 291.
[376] IGEM review, CB 305.
[377] Statement of Nicole Ashworth, CB 639.
[378] Statement of Nicole Ashworth, CB 640.
[379] Statement of Nicole Ashworth, CB 651.
[380] Statement of Nicole Ashworth, CB 651.
[381] Statement of Nicole Ashworth, CB 651.
[382] Statement of Nicole Ashworth, CB 651.

309. In September 2021, IGEM's *Monitoring of the Emergency Services Telecommunications Authority's call taking and dispatch performance Annual Report 2020-21* was provided to the Minister. According to IGEM, the report "demonstrates that ESTA's state-wide emergency ambulance call answer performance only exhibited minor declines (with some erratic improvements) prior to September 2021.[383] The report observed that ESTA had not been compliant with the benchmark "since the onset of a surge in AV emergency calls from November 2020 onward". It was noted that ESTA had commenced a program to recruit additional ambulance call-takers to improve call answer speed.[384] It also noted that ESTA was facing "considerable challenges" in its call-taking and dispatch services for ambulance. However, overall, IGEM regarded ESTA as continuing to "appropriately plan, prepare and provide adequate emergency telecommunications during another very challenging year".[385]

310. IGEM also provided ESTA with a letter dated 7 September 2021, regarding its *Annual assessment of ESTA's non-financial performance for 2021-2021*. The Inspector-General noted, "I am concerned about ESTA's emergency ambulance call answer speed performances that have been regularly below-benchmark since December 2020". The letter referred to advice from ESTA on 29 March 2021, "regarding the significant increase in demand for emergency ambulance services that are affecting ESTA's forecasting and staffing levels". It also noted ESTA had recently employed new call-takers, stating, "[t]his initiative will go some way to improving performance. Nevertheless, it is a worrying indicator that ESTA's July 2021 call-answer speed for emergency ambulance was significantly below the benchmark (77.2 per cent)".[386]

311. By late September 2021, "ESTA became aware of acute standard non-compliance" as well as effects on the Telstra E000 service.[387] From mid to late September, Telstra was aware of the delays in ambulance call answering in Victoria and it was acknowledged that those delays would impact the National Emergency Call Service (**Telstra national call service**).[388] Telstra understood that the degradation in ESTA call answer time was attributable not just to increased call demand, but also due to ESTA's resourcing and

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[383] Exhibit H1, email to the Coroners Court of Victoria from Christopher Mercovich dated 30 April 2024.
[384] Exhibit H2, annexure to email from Christopher Mercovich dated 30 April 2024, *Monitoring of the Emergency Services Telecommunications Authority's call taking and dispatch performance Annual Report 2020-21,* page 10.
[385] Ibid, page 11.
[386] Annexure 3 to Exhibit I, further supplementary statement of Nicole Ashworth dated 7 May 2024.
[387] Statement of Nicole Ashworth, CB 640.
[388] T 27 March 2024, 208:13-27.

staffing issues.[389] ESTA was contacting Telstra to discuss initiatives to mitigate the impact of increasing demand, and Telstra was asking if it could do anything to assist.[390]

312. On 13 September 2021, representatives of ESTA, Ambulance Victoria and Telstra attended a NECWG A/NZ Ambulance Sub-committee meeting. Telstra indicated that the next six to eight weeks would be challenging. There was discussion about using the extreme event RVA, the delay RVA and the 4-minute rule.[391] Representatives from AV indicated ESTA was experiencing significant performance delays, including due to impact of the pandemic on staff.[392]

313. On 17 September 2021, ESTA emailed Telstra, noting "significant call answer delays" and requesting relevant data from Telstra on a daily basis.[393] ESTA also stated "that call wait times are increasing further"[394] and that "ESTA is doing everything we can to meet demand, and as you know demand continues to increase".[395] There was also discussion of implementing the 4-minute rule for Victoria to free up Telstra operators.[396]

314. Between 23 September and 30 September 2021, there was ongoing correspondence between Telstra and ESTA about possible strategies to mitigate call demand in Victoria.[397] This included an email to Telstra on 27 September 2021, in which ESTA noted the 4-minute rule had been applied for a significant number of events and "sustained calls waiting for ambulance is a regular occurrence now and we are trying to mitigate this as best as possible from within ESTA, but also looking to see what else we can do for those extreme moments".[398] Telstra notified ESTA that they were experiencing "significant delays" and believed it was due to ESTA staffing issues. The delays caused Telstra to call in its additional staff and extend shifts.[399] It was also noted that the "current workload for both Telstra and ESTA will most likely continue to rise".[400]

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[389] Annexure to statement of Jane Elkington, CB 401.
[390] Annexure to statement of Jane Elkington, CB 402.
[391] Annexure to statement of Jane Elkington, CB 407.
[392] Annexure to statement of Jane Elkington, CB 407-408.
[393] CB 501-503.
[394] Ibid.
[395] CB 507.
[396] CB 505-506.
[397] CB 514-534.
[398] CB 575.
[399] CB 574.
[400] CB 584.

315. The trend of declining performance significantly worsened in October 2021. This was ESTA's busiest month for ambulance calls, and the lowest performance for ambulance call answer speed on IGEM's records. In that month, ESTA answered only 47.4 per cent of calls within five seconds,[401] its lowest ever performance against the performance benchmark.[402] By that time, daily call activity had increased 30.1 per cent when compared to October 2020, and there was increasing staff absenteeism.[403]

316. On 6 October 2021, ESTA's then Head of Emergency Management sent an email to relevant ESTA staff, copying in Telstra, which acknowledged that "the current workload for both Telstra and ESTA will most likely continue to rise".[404] The stress being experienced by staff was also referred to, and ESTA employees were asked to "[p]lease remember that our Telstra friends are also very busy taking calls from all over Australia and are waiting on the line with distressed callers at times. Their Team Leaders are also in stressful situations. Please be kind to each other to work through this unprecedented time".[405] ESTA also advised Telstra that "We are seeing delays occurring on a daily basis now".[406]

317. I note the evidence about pressures on Telstra staff mirrors evidence from Ms Ashworth that at times during the call-taking crisis, the stress on ESTA ambulance call-taking staff was so great that information visible to call-takers regarding the large number of calls waiting to be answered had to be turned off due to staff welfare concerns.

318. Also, on 6 October 2021, Telstra made notification to the Australian Government Department of Infrastructure, Transport, Regional Development and Communications) (**DITRDC**) that it had not met its own performance requirements for the day, and this was thought to be due to the delays being experienced in Victoria which were outside of Telstra's control. Telstra also sought an urgent meeting with ESTA to discuss Victoria's excessive call volumes.[407] The same day, ESTA's then CEO, Marty Smyth, informed the Victorian Minister and the Emergency Management Commissioner that Telstra had sought a meeting about excessive call volumes".[408]

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[401] Statement of Nicole Ashworth, CB 640; T 25 March 2024, 18:26-31.
[402] T 26 March 2024, 104:29 - 105:3.
[403] Statement of Nicole Ashworth, CB 640-641.
[404] CB 584.
[405] CB 584.
[406] Annexure to statement of Jane Elkington, CB 408.
[407] Statement of Nicole Ashworth, CB 641; Attachment AD to statement of Jane Elkington, CB 588.
[408] Statement of Nicole Asworth, CB 641.

319. Mr Smyth also sent an email on that day to the Emergency Management Commissioner, Andrew Crisp, copying in Telstra, as follows:

> We have reached a new level in our call-taking crisis this evening with Telstra now seeking another urgent executive briefing in the morning as to what we are doing in Victoria about the excessive call volumes being currently experienced […] I also have a Board meeting Thursday morning so will brief them as well.
>
> Having discussed this internally, we can develop a quick reference course of two weeks for services such as other States or ADF personnel to take E000 ambulance calls as a strategy to this crisis. Flavia and I spoke to the Minister tonight and she is very keen to advocate and assist us in any way she can, which is very helpful. She will also seek a Treasurer's Advance funding between now and Christmas to fly in additional personnel from inter-state and is seeking a further briefing within 3-4 weeks on progress.
>
> I am keen to urgently seek yours and Joe Buffone's assistance in addressing this evolving need for additional workforce at a national level for FIFO personnel to assist ESTA. Happy to make any diary adjustments to meet with you both to urgently progress assistance in this space from other States or ADF.[409]

320. In response, Mr Crisp advised he would explore the option of Australian Government/ADF support,[410] but ultimately this was not pursued.[411]

321. This evidence is the first indication that ESTA accepted the call-taking delays were an emergency which required urgent rectification beyond its own capabilities and resources. However, the crisis had become so entrenched by that point that Victoria simply did not possess the resources necessary to resolve it, and ESTA accepted there was no expectation it would resolve within current resourcing or anticipated recruitment.

322. By 7 October 2021, the crisis in Victoria was so significant that a Senior Government Relations Minister at Telstra sent an email to the federal office of the Minister for Communications about the Victorian ambulance call delays. It was noted that the influx of calls was attributable to the pandemic, and the issue of long wait times was not attributable to the Telstra Triple Zero platform, but to the number of Victorian ESTA agents available to answer calls. It was also noted that "medical staff from the ADF

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[409] Annexure to statement of Jane Elkington, CB 403; email at CB 535.
[410] Email dated 6 October 2021, CB 537.
[411] Statement of Jenni Rigby, CB 979-980.

may be engaged to assist with answering calls" and that there was media attention regarding the issue.[412]

323. The requested meeting between the ESTA CEO, Telstra and the EMC occurred on 7 October 2021 to discuss urgent actions which could be implemented to address the crisis. Actions discussed included use of urgent disconnect, the extreme event Recorded Voice Announcement, and use of the media to alert the public to the need to reserve 000 for emergencies.[413] Telstra's understanding was that the EMC could assist ESTA in obtaining funding for resourcing and that there had been discussion with the ESTA CEO about escalating concerns to the Australian Government.[414]

324. On 8 October 2021, a further email was sent from a Senior Government Relations Minister at Telstra to the federal office of the Minister for Communications. It advised there was an expectation that calls to 000 would increase over the next 12 weeks, with increases of over 20 per cent and a forecast peak in mid-October 2021. The email noted "marked deterioration in the service levels" for ambulance in Victoria and outlined the mitigation strategies being put in place. It also stated that ESTA would meet with Emergency Management Australia to discuss support options.[415]

325. On that date, at ESTA's request, a National Coordination Mechanism (**NCM**) meeting was held which included Victorian delegates from ESTA, AV, EMV and IGEM, to assist ESTA to address the crisis. ESTA requested partner support for resourcing and call handling, which included seeking interstate workers as a temporary workforce, ADF assistance, and an opportunity to discuss lessons learnt from other State Ambulance Services.[416]

326. Also on that date, IGEM wrote to the Minister for Emergency Services and advised that the crisis was close to replicating the thunderstorm asthma event – the single biggest ambulance call surge event on record – on a daily basis, and with no end in sight. This was the first contact from IGEM to the Minister regarding the call answer delays being experienced by ESTA which was in addition to its regular reporting.[417]

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[412] Attachment AE to statement of Jane Elkingtin, CB 590-591.
[413] T 27 March 2024, 205:26 - 207:11; Annexure to statement of Jane Elkington, CB 403-404.
[414] T 27 March 2024, 208:1-7.
[415] CB 592-593.
[416] Statement of Nicole Ashworth, CB 641.
[417] CB 1302.

327. On 8 October 2021, the Victorian Government announced that Mr Graham Ashton would conduct a review of ESTA.

328. It was the occurrence of the NCM and contact between the ESTA CEO and the EMC that led to the formation of the ESTA Joint Agency Support Team (**EJAST**) and broader government intervention.[418] EJAST was led by the Deputy Emergency Management Commissioner at Emergency Management Victoria. It included members from AV, the Department of Environment, Land, Water and Planning and Victoria Police. The team was specifically formed to address ESTA's performance issues[419] and to "assist in the development of mitigation strategies and activities to restore performance of ESTA's call-taking and dispatch services.[420] This marked the first instance of broader government intervention in ESTA.[421] EJAST commenced meeting in the week beginning 11 October 2021 and began exploring options for a surge workforce for ESTA.[422]

329. Meetings between Telstra and ESTA continued throughout October 2021 to discuss measures which could address the further decline in ESTA's call answer performance.[423] From 7 October 2021, an Extreme Event Recorded Voice Announcement for Victoria was activated and "implemented daily for long periods of time" thereafter.[424] This recording advised callers that emergency ambulance in Victoria was very busy, and to stay on the line or call Nurse on Call if their health need was not urgent.[425] The 4-minute rule was also being utilised on hundreds and sometimes thousands of occasions each month from October 2021 to March 2022.[426] Throughout that period, the ESTA delays were adversely impacting the Telstra national emergency call service.

330. During October 2021, Telstra continued communicating with the office of the Federal Minister for Communications regarding the ESTA call delays,[427] as well as updating the DITRDC and its regulator, the Australian Communications and Media Authority

[418] Statement of Jenni Rigby, CB 978; statement of Nicole Ashworth, CB 641 and 652
[419] T 26 March 2024, 116:24 - 117-16.
[420] T 26 March 2024, 118:15-18.
[421] T 26 March 2024, 117:9-12.
[422] Statement of Nicole Ashworth, CB 652.
[423] Annexure to statement of Jane Elkington, CB 402-403.
[424] Annexure to statement of Jane Elkington, CB 405.
[425] Annexure to statement of Jane Elkington. CB 405.
[426] Annexure to statement of Jane Elkington, CB 407.
[427] Annexure to statement of Jane Elkington, CB 410.

(**ACMA**), each morning.[428] On 8 October 2021, the Federal Minister contacted the Victorian Minister for Emergency Services referring to advice from Telstra that there had been significant delays in ESTA accepting the transfer of 000 ambulance calls from Telstra, and that this was impacting Telstra's ability to answer calls from elsewhere in the nation. The Federal Minister sought assurances from the State Minister that staffing levels would be increased.[429]

331. Further external concerns were directed to ESTA when, on 9 October 2021, AV's CEO wrote to ESTA regarding patient safety issues identified by AV relating to the deterioration in ESTA's call answer speed.[430] On 14 October 2021, ESTA briefed the Minister for Emergency Services about the information received from AV.[431]

332. On 16 October 2021, the day of Nick's emergency, ESTA received 85 per cent of the call volume it had forecast for that day.[432] However, ESTA still did not have adequate ambulance call-taking staff to meet its forecast of operational staffing hours required for that day, meaning that ESTA did not have enough staff available to service the demand. Between 12:30 pm and 12:45 pm, when the first three calls relating to Nick's emergency were made, ESTA was operating at only 57.5 per cent of the staffing it required to meet forecast demand.[433]

333. On 18 October 2021, AV's Emergency Management Unit and ESTA discussed a potential request for assistance from the Commonwealth. EMV also met with ESTA and AV regarding public communications to reduce call volume, including the "Save Triple Zero for emergencies" campaign.[434]

334. On 22 October 2021, ESTA's CEO resigned. A new interim CEO was appointed on 25 October 2021,[435] and an Interim Deputy CEO appointed on 8 November 2021.[436]

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[428] Email dated 3 November 2021, CB 555.
[429] Ibid, referring to https://www.theaustralian.com.au/nation/politics/victoria-under-fire-over-chronic-triple0-delays/news-story/7751574bffa7baa1ddf3649929dd415?btr=298ffb9bed9bb60c7eebb47d8392ec0
[430] Statement of Nicole Ashworth, CB 641.
[431] Statement of Nicole Ashworth, CB 642.
[432] Statement of Nicole Ashworth, CB 625.
[433] Statement of Nicole Ashworth, CB 626.
[434] Statement of Nicole Ashworth, CB 642.
[435] Statement of Nicole Ashworth, CB 642.
[436] Statement of Nicole Ashworth, CB 642.

This coincided with the commencement of an urgent re-prioritisation of measures within ESTA to uplift and support the CTD service.[437]

335. On 28 October 2021, in email correspondence between ESTA and Telstra, ESTA acknowledged a "torrid night last night" and apologised for the impact on Telstra teams.[438] Their correspondence included further discussion about the causes of the delays and initiatives to reduce call volumes, with ESTA acknowledging to Telstra that "[t]he biggest impact will come when we have more people in seats to answer the calls and that is weeks away. The rest is fiddling at the margins".[439]

336. From late October 2021, there was a concerted and coordinated effort to correct the degradation in ESTA's performance, which would ultimately not succeed until August 2022. By that time, direct intervention in ESTA's operations had finally occurred by way of emergency management and significant additional government funding. The scale of the response and the emergency financial investment which was ultimately required was indicative of just how severe and entrenched the crisis had become, and that there was no hope it would resolve without broader government intervention.

337. By that stage, the crisis involved the Victorian Minister for Emergency Services, Emergency Management Victoria, the Emergency Management Commissioner, Ambulance Victoria, the Victorian Department of Environment, Land, Water and Planning, and Victoria Police. It had also impacted and involved Telstra, its regulator ACMA, DITRDC,[440] and the Federal Minister for Communications. ESTA was also providing regular updates, through EMV, to the Department of Premier and Cabinet and the Premier's Office regarding efforts to address performance.[441]

338. Whilst it was finally recognised that ESTA immediately needed more ambulance call-takers, even with the injection of funds from the Treasurer's Advance, recruitment would take some time. Notably, despite the funds approved for an additional 43 FTE call-taker positions, those roles had not been filled as at October 2021. In the short term, ESTA managed to obtain call-takers from the New South Wales Ambulance Service and a paramedic student surge workforce to try to meet demand in November 2021.

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[437] Statement of Nicole Ashworth, CB 652.
[438] CB 553.
[439] CB 552.
[440] Attachment AD to statement of Jane Elkington, CB 588-589.
[441] Statement of Nicole Ashworth, CB 643.

Other initiatives which were explored but found not to be possible included obtaining staff from Telstra, Victoria Police, AV, the Department of Justice and Community Safety, New Zealand, the ADF and the broader Victorian Government pool.[442]

339. Ultimately, throughout 2021-22 and beyond, the additional government funding allowed ESTA to substantially increase its workforce.[443]

The significance of time-based performance standards

340. Despite the lack of more urgent mitigation efforts by ESTA, the available evidence, as recounted above, demonstrates that ESTA and other emergency management bodies regarded non-compliance with the ambulance call answer speed performance standard as indicative of broader demand issues from the outset. Failure to comply with this time-based metric from December 2020 was not dismissed or minimised in any way, nor was it treated by ESTA as a mere failure to meet a KPI that had no real-world meaning.

341. To the contrary, it was plainly understood by ESTA that delays in ambulance call answer speed posed a safety risk to the community. As a matter of logic, the more severe the degradation in performance regarding call answer speed, the greater the exposure to that risk. ESTA's recurrent inability to meet the performance standards was obviously regarded as indicating a broader issue with delay across the system. Put simply, it was appreciated that failure to meet the performance benchmark equated to more callers experiencing delays in their calls being answered.

342. Whilst there may well be issues with the ability of the time-based standards to accurately reflect ESTA's operational performance and customer experience at specific times throughout the month,[444] it does not appear that they are designed to do so. The utility of the benchmark is from the snapshot it provides of average monthly performance, and the inherent acknowledgment that ESTA should be answering the overwhelming majority of calls within seconds.

343. This is wholly consistent with the time-critical nature of health emergencies. Inability to meet the time-based goal over the course of a month is therefore an indicator of a broader, more frequent problem with delay which requires correction. Having regard to

[442] Statement of Nicole Ashworth, CB 658-659.
[443] Statement of Nicole Ashworth, CB 665, 669.
[444] As found by the Ashton review and discussed earlier.

the available evidence, there was a clear correlation between increasing periods of time where ESTA could not service demand, and increasing deterioration in compliance with the ambulance call- answer speed performance standard. The time-based performance standard was therefore a useful indicator of whether ESTA was able to achieve a satisfactory standard of performance over the course of a month. Inability to do so was a warning sign.

344. It was also known to ESTA throughout the pandemic that delays in ambulance call answering could result in delayed attendance of ambulances, and delayed provision of pre-arrival first aid advice. It was acknowledged that such delays carried a risk to the community that needed to be avoided. The importance of mitigating this risk was reflected in all ESTA's pre- and post-pandemic planning, as well as its ongoing efforts to provide accurate modelling and forecasting to meet the demand.

345. It is evident that as early as January 2021, ESTA understood that their call answer performance degradation below the 90 per cent benchmark was attributable to real, quantifiable events, namely, an increase in call numbers and a reduction in available workforce, both due to the COVID-19 pandemic. By March 2021, concern about the ongoing failure to meet the benchmark was regarded as problematic, and this was apparent not just to ESTA.

346. This link between the ongoing degradation in call answer speeds in early 2021, and adverse outcomes for the community was directly acknowledged in ESTA's communications to EMV in March 2021.

347. There was an increasing degree of alarm and desperation evident at ESTA as the non-compliance percentages worsened throughout 2021. This must have been at least in part due to an awareness on ESTA's part that non-compliance with the benchmark was a warning sign for an increasing danger of adverse outcomes, and that worsening non-compliance corresponded with an increasing risk.

348. It is telling that the first adverse events associated with ambulance delays were reported in August 2021, as call answer speeds worsened to levels not previously seen. The evidence that ESTA began making enquiries at that time about the possibility of assistance from interstate indicates just how serious this risk was perceived to be.

349. It is also no coincidence that Nick's death occurred in a month when ESTA's call answer speed performance reached historic lows. In October 2021, the degree of exposure to widespread delays in ambulance call answering was higher than it had ever been for 000 callers requesting an ambulance. More generally, the evidence establishes that as the degree of non-compliance with the performance benchmark increased, so too did the reporting of adverse patient events from delay in ambulance call answering.

350. I note that the Ashton review commented on the limited utility of ESTA's time-based performance benchmarks and recommended that there be additional metrics which could more accurately account for patient outcomes. Whilst such additional standards may no doubt be useful, the available evidence demonstrates that non-compliance with the existing time-based performance standard was, and remains, an effective indicator of increasing risk to the Victorian community and that this was well understood at the relevant time.

351. It is therefore unsurprising that when the Victorian Government accepted the recommendations in the Ashton review, it also retained time-based performance metrics, namely, ESTA's call answer speed performance standard. Retention of that particular metric is an acknowledgment of its proven utility in measuring whether ESTA is performing its statutory function at an acceptable level and, concomitantly, at a level that protects public safety. It is also an implicit acknowledgment that performance benchmarks can be an important protective factor against bottlenecks within the 000 system and the emergency management sector more broadly.

MONITORING OF ESTA'S CALL ANSWER SPEED PERFORMANCE

352. At all times relevant to this case, IGEM was the statutory body charged with setting and monitoring performance standards for ESTA. Accordingly, throughout the period spanning December 2020 to August 2022, IGEM continuously monitored ESTA's ambulance call answer speed performance using the performance standard. Yet, despite intensive oversight by IGEM, the crisis in call taking still occurred, and it did not come without warning or without any opportunity to avert it. Understanding how that was possible was a central issue explored during the coronial investigation and inquest

353. ESTA was at all relevant times the statutory body with legislated responsibility for providing ambulance call taking and dispatch services in Victoria.[445] ESTA's functions, powers and governance were legislated by the *Emergency Services Telecommunications Act 2004* (**ESTA Act**), and ESTA's Board was ultimately accountable for ensuring its people and systems met government and community expectations.[446] However, ESTA did not perform its functions in a silo or without any assistance.

354. Within ESTA, there were multiple operational roles, analysts and teams which had responsibility for monitoring ESTA's call performance data in real time.[447] This meant that in relation to emergency ambulance calls, ESTA knew in real time the number of calls waiting to be answered, and the approximate wait time for those calls. In fact, within the three ESTA State Emergency Communications Centres (**SECC**s) where call-takers operated, this data was displayed on a "wallboard" which showed the numbers of calls waiting and approximate wait times for all the ESOs serviced by ESTA, not just ambulance.[448] ESTA frontline staff therefore had a very acute awareness at all times of the volume of calls being received,[449] and this data was used for rostering and resourcing decisions to meet the variations in daily call demand.[450]

355. Evidence was also heard that ESTA's executive director of emergency communication services, data science teams and the full executive were all aware of daily call answer speeds.[451] As such, knowledge of daily call volumes and pressures was known from the floor of each SECC up to the ESTA executive.

356. Significantly, ESTA also had legislated obligations to provide data and report on its own performance to the ESTA Advisory Committee[452] and to IGEM.[453]

357. A member of the ESTA Board chaired the Advisory Committee, which included executive-level representatives from AV, Victoria Police, FRV, CFA, VICSES, EMV,

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[445] IGEM Annual Forward Plan of Reviews 2022-23, CB 1058.

[446] IGEM review, CB 211.

[447] Established by Part 3 of the *Emergency Services Telecommunications Authority Act 2004* (**ESTA Act**): T 26 March 2024, 99:5-10.

[448] T 26 March 2024, 101:2-30.

[449] T 26 March 2024, 101:11-23.

[450] T 26 March 2024, 100:5-28.

[451] T 26 March 2024, 105:18-23; statement of Nicole Ashworth, CB 628-630.

[452] Pursuant to section 23 of the ESTA Act.

[453] Pursuant to sections 64(1)(f) and 71 (1) of the *Emergency Management Act 2013* (Vic). (**Emergency Management Act**),

and IGEM (attending as an observer).[454] The Committee's functions were to advise ESTA of any specific requirements of, or issues relating to, the organisations represented on the Committee, and to carry out any other functions conferred on the committee by legislation or regulations.[455] ESTA was also required to provide monthly reports to the Committee setting out its performance measured against standards, and any measures taken by ESTA to deal with matters raised by the ESOs.[456] Essentially, it was the role of the Advisory Committee to discuss information regarding ESTA's performance.[457]

358. ESTA also made monthly notifications to IGEM, analysing its performance against the performance standards set by IGEM.[458] This included notifying IGEM of any non-compliance with those standards. Additionally, ESTA provided its Board, EMV and IGEM with periodic Ministerial Statement of Expectation Reports, which set out its compliance with reporting requirements and other legislative responsibilities.[459]

359. Measuring performance, particularly the timeliness of its CTD functions, was therefore built into ESTA's operations and reporting obligations, and there was a high degree of visibility regarding ESTA's performance amongst the ESOs and broader emergency management sector.[460]

360. Whilst ESTA made reports regarding its performance both internally and externally, IGEM played a distinct and important role due to its responsibility for setting ESTA's call-taking and dispatch performance standards,[461] as well as monitoring ESTA's compliance against those performance standards.[462] Performance against those standards was reported to IGEM monthly, with IGEM receiving such reports approximately two weeks after month's end,[463] and from early 2021, ESTA reported its

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[454] ESTA Annual Report 2021-2022, CB 722; pursuant to section 21 of the ESTA Act.
[455] Section 22 of the ESTA Act.
[456] Section 23 of the ESTA Act.
[457] T 26 March 2024, 99:17-19.
[458] Pursuant to the IGEM's *Standards for the Performance of ESTA in Delivering Services to Ambulance Victoria (Metropolitan Region only)*: Statement of Nicole Ashworth, CB 628-629.
[459] Section 62 of the Emergency Management Act; Ibid, CB 629.
[460] Statement of Nicole Ashworth, CB 628-631; T 26 March 2024, 99:11 - 102:21 and 105:18-23.
[461] Pursuant to section 30 of the ESTA Act.
[462] Pursuant to section 71 of the Emergency Management Act.
[463] T 25 March 2024, 6:27 - 7:10.

performance to IGEM daily. The change in frequency was in response to the continuing decrease in ESTA's ambulance call answer speed performance.[464]

THE ROLE OF IGEM

The legislative framework and monitoring by IGEM

361. As set out in the Emergency Management Act, IGEM has the following legislated objectives:

    a. to provide assurance to the Government and the community in respect of emergency management arrangements in Victoria; and

    b. to foster continuous improvement in emergency management in Victoria.[465]

362. IGEM also has "specific, legislated assurance responsibilities relating to ESTA, as it determines the standards against which ESTA's call-taking and dispatch performances are benchmarked, as well as monitoring and investigating ESTA's non-financial performance".[466] IGEM's monitoring of ESTA's "non-financial performance" included assessing ESTA's compliance with the standards it set for ESTA's call-taking and dispatch performance. Relevantly, this included the time-based performance benchmark for emergency ambulance call answer speed, which required that 90 per cent of calls within a calendar month be answered by ESTA within five seconds. A secondary standard was that 95 per cent of calls be answered within 30 seconds. The effect of these requirements[467] was that IGEM monitored ESTA's performance of ambulance call taking and dispatch services on a continual basis.[468]

363. To facilitate monitoring of this benchmark, ESTA was required to provide monthly activity and data reports to IGEM which contained quantitative and qualitative performance data.[469] IGEM's monitoring then involved comparing and analysing this

[464] Statement of Christopher Mercovich, CB 369; supplementary statement of Christopher Mercovich, CB 993.
[465] IGEM review CB 211.
[466] ESTA Annual Forward Plan of Reviews 2022-23, CB 1058; T 25 March 2024, 4:30 - 5:29.
[467] Established by sections 64 and 71 of the Emergency Management Act.
[468] T 25 March 2024, 5:20 - 6:31. From December 2023, responsibility for setting performance benchmarks was moved to the Emergency Management Commissioner in relation to the performance of Triple Zero Victoria. During evidence, Mr Mercovich noted that this change removed a conceptual conflict, whereby IGEM was previously responsible both for setting the standard and monitoring it, creating a monitoring mechanism more in accordance with "best practice". However, whilst IGEM no longer sets the performance benchmark, it is still responsible for monitoring and investigating Triple Zero Victoria's performance: T 25 March 2024, 8:1 - 10:2.
[469] T 25 March 2024, 6:27 - 7:7.

data against the performance standards, to determine whether ESTA was compliant, and to identify whether any opportunities existed for improvement.[470]

364. The reporting included a detailed report from ESTA with data and analysis about emergency call answer speed performance, with forecasts and modelling, including about staffing.[471] Consequently, from March 2021, as soon as ESTA was aware of a degradation in performance, IGEM was aware shortly thereafter, rather than after the month's end.[472]

365. As part of its assurance oversight of ESTA, IGEM also investigated singular incidents and events, or systemic matters, which were regarded as "potential adverse events". These were emergencies in which ESTA did not meet expectations, either under the performance standards, or the expectations of government and the community. IGEM then determined whether to conduct an independent investigation into the incident, or whether ESTA should conduct its own internal investigation with review by IGEM.[473] IGEM was also empowered to undertake system-wide reviews under section 64 of the Emergency Management Act, an example of which was the IGEM review into ESTA's ambulance call-taking and dispatch delays.[474]

366. Moreover, IGEM's monitoring of ESTA was not at arm's length. It involved routine meetings between its performance monitoring staff and ESTA staff.[475] IGEM was also an observer and chair on various committees that examined ESTA's performance,[476] and there were additional meetings and involvement in forums between IGEM and ESTA which commenced or increased in frequency due to the COVID-19 pandemic. Additionally, there were meetings between the Inspector-General of Emergency Management and the Minister for Emergency Services as deemed appropriate,[477] regular meetings between the Inspector General of Emergency Management and the

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[470] T 25 March 2024, 4:9-13.
[471] T 25 March 2024, 23:6-17.
[472] T 25 March 2024, 23:18-19.
[473] T 25 March 2024, 14:6-27.
[474] Statement of Nicole Ashworth, CB 631.
[475] T 25 March 2024, 10:27 - 11:3 and 17:3-24. These included monthly/bi-monthly meetings between IGEM's Performance Monitoring Team and ESTA's Management Information Reporting (**MIR**) Team regarding data kept by them, chaired by IGEM; and monthly/bi-monthly meeting between IGEM and ESTA's Quality Assurance and Investigations Team (**QAI**), also chaired by IGEM. See also Annexure 8 to statement of Christopher Mercovich, IGEM *Procedures for monitoring and reporting the performance of ESTA*, CB 1152.
[476] Including the ESTA Advisory Committee and the ESTA Service Performance and Commercial Committee: T 25 March 2024, 11:15-24.
[477] T 25 March 2024, 33:1-5.

CEO of ESTA,[478] as well as regular communication between ESTA and IGEM staff via email and telephone as issues arose.[479] In summary, IGEM was intimately aware of ESTA's performance on a continual basis throughout the pandemic period.

367. The nature and purpose of IGEM's monitoring of ESTA's performance were documented in an internal IGEM document *Procedures for monitoring and reporting the performance of the Emergency Services Telecommunications Authority 2019* (**monitoring document**).[480] The purpose of the document was to detail "the procedure by which IGEM monitors, analyses and reports upon ESTA's non-financial performance of its services".[481]

368. The monitoring document describes IGEM's responsibility to produce periodic reviews and reports regarding its monitoring of ESTA's call-taking and dispatch performance, and its compliance with performance standards.[482] These included:

    a. an annual report to the Minister for Emergency Services (1 July to 30 June financial year);[483]

    b. a cover brief for the Minister for Emergency Services that supported the IGEM annual report;[484]

    c. a half-yearly report for the Inspector-General (January-June);[485] and

    d. an appraisal every six months to the CEO of ESTA.[486]

[478] T 25 March 2024, 30:6-7.
[479] T 25 March 2024, 30:7-11.
[480] Annexure 8 to statement of Christopher Mercovich, CB 1129. Noting this document is dated June 2023, Mr Mercovich stated that it was supplied to the Court to assist in understanding IGEM's monitoring practices and was active and in use at the time of Nick's death: CB 996.
[481] Ibid, CB 1133.
[482] Statement of Nicole Ashworth, CB 631.
[483] T 25 March 2024, 11:6-9 and 12:9-12.
[484] This focussed on any critical areas of under-performance and risks to ESTA's ability to deliver its services (what the Minister for Polce and Emergency Services must know if questioned in parliament, raised by an agency or highlighted in the media). The report was made available to ESTA: Annexure 8 to statement of Christopher Mercovich, *Procedures for monitoring and reporting the performance of the Emergency Services Telecommunications Authority 2019*, CB 1160. (**IGEM monitoring document**)
[485] The purpose of this report was to identify and consider areas of concern and to track and consider efforts and activities to improve and ensure compliance with performance standards. The report was made available to ESTA: IGEM monitoring document, CB 1154-1155; T 25 March 2024, 13:16 - 14:3.
[486] IGEM assessed ESTA's annual performance and summarised areas of good performance and issues for IGEM's focus in the coming year: IGEM monitoring document, CB 1138; T25 March 2024, 10:25-27.

369. Additionally, IGEM could undertake non-periodic reporting of ESTA's performance as follows:

> From time to time, the Performance Monitoring team may prepare an ad hoc brief for the Inspector-General and/or the Minister for Police and Emergency Services,[487] if it identifies a performance-related issue that requires urgent attention. For example, this may include a significant degradation in its performance that may affect its service delivery to the community or emergency services organisations, or an issue that may attract significant and sustained media attention.[488]

370. The monitoring document also outlines consequences for non-compliance by ESTA with the performance benchmarks set by IGEM. It states that ESTA was required to explain any reasons for non-compliance with benchmarks in a monthly written or verbal report to IGEM, to be followed by a discussion in the next regular ESTA/IGEM performance meeting.[489] Generally, such explanations were to be provided to IGEM from ESTA in the monthly performance summary reports and those reports were reviewed by the IGEM Performance Monitoring Team. The monitoring document describes varying consequences for non-compliance by ESTA, as follows:

> If ESTA does not provide a satisfactory reason for its non-compliance against performance benchmarks or does not supply requested evidence to corroborate its reasons, IGEM may seek further information, or take another course of action. This may include, for example, writing to ESTA's chief executive, or briefing the Minister for Police and Emergency Services.[490]

371. Issues about which IGEM could require further explanation from ESTA included "unexplained downward trends in performance" and "ongoing and/or unexplained failure to meet performance benchmarks". The monitoring document also details that if no satisfactory explanation was provided by ESTA after repeated requests, the issue would be escalated within IGEM.[491]

ESTA's understanding of Ministerial oversight of ESTA and IGEM's monitoring

372. ESTA understood that a failure to meet the performance standards set by IGEM could result in IGEM exercising its investigation and review powers. This, in turn, could lead

[487] In August 2021 the portfolio was split, creating a separate portfolio for Emergency Services
[488] IGEM monitoring document, CB 1138.
[489] IGEM monitoring document, CB 1152.
[490] IGEM monitoring document, CB 1152.
[491] IGEM monitoring document, CB 1152.

to a report by IGEM directing recommendations to ESTA. If this occurred, ESTA would then consider the recommendation, act upon them as appropriate, and report back to IGEM on its response.[492]

373. ESTA also understood that IGEM was responsible more generally for “developing and maintaining an assurance framework”, and that this included providing assurances to the Minister regarding ESTA’s non-financial performance, which covered ambulance call answer speed performance.[493]

374. ESTA explained that it was also subject to the general direction and control of the Minister in the performance of its functions and the exercise of its powers, and that the Minister was authorised to give directions to ESTA regarding performance of its functions or powers.[494] However, ESTA’s expectations regarding the likelihood of Ministerial intervention were heavily qualified by reference to the monitoring role it understood was played by IGEM as follows:

> While there is no statutory requirement to, the Minister has the statutory power to direct the performance of ESTA in response to a performance failure. In practice however, this does not occur due to the IGEM’s role as ESTA’s **regulator**.[495] [emphasis added]

375. References by ESTA to IGEM as its “regulator” appeared throughout the initial statements it supplied to the coronial investigation. It was also explicitly stated on behalf of ESTA that “[w]hilst ESTA does report to the Minister for Emergency Services, it is ultimately monitored and accountable to its **regulator** the IGEM” [emphasis added].[496]

376. This characterisation of IGEM as ESTA’s “regulator” was disputed by IGEM. In evidence, Mr Mercovich drew a sharp distinction between the “assurance” role performed by IGEM under the Emergency Management Act, and the role of a “regulator in the traditional sense”.[497] He described IGEM as being a “non-operational body” whose role was not to intervene or “fix things”, and noted that there was no

[492] Statement of Nicole Ashworth, CB 631.
[493] Statement of Nicole Ashworth, CB 631-632.
[494] Section 20(1) of the ESTA Act; statement of Nicole Ashworth, CB 632.
[495] Statement of Nicole Ashworth, CB 632.
[496] Statement of Nicole Ashworth, CB 637.
[497] T 25 March 2024, 27:25 - 28:10; 31:2-4.

legislative provision permitting IGEM to conduct itself in that manner.[498] According to Mr Mercovich, the responsibility to fix ESTA's non-compliance with the IGEM performance standards resided solely with ESTA, pursuant to section 20 of the ESTA Act, and under the general direction and control of the Minister for Emergency Services.[499]

377. Ultimately, it was not until Ms Ashworth gave the following evidence on behalf of ESTA, that ESTA conceded that IGEM was not its "regulator":

> I believe yesterday […] Mr Mercovich discussed it believing it was more of an assurance role, which I probably concede is correct. I think regardless, the IGEM's abilities in the Act are very clear around investigation, monitoring and review. And they certainly had a very active role in attending and observing meeting in regards to ESTA and its performance.[500]

378. Despite this somewhat hesitant concession, Ms Ashworth maintained that whilst the Minister had the power to direct ESTA regarding any performance failure, this did not occur in practice because ESTA's monthly reporting regarding its performance went to IGEM, not the Minister. According to Ms Ashworth, the Minister would therefore only become aware of a performance failure by ESTA "[t]hrough the IGEM and escalation". Ms Ashworth stated that this was the understanding and practice at the time, and it had not changed.[501]

379. Ms Ashworth later stated that she "could not comment directly on ESTA's leadership's expectation of the IGEM pre-October 2021 because previous ESTA executives have departed since I arrived at ESTA in November 2021".[502] However, there was evidence that this was how IGEM's role was understood within ESTA at the relevant time. This was demonstrated by the correspondence sent in March 2021 by the CEO of ESTA to EMV which referred to IGEM as "the regulator".[503] I also note that Ms Ashton had this understanding herself whilst in her position at ESTA, and then continuing as Chief Operating Officer of Triple Zero Victoria.

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[498] T 25 March 2024, 31:3-10.
[499] T 25 March 2024, 31:10-13. Previously the Minister for Police and Emergency Services.
[500] T 26 March 2024, 109:22-29.
[501] With the qualification that daily reports were shared directly with the Minister from late 2021. T 26 March 2024, 114:18 - 115:19; statement of Nicole Ashworth, CB 632.
[502] Exhibit I, further supplementary statement of Nicole Ashworth dated 7 May 2024.
[503] Letter from ESTA to EMV dated 25 March 2021, CB 877.

IGEM as an "assurance" body

380. Throughout the evidence of Mr Mercovich, and in written statements and submissions provided by IGEM, it was maintained that ESTA was solely responsible for improving its own performance.[504] IGEM explained that its role was limited to assisting ESTA with this objective, and this was only through its monitoring and investigation functions under the Emergency Management Act and as part of its statutory obligation to foster "continuous improvement".[505] The evidence of IGEM emphasised that this limited involvement was in accordance with its "assurance" role, and I note that extensive written submissions were filed on behalf of IGEM regarding the limits of this role, to which I have had regard.

381. When explaining the role of IGEM in relation to its monitoring of ESTA's performance standards, Mr Mercovich noted that whilst ESTA and IGEM both reported to the Minister for Emergency Services, IGEM is independent and separate from government.[506] As part of IGEM's independent role, and in accordance with the Emergency Management Act, IGEM prepares and maintains an "assurance framework" which sets out that IGEM will conduct itself in an "assurance manner" and that each emergency management organisation is responsible for its own performance.[507]

382. This assurance role performed by IGEM is guided by the *Assurance Framework for Emergency Management,* (**the framework**), which IGEM authored. According to the Minsiter's foreword in that document,

> The Inspector-General for Emergency Management is responsible for developing and maintaining an assurance framework against which the capacity, capability and performance of the emergency management sector is to be assessed.[508]

383. The Minister's foreword also explains that,

> Assurance activities help us understand our performance and to learn from our experiences. They also help us to understand the needs of communities, our volunteers, paid workers and emergency management partners so that we can

[504] T 25 March 2024, 30:12 - 31:13.
[505] T 25 March 2024, 30:16-19.
[506] T 25 March 2024, 27:28 - 28:2.
[507] T 25 March 2024, 28:2-13; Annexure 5 to statement of Christopher Mercovich, IGEM *Assurance Framework for Emergency Management*, CB 1036. (**IGEM Framework**)
[508] IGEM Framework, CB 1027.

> continually improve and achieve our vision of safer and more resilient communities.[509]

384. The framework includes a message from the Inspector-General, which states that over time, Victoria has built a capability to manage emergencies and all sector organisations within the emergency management system are said to have a role in assurance. The Inspector-General describes how assurance activities contribute to "identifying opportunities for better emergency management practices" and how "[s]haring successes and opportunities across the sector fosters the continuous improvement of the system before, during and after emergencies".[510]

385. The parties to an assurance activity are specified in the framework as follows:

> In theory there are three parties to an assurance activity: the people whose work is the subject of the assurance activity, the assurance provider, and the decision maker(s) who receive the results of the assurance activity. In practice in the sector, one person or team may perform more than one of these parts in an assurance activity.[511]

386. The framework also defines what "an assurance" means:

> In the context of this Framework, ***an assurance*** is a statement designed to increase the confidence of government, the sector and the community in the ability of the system to plan for, respond to, and recover from emergencies.
>
> ***Assurance*** is a feeling of confidence by the government, the sector and the community in the ability of the system to achieve intended outcomes. This feeling of confidence should be proportionate to the quality of the assurance provided.[512]

387. More specifically, assurance activities involve "monitoring, debriefing, reviewing, investigating, auditing and evaluating".[513] These are referred to as "analytical processes" which utilise information or evidence to answer questions such as:

- What is happening?
- Why is it happening?
- Does it meet standards?

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[509] Ibid, CB 1027.
[510] IGEM Framework, CB 1028.
[511] IGEM Framework, CB 1032.
[512] IGEM Framework, CB 1032.
[513] IGEM Framework, CB 1032.

- Does it fulfil commitments; and,
- Does it achieve intended outcomes.[514]

388. Assurance providers are said to analyse evidence and then report findings to the decision maker,[515] and the framework explains that assurance activities result in three broad categories of findings:

    - the system is working as intended
    - the system is working as intended, but there are opportunities for improvement
    - the system is not working as intended, and there are opportunities for improvement.[516]

389. The provision of "assurance" allows a decision maker to have confidence about the ability of the system to meet its objectives.[517] When a system is identified as not working as intended by an assurance provider, they can provide the decision maker with reasons why improvement is needed and identify improvement opportunities. This is said to benefit the decision maker when deciding on changes to be made.[518]

390. In relation to Victoria's emergency management, the framework concludes that "[t]he goal of the system is to minimise the likelihood, effect and consequences of emergencies for Victorian communities".[519] Assurance activities are said to contribute to this goal by providing evidence-based information to decision makers on which parts of the system are working and not working.[520] Assurance activities which are guided by the principles in the framework are expected to "add value" and thereby improve the system, contributing to better outcomes for Victorian communities before, during and after emergencies.[521]

391. Furthermore, according to the framework,

> The principle of adding value is put into practice when the assurance provider:

[514] IGEM Framework, CB 1032.
[515] IGEM Framework, CB 1035.
[516] IGEM Framework, CB 1034.
[517] IGEM Framework, CB 1034.
[518] IGEM Framework, CB 1034.
[519] IGEM Framework, CB 1048.
[520] IGEM Framework, CB 1048.
[521] IGEM Framework, CB 1048.

- proactively identifies risks that may hinder the achievement of intended outcomes
- is 'risk-based' or proportionate which means scoping assurance activities to those parts of the system where this is higher risk
- is 'evidence-based' which means maintaining the line of sight from the evidence to the analysis and through to findings and recommendations – so that any assurances given will build confidence and so that the reasoning behind any identified improvement opportunities can be well understood
- reports the results of the assurance activity without avoidable delay and in a way which can be readily understood by decision makers.[522]

"Assurance" and monitoring of performance standards by IGEM

392. At the inquest, evidence was given by Mr Mercovich which expanded upon the nature of the assurance role performed by IGEM when it was monitoring and reporting upon ESTA's ambulance call answer speed performance.

393. Mr Mercovich emphasised that whilst IGEM was monitoring ESTA's compliance with performance benchmarks throughout the COVID-19 pandemic,[523] IGEM was acting solely as an "assurance body". This meant that IGEM would "liaise with ESTA, look at their data, [and] assist them in ways we could".[524] Another aspect of IGEM's monitoring involved ESTA advising IGEM about its operational activities, and how it was trying to meet the performance standards.[525]

394. When performing this monitoring, IGEM was acting as an "assurance body", not an "operational entity". IGEM did not see its role as inserting itself into ESTA's operational matters,[526] and regarded itself as legislatively prohibited from doing so.[527] However, Mr Mercovich did agree with the proposition that "IGEM was intimately involved in understanding what ESTA's operations were".[528]

395. This is apparent from IGEM's regular meetings with ESTA throughout the pandemic, and during which ESTA was providing information to IGEM about call volumes that

[522] IGEM Framework, CB 1039.
[523] Statement of Christopher Mercovich, CB 365.
[524] T 25 March 2024, 27:12-14.
[525] T 25 March 2024, 27:20-24.
[526] T 25 March 2024, 27:14-16.
[527] Inspector General for Emergency Management's Submissions in Response to Counsel Assisting's Submissions, para 2.1(3), 3, 7, 28- 33, 34.
[528] T 25 March 2024, 27:17-19.

were "unprecedented" and described as being "like having New Year's Eve every day".[529] IGEM understood from these meetings that the volume of calls "kept getting stronger and stronger, certainly up until October 2021".[530] According to Mr Mercovich, it was also unclear to ESTA when the increased activity would cease and "it wasn't clear that all of sudden things were going to get back to normal".[531]

396. IGEM understood from ESTA that it knew it did not have sufficient call-takers if the increase in demand continued. ESTA was also informing IGEM that the major issue was that ESTA did not have sufficient call-takers to be able to meet the increased demand daily.[532] Whilst ESTA did not know when, or if, the increase in calls would cease, its modelling was accurate in terms of expected demand,[533] although the forecasting in October 2021 and into early 2022 was complicated by the Delta and Omicron waves of COVID-19.[534]

397. In response to the information being received from ESTA, IGEM enhanced its monitoring with increased frequency of data collection, and it obtained information in meetings with ESTA regarding what was being done to either suppress call demand or increase its staffing.

Communications by IGEM with the Minister

398. IGEM ultimately communicated directly with the Minister regarding the call answer delay crisis on three occasions, on 8 October, 27 October and 24 November 2021.[535] These reports were in addition to IGEM's periodic reporting.

a. Letter dated 8 October 2021

399. On 8 October 2021, the Inspector-General wrote to the Minister for Emergency Services regarding ESTA's call answer speed performance. This was the first time that IGEM had communicated in this manner with the Minister regarding ESTA's

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529 T 25 March 2024, 20:6-11.
530 T 25 March 2024, 20:11-13.
531 T 25 March 2024, 20:23-29.
532 T 25 March 2024, 20:29 - 21:2.
533 T 25 March 2024, 21:14-20.
534 T 25 March 2024, 21:22-27.
535 Annexures 12, 13 and 14 to statement of Christopher Mercovich, CB 1301, 1310, 1320.

ambulance call answer delays.[536] The letter from IGEM included the following information for the Minsiter's attention:

> I write to brief you on my current monitoring and assurance activities regarding the Emergency Services Telecommunications Authority (ESTA), specifically in the context of the unprecedented demand for Ambulance Victoria (AV) services via Triple Zero (000).
>
> As part of my monitoring function I am closely liaising with the Chief Executive Officers of ESTA and AV, and the Emergency Management Commissioner (EMC) to provide coordinated assurance in relation to this emergency.
>
> […]
>
> In the period 1 July to 30 September 2021, AV call activity continued to increase. Consequently, ESTA's emergency ambulance call answer performance steadily degraded from 77.2 percent in July down to 67.8 percent in September.
>
> On 27 September 2021, ESTA reported a large spike in daily emergency call activity to 3250 calls, the largest one-day call volume since the thunderstorm asthma event of November 2016. ESTA has since advised IGEM that emergency ambulance call volumes increased in the first week of October 2021 to over 3000 calls in all but one day. This is approaching a 50 percent increase in calls over the same period last year.
>
> As daily COVID-19 case numbers rise, there is no sign of the situation abating in the short term and it may compound further as planned easing of COVID-19 restrictions occur. Notably, when easing of COVID-19 restrictions occurred in November 2020, ESTA experienced a significant and growing volume of calls for ambulance.
>
> While the thunderstorm asthma event was the single biggest ambulance call surge event on record, it effectively occurred over a 24-hour period. The current situation is close to replicating this on a daily basis with no end in sight.
>
> […]
>
> On 6 October 2021, ESTA's daily ambulance emergency call answer performance was 25.4 percent.
>
> Additionally, there have been extended periods when ESTA has not answered any 000 ambulance call within five seconds. […][537]

400. Graphs were included in the correspondence showing emergency ambulance call volume had steadily increased since July 2020, and that ESTA had not met its performance benchmark for ambulance call answer speed in any month from December

[536] CB 1301; T 25 March 2024, 33:6-22.
[537] CB 1302.

2020 to September 2021.[538] As an example of "what the community is experiencing on some days", as compared to the daily figure, it was noted that on 6 October 2021, for 10 of the 24 hours, ESTA failed to answer even 10 per cent of calls at or within five seconds.[539] Specific reference was made to ESTA and AV having tried various strategies to try to improve call answer speed performance, but it was conceded that "there are no quick fixes".[540]

401. By this stage, IGEM concluded that the actions that were being taken to correct the situation were not working, and that as there had already been allegations that call answer delays had contributed to deaths of patients, the Coroner would have an interest in IGEM's monitoring work.[541] IGEM also referred to several potential adverse events, four of which had received media reporting, and reference was made to media reporting of cases waiting over 30 minutes, noting "it is fortunate there were no negative outcomes from these reported events".[542] IGEM anticipated that there would be further adverse events identified over time, and expressed an intention to conduct its investigations into the volume of potential adverse events "in a holistic manner and provide system level assurance".[543]

402. IGEM had also formed a view that the changes already implemented by ESTA in response to the crisis had a small effect.[544] Whilst IGEM advised the Minister which actions were being taken in the short, medium and long term, it did not comment upon the effectiveness of these measures, although it could have done so.[545] The letter commented that urgent action was being taken by both ESTA and AV, with a range of strategies in place or in development, but acknowledged that actions such as employing and training new staff would take longer.[546]

403. The letter noted historical "relationship issues between ESTA and the emergency services organisations […] in the form of tension around perceptions of ESTA's ability to deliver on the agency's requirements",[547] however, IGEM considered that overall,

[538] CB 1305-1306.
[539] CB 1307.
[540] CB 1302.
[541] CB 1301; T 25 March 2024, 36:21 - 37:4.
[542] CB 1303.
[543] CB 1303.
[544] T 25 March 2024, 37:13-20.
[545] T 25 March 2024, 38:7 - 39:5.
[546] CB 1303.
[547] CB 1303.

ESTA still delivered a highly effective service that efficiently coordinated the initial response of all ESOs.[548]

404. The letter concluded that the sector needed to remain focused on its immediate management, but that after the pandemic surge, consideration ought be given to coordinated state level assurance activities and identifying learnings. The letter also advised that IGEM would report weekly to the Minister on the issue.[549]

405. According to Mr Merovich the purpose the letter was “outlining our concerns now that IGEM had a few months’ worth of data and it became clear that not only was the demand for Triple Zero not going to decrease, but also the actions ESTA was taking to try and improve its call answer performance, well, likewise, were not working”.[550] Mr Mercovich indicated that IGEM was at that time still gathering information in anticipation of deciding whether to conduct a larger review of the ambulance call answer delay issue.[551]

406. Mr Mercovich stated that the point of briefing the Minister at that time was to “ensure that the Minister was completely aware of how performance had really dropped off in October”.[552] In explaining why it was only becoming evident by that time that something needed to happen, Mr Mercovich stated that it was only from August 2021 that IGEM started receiving potential adverse event notifications,[553] and the briefing to the Minister was about justifying why IGEM may conduct a review.[554] However, the letter was clearly also prompted by the advent of adverse event notifications connected with the delays being received from August 2021, as well as the extensive media reporting about them.[555]

b. Letter dated 27 October 2021

407. On 27 October 2021, the Inspector-General again wrote to update the Minister on the monitoring of the ambulance call answer speed issues. The letter advised that the situation regarding call answer delays had not improved, and performance had further

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[548] CB 1303-1304.
[549] CB 1304; T 25 March 2024, 47:6-16.
[550] T 25 March 2024, 25:16-25.
[551] T 25 March 2024, 41:5-18.
[552] T 25 March 2024, 42:18-20.
[553] T 25 March 2024, 42:28-31.
[554] T 25 March 2024, 43:2-7.
[555] T 25 March 2024, 35:1-21; Letter from IGEM to Minister for Emergency Services (8 October 2021), CB 1303.

decreased, with ESTA recording its worst two days of performance on 20 and 22 October 2021, at below 25 per cent.[556]

408. IGEM advised the Minister that ESTA was tracking to achieve under 50 per cent of calls answered within 5 seconds for the month of October 2021, its worst monthly performance on record. It was acknowledged that some initial improvement in performance after changes made by ESTA on 8 and 15 October 2021 had not been sustained.[557]

409. IGEM noted that the recently formed EJAST[558] was attempting to "ameliorate the problems that ESTA had been experiencing since the previous December 2020",[559] and that it was an observer on weekly meetings of the Joint Governance Group overseeing the work of EJAST.[560]

410. IGEM advised that it had compared information from ESTA about recent initiatives and their effectiveness against ESTA's performance data. Whilst ESTA reported some improvements, IGEM advised it was not observing the same trends.[561] IGEM also advised that AV had activated its "Save 000 for emergencies" public awareness campaign, but noted this could have been commenced earlier as the surge had been occurring since August 2021, and that this was a missed opportunity. It was also noted that the campaign did not specifically refer to how the current COVID-19 situation was affecting response times.[562]

411. IGEM advised that ESTA had identified staffing as one of its biggest challenges and IGEM noted that most of the focus of EJAST was on staffing solutions, the solution to which was funding.[563] IGEM knew that whilst funding had been granted, ESTA required still more funding to recruit sufficient call-takers to overcome its basic staffing deficit, and to address the ongoing deficit from staff furloughing due to COVID-19.[564]

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[556] Letter from IGEM to Minister for Emergency Services, CB 1310; T 25 March 2024, 47:24 - 48:1.
[557] CB 1314.
[558] A joint governance group including ESTA, Ambulance Victoria, Emergency Management Victoria and the Emergency Management Commissioner. (T 48) As Mr Mercovich explained, EJAST was led by the Deputy Emergency Management Commissioner and it was primarily a group of executives.
[559] T 25 March 2024, 48:10-14.
[560] CB 1310.
[561] CB 1310.
[562] CB 1311.
[563] CB 1311; T 25 March 2024, 51:20-26.
[564] T 25 March 2024, 50:2-21.

412. AV and ESTA were noted to be conducting a review for potential adverse events arising from the delays, and IGEM advised the Minister that the review process was "demonstrating that a significant number of patients are at risk of harm from these ongoing and sustained call answer delays".[565]

c. Letter dated 24 November 2021

413. On 24 November 2021, the Inspector-General again wrote to the Minister. The purpose of this correspondence was to advise that IGEM intended to undertake a thematic review in relation to the issue of ambulance call answer delay pursuant to section 64(1)(b) of the Emergency Management Act.[566] The letter noted that the Minister had sent correspondence on 22 November 2021 specifically referring to Nick's case,[567] and that this would be considered as an adverse event in the planned review.[568]

414. It was also noted by IGEM that the Ashton review had been commissioned. IGEM advised that it did not intend to complete its review until after Mr Ashton's review was finalised,[569] and that the State Coroner would likely also wait for IGEM's findings before progressing the coronial investigation. IGEM's review was to commence in January 2022 and be completed by July 2022.[570]

415. IGEM acknowledged that the situation had not improved and the "emergency is still ongoing". Specifically, IGEM commented that there had been "high levels of potential adverse events for the community with over 295 cardiac arrest calls waiting more than one minute to be answered since 20 September 2021.[571] It was also noted that ambulance call answer speed performance remained significantly below performance benchmarks on most days, and some calls were still taking more than 10 minutes for ESTA to answer.[572]

416. For the first time in its communications to the Minister, IGEM advised that there were nation-wide effects flowing from the situation in Victoria, which was impacting

[565] CB 1311.
[566] Letter from IGEM to the Minister for Emergency Services, CB 1320; T 25 March 2024, 52:3-8.
[567] CB 1320, T 25 March 2024, 52:15-19.
[568] CB 1320.
[569] T 25 March 2024, 54:19-27.
[570] CB 1320.
[571] CB 1320.
[572] CB 1321.

Telstra's 000 call answer and transfer times in other states, as well as ESTA's call answer speed in Victoria for emergency services other than ambulance.[573]

417. The letter noted ongoing actions by ESTA and AV to improve call answer speed performance, which included using trainee paramedics and NSW call-takers, media campaigns and a rapid pre-triage call-taking process.[574] IGEM commented that, given the range of actions being undertaken by ESTA, "there are reasons to be hopeful that its current performance may improve in the coming months.[575]

418. Unfortunately, this proved to be incorrect, and the percentage of emergency ambulance calls answered by ESTA within five seconds dropped to 57 per cent in December 2021, then a record low of 39 per cent in January 2022. From February to April 2022, performance improved gradually, with compliance levels of 66 per cent to 69 per cent, then 71.8 per cent in May 2022, and 86.2 per cent in June 2022.[576]

The timing of IGEM's contact with the Minister

419. As referred to in the correspondence, IGEM's contact with the Minister occurred as part of its assurance functions, being its monitoring and investigation of ESTA's performance. During his evidence at the inquest, Mr Mercovich was questioned about the timing of this contact, and why the Minister was not alerted to the degradation in call answer speed performance sooner by IGEM. Mr Mercovich agreed that it was IGEM's role to report failings to the Minister,[577] and that it would have been possible for IGEM to make recommendations to the Minster as part of its statutory oversight of ESTA, although he stated that IGEM did not traditionally do so.[578]

420. When asked why the need to brief the Minister had not crystallised for IGEM sooner, Mr Mercovich referred to the actions that ESTA was seen to be taking at the time, noting that some of these took time to implement, and it also took time to determine if those measures would work.[579]

[573] CB 1321.
[574] CB 1322.
[575] CB 1322.
[576] IGEM review, CB 241.
[577] T 25 March 2024, 44:11-14.
[578] T 25 March 2024, 31:29 - 32:3.
[579] T 25 March 2024, 25:26 - 26:20.

421. Mr Mercovich also noted that from IGEM's perspective, "Emergency services organisations must be given the time and space to be able to improve their performance in the middle of, a global pandemic and a major emergency".[580] He stated that it was not clear in the beginning of October 2021 that the situation may not improve.[581]

422. It was not until August 2021, that IGEM regarded ESTA's performance as "more dire", and it was only when IGEM began receiving adverse event notifications "that it was clear that this was no longer a small issue over a few months but performance had significantly degraded to the point where it was causing issues in individual emergency events".[582]

423. However, at that stage, IGEM was still only "considering next steps",[583] and use of its investigation function was limited to screening potential adverse event notifications it was receiving which were associated with ambulance call delays.[584]

424. When questioned whether it was obvious that action needed to be taken urgently in October 2021 following ten months of declining performance, Mr Mercovich stated that it was only "becoming obvious" and the "evidence was becoming very strong that something needed to happen at that that point".[585]

425. Mr Mercovich gave evidence that it took a few months of monthly reporting for IGEM to "determine a trend",[586] and it was only later in 2021, when ESTA modelling became more erratic, and when the actions by ESTA and other organisations were not working, that IGEM determined it could add value by way of a thematic review.[587] Mr Mercovich also gave evidence that prior to the determination in November 2021 to conduct a review, IGEM "didn't have the evidence or the data to be able to hand on heart say that performance was not going to improve and demand was not going to reduce".[588]

426. Mr Mercovich also stated that ESTA was responsible for its own performance "in the first instance". He did not believe it would have been appropriate for IGEM to make

[580] T 25 March 2024, 30:29 - 31:1.
[581] T 25 March 2024, 44:1-6.
[582] T 25 March 2024, 26:20-26.
[583] T 25 March 2024, 26:28-30.
[584] T 25 March 2024, 27:2-12 and 31:26-28.
[585] T 25 March 2024, 41:19-22 and 42:24-26.
[586] T 25 March 2024, 25:14-16.
[587] T 25 March 2024, 28:29 - 29:8.
[588] T 25 March 2024, 28:31 - 29:2.

recommendations to ESTA regarding operational matters, about which ESTA were the subject matter experts, and added that IGEM did not have the resources or expertise to make such recommendations.[589] According to Mr Mercovich, IGEM was not in possession of all the facts, and such intervention was outside of IGEM's assurance role.[590]

427. It was IGEM's position that there was nothing it could have done in the short term to address the problems being faced by ESTA, because it was not an operational body, and because "IGEM's expertise is in providing assurance, which is operationalised through our monitoring and investigation of ESTA".[591]

428. Mr Mercovich stated that representations that more money and more people were needed by ESTA to fix the problem were being made by ESTA itself, and that whilst IGEM had previously made representations to government that ESTA's implementation of certain actions was "subject to more funding", he did not believe it was IGEM's role to recommend to the Minister that ESTA needed additional funding.[592]

429. Furthermore, Mr Mercovich gave evidence that he did not know what recommendation IGEM could have made, given that a large review of the kind ultimately completed by IGEM was needed to work out appropriate recommendations that were sustainable, and that were actually going to assist ESTA in fixing the problems that they were experiencing with their performance.[593] The review which was then undertaken "focused on trying to determine what happened, why it happened, and really what needed to occur in order to - to arrest the demand and the drop in performance".[594]

430. Mr Mercovich characterised the situation ESTA found itself in as being an "emergency situation" that ESTA was actively trying to manage and improve, and which IGEM could add no immediate value to. Ultimately, the value it determined to add was by way of a review of what had occurred after the event. Mr Mercovich explained that "IGEM

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[589] T 25 March 2024, 55:12-22.
[590] T 25 March 2024, 58:21-26.
[591] T 25 March 2024, 59:14-22.
[592] T 25 March 2024, 57:19 - 58:7.
[593] T 25 March 2024, 32:5-16.
[594] T 25 March 2024, 37:2-5.

is by its nature reactive", and that it provides assurance and investigates after the fact to look at "system-wide, high-level fixes to issues".[595]

431. Yet, Mr Mercovich also agreed with the proposition that, from an emergency management perspective, the goal is to avoid adverse events from occurring. Mr Mercovich also agreed with the proposition that the purpose of the ESTA call answer benchmarks was to avoid delay and thereby avoid adverse events occurring in the first place.[596]

Conclusions regarding IGEM'S monitoring of the ESTA performance standard

432. It is difficult to reconcile IGEM's understanding of its assurance role with the purpose of the call answer speed benchmarks that were set by IGEM, the underlying purpose of which was to proactively avoid the occurrence of adverse events caused by delay.

433. This proactive and protective purpose of the performance standards was patently not achieved during the COVID-19 pandemic, when from December 2020 onwards there was deteriorating non-compliance with the ambulance call answer speed performance benchmark for a ten-month period, with forecasting that this would worsen. This long decline in performance was not corrected and predictably resulted in a crisis in ambulance call-taking delays.

434. The evidence reveals a disconnect between IGEM's understanding of its assurance role, and ESTA's understanding of the character of the monitoring undertaken by IGEM throughout that period. There has been no satisfactory explanation for the characterisation on behalf of ESTA (now Triple Zero Victoria) of IGEM as a "regulator" to which it was accountable. This perception by ESTA may explain in part why there was no timely escalation of the issue of ambulance call answering delays prior to October 2021. This is demonstrated by the evidence from ESTA that it could have reported its performance issues directly to the Minister, but that it did not do so because it was not the practice at that time due to IGEM's oversight. Conversely, whilst IGEM agreed it had power to raise ESTA's performance issues with the Minister, and to make recommendations in that regard, it was not accustomed to doing so and believed it was outside its assurance role in these circumstances. Having regard to IGEM's

[595] T 25 March 2024, 44:17-21.
[596] T 25 March 2024, 90:14-20.

understanding of its assurance role, there was never any prospect that IGEM would proactively intervene to assist in preventing the occurrence of adverse events, despite being the independent body ESTA reported its performance to.

435. IGEM regarded its assurance role as reactive in nature. This meant that proactive involvement in correcting obvious non-compliance with performance standards was regarded by IGEM as an 'operational' concern for ESTA to address. Moreover, IGEM did not regard itself as having the expertise to add any value in ESTA's attempts to correct its non-compliance. This is demonstrated by the late timing of IGEM's correspondence with the Minister in October 2021. By that stage, IGEM was acknowledging that the situation had evolved into an emergency, and IGEM's involvement would be limited to investigating the adverse events which had been reported, and which were attracting high levels of media attention.

436. I accept that IGEM was not the "regulator" of ESTA, but it was the only independent body tasked with monitoring ESTA's performance. Having regard to the absence of IGEM having a 'regulatory' function, when ESTA was non-compliant with its performance benchmark for an extended period of time, ESTA was effectively unaccountable for its performance falling below community and government standards in relation to ambulance call answer speed. Without a proper escalation framework, or regulatory oversight, ESTA's non-compliance drifted uncorrected, and foreseeably, into a crisis which exceeded Victorian resources and required large-scale government intervention to resolve. All the while, public safety was put at risk and in Nick's case, he lost the chance to survive his emergency.

437. The limited role of the assurance function performed by IGEM is further demonstrated by the actions taken when the crisis came to a head in October 2021. IGEM's only intention at this point, in accordance with its assurance function, was to investigate the reported adverse events and to provide a thematic review. It took two months for IGEM to determine that the review would be undertaken, and it would not be completed for a further six months. Therefore, the review was disconnected from the urgent emergency management response being undertaken by EJAST to return ESTA to compliance with the performance benchmark for ambulance call answer speed. There was never any prospect that the IGEM review would contribute to the resolution of the crisis which had developed, rather, it was intended as a post event learning exercise which would contribute to future improvement.

438. In my view there were adequate legislative powers available to both ESTA and IGEM which enabled direct escalation of the issue of call-answer delays to the government at an earlier point in time. Yet this did not occur for reasons unrelated to the nature of the powers in the legislation. IGEM did not act proactively to correct ESTA's non-compliance and prevent adverse events, as this was not understood to be part of its assurance role. At the same time, ESTA may have mistakenly understood that IGEM acted as a kind of regulator in its monitoring of ambulance call answer speed, and was not accustomed to raising matters directly with government even though it had power to do so. ESTA only escalated the situation and requested urgent assistance when the crisis was entrenched and adverse events became apparent, with no end in sight. ESTA may not have escalated its concerns regarding its performance to government, or requested EMV assistance, as early as it could have done as it mistakenly understood that it was primarily accountable to IGEM regarding its performance, and that IGEM would escalate issues to the Minister. Whilst it is true that ESTA could have raised the issues with the Minister directly, surely the purpose of independent monitoring of ESTA's performance is to provide a safety net in case it does not do so, in acknowledgment of the critical functions performed by ESTA.

439. For all these reasons, I regard the performance monitoring system in place for ambulance call answer speed at that time as characterised by confusion and lack of clear escalation pathways. This played a large part in the crisis which eventuated.

440. The utility of the ambulance call answer performance standard as a measure to ensure ESTA's service delivery, and ensure public safety, was largely rendered worthless due to these issues. It should have acted as a warning bell prompting urgent action. Instead, prior to October 2021, it was primarily used as a means of describing a failing service.

441. I acknowledge that the degradation in performance against the benchmark initially caused ESTA to enact strategies that it hoped may correct the issue with ambulance call delays. However, having regard to the intelligence it received in early 2020 and its own pandemic planning, it should have been apparent to ESTA that what was required was more call-taking staff. ESTA had forecasting and modelling which anticipated increases in call volume and a decrease in available staff. This indicated there was a high risk that delays would result without an increase in call-taking staff. This was particularly so in circumstances where the evidence establishes that ESTA already regarded its workforce as having been underfunded for several years prior to the COVID-19 pandemic.

442. The weight of the available evidence does not indicate that ESTA had any sound basis to expect that measures outside of an increase in call-taker numbers would arrest the decline in performance. I have also found IGEM's assessment that ESTA should be given time to correct its performance difficult to reconcile with the available evidence. ESTA did not convey evidence to IGEM that the measures it had implemented were going to fix the issue and return it to compliance with the standards in the absence of additional staff.[597] Moreover, IGEM had not formed a view that the actions taken by ESTA would resolve the situation[598] as it did not regard itself as having operational subject matter expertise to make that assessment. Based on the information it did have, which was the data about ESTA's non-compliance with the performance standard, it was not indicated that measures being implemented by ESTA were having a corrective effect.

443. In the absence of an independent regulator, there was no independent oversight or assessment of the utility of ESTA's response to ongoing non-compliance with the performance benchmark. In this regard, it is interesting to note by comparison the quick escalation which occurred when Telstra experienced issues with its Grade of Service as a result of the ESTA delays. When Telstra reported issues with its performance, there was an established pathway of reporting to its Regulator and to the Federal Minister's office, which quickly led to direct Ministerial intervention regarding the issue.

444. I have therefore concluded that IGEM's monitoring of ESTA's ambulance call answer speed performance standard was not a protective factor due to IGEM's assurance role. Whilst there were many entities and individuals which became aware of ESTA's performance issues, and to varying degrees, this diffuse exposure of the problem was not protective either. What was needed was total clarity in escalation. Instead, the nature of assurance monitoring by IGEM had the effect of leaving ESTA unregulated and unassisted in its response to ongoing non-compliance with the performance standard when it should have been apparent that despite its sole responsibility to perform its functions, it was not doing so.

445. I note that IGEM no longer determines performance standards for ESTA, which is now Triple Zero Victoria. This is the remit of the Emergency Management Commissioner

[597] T 25 March 2024, 39:17-23.
[598] T 25 March 2024, 40:30 - 41:4.

and the Minister for Emergency Services.[599] According to IGEM, "this change was to address recommendations from the [Ashton review] aimed at ensuring independent monitoring, investigation, and reporting of ESTA's (now 000Vic) performance by IGEM".[600] The change acknowledged the undesirable conflict of IGEM monitoring performance standards that it set. IGEM explained the change as follows:

> In essence, the legislative change came about as a result of the [Ashton Review's] findings regarding IGEM setting performance standards and measures that could potentially inhibit its ability to provide objective and independent assurance with respect to the adequacy of the standards and measures themselves and the need for future improvements to performance frameworks.[601]

446. However, IGEM is still legislated to monitor and investigate Triple Zero Victoria's non-financial performance, which includes performance standards for all ESOs in relation to call-taking and dispatch. Triple Zero Victoria, like ESTA, is still required to answer 90 per cent of calls within five seconds in a calendar month and report its performance to IGEM. IGEM's role in relation to the performance standards remains otherwise unchanged.[602]

447. There is therefore a remaining conflict in the current assurance arrangements whereby IGEM investigates Triple Zero Victoria's performance when it is also required to monitor that performance. The conflict exists for the same reasons which were articulated in the Ashton review in relation to IGEM setting and monitoring performance standards.

448. The potential conflict is demonstrated by the nature of the IGEM review itself. Understandably, the review did not analyse IGEM's own monitoring of ESTA's ambulance call answer performance, despite the obvious issue with uncorrected non-compliance commencing from December 2020. IGEM's review was largely silent on the specifics of the issue of escalation and why the monitoring of the performance benchmark did not assist in preventing the crisis which eventuated.

449. Due to the enactment of the *Triple Zero Victoria Act 2023* (**Triple Zero Act**), there have been significant changes to ESTA's governance, reporting and escalation

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[599] Statement of Christopher Mercovich, CB 992.
[600] Statement of Christopher Mercovich, CB 992.
[601] Statement of Christopher Mercovich, CB 992.
[602] T 25 March 2024, 15:9-23, 85:10-12, 86:3-5.

requirements, including in relation to its compliance with performance standards. I acknowledge that there is a now a legitimately high degree of confidence within Triple Zero Victoria that the call-taking crisis which occurred during the COVID-19 pandemic would not be repeated.

450. However, IGEM continues to provide assurance in relation to performance standards for ESTA's call-taking and dispatch services, and its functions with respect to monitoring of Triple Zero Victoria's emergency ambulance call answer performance are no different now to what they were for ESTA. Moreover, in evidence on behalf of IGEM, Mr Mercovich stated that IGEM would not do anything differently if faced with the same situation again.[603] There is reason to question whether any value was added by IGEM's continuous monitoring of these standards in an assurance role, when it is reactive, rather than proactive and protective in nature, and the call-taking crisis occurred despite intensive monitoring performed by IGEM. The question of the utility of monitoring of that nature is an issue which still needs to be considered and addressed.

451. That monitoring documented ongoing and worsening non-compliance which ESTA regarded as explicable by reference to its inadequate workforce, and IGEM was aware of this from March 2021. Additional recruitment was critical to resolving the situation, and ESTA believed that this required additional funding. I accept that IGEM only monitored ESTA's non-financial performance, and that it did not intervene in the financial and operational affairs of ESTA. However, in circumstances where the available explanation from ESTA was that its non-compliance was being driven by inadequate staffing, I do not accept that this was a matter that could not have been brought to the attention of the Minister as a fact, being the information provided by ESTA, particularly as IGEM had previously addressed ESTA funding issues with government and did draw attention to the issue in communication with the Minister on 27 October 2021.[604]

452. There is a great deal of difference between drawing attention to an issue as a fact and advocating for an outcome or usurping or displacing the functions which ESTA was responsible for.[605] I see no legislative prohibition preventing IGEM from advising the Minister about ESTA's non-compliance, including ESTA's explanations for its

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603 T 25 March 2024, 30:20-29.
604 T 25 March 2024, 57:19 - 58:7. See also Part 8 of the IGEM review, CB 295-312.
605 See generally the submissions of IGEM, for example para 90.

performance issues, to bring this to the attention of the Minister as a matter of fact. Nor do I understand that there was any prohibition on IGEM separately raising matters with the Minister within the confines of its assurance role, even if ESTA had the power to raise that same issue itself, and should have been doing so. The independent and objective role performed by IGEM encompassed bringing matters to the attention of the Minister, regardless of whether ESTA was able to do so. The appropriate exercise of IGEM's powers does not depend on whether ESTA's position is aligned or not with the views of IGEM. This is not "overriding" ESTA's functions, as IGEM's role and purpose is entirely different in nature.

453. It is important to acknowledge that the call-taking crisis occurred in unprecedented circumstances, at a time when the scale and impact of the COVID-19 pandemic challenged all sections of society. It may be that IGEM's assurance role was not well suited to monitoring and investigation of a prolonged period of non-compliance with performance standards by ESTA in those specific circumstances. However, the investigation into Nick's death and the ambulance call delays which contributed to his passing, raises the issue of whether IGEM's assurance function is the most appropriate methodology for monitoring call-taking and dispatch services provided by Triple Zero Victoria. The changes brought about by the Triple Zero Act certainly create a new scheme of reporting and escalation in relation to ESTA's performance standards within government, but IGEM remains the only objective and independent oversight of the performance standards. IGEM's investigative function which involves learning from adverse incidents after the event is of obvious utility, but the utility of its monitoring function remains unclear. This is a matter connected to the death which concerns public health and safety and requires consideration by the Minister for Emergency Services.

PART 3: FINDINGS AND CONCLUSION

FINDINGS IN RELATION TO ESTA AMBULANCE CALL-ANSWER DELAYS

454. From March 2020, it was understood by ESTA that the COVID-19 pandemic posed a risk of significant increase in requests for emergency ambulance. ESTA was also aware of the risk that the COVID-19 pandemic would lead to a decrease in its available workforce. These factors posed a risk that there would be delays in ambulance call-answer time, which would in turn have an adverse impact on patient safety and the Victorian community.

455. ESTA was required to answer 90 per cent of emergency ambulance calls within five seconds over a calendar month. ESTA must have appreciated that degradation in its emergency ambulance call-answer speed below this performance benchmark put patient safety at risk. ESTA must also have appreciated that the degree of risk increased as degradation of the performance standard increased, as this represented a larger number of calls waiting for long periods of time.

456. From March 2020, ESTA understood that the most appropriate mitigation strategy to address this risk and prevent degradation to its ambulance call answer speed performance was the recruitment of additional ambulance call-taking staff. At that time, if ESTA did not believe it had sufficient funding to undertake additional recruitment, an urgent request to government should have been made. Not recruiting additional call-taking staff at this time was a missed opportunity to prevent, or minimise, the severity of the ambulance call-taking crisis which occurred in 2021-2022.

457. In December 2020, ESTA submitted a request for government funding through the annual State budget process to recruit an additional 43 full-time employees. This recognised that ESTA required additional call-takers to meet anticipated demand. At this time, if ESTA did not believe it had sufficient funding to undertake additional recruitment, ESTA should have made an urgent request to government for additional funding outside the usual budgetary processes. Not recruiting additional call-taking staff at this time was a missed opportunity to prevent, or minimise, the severity of the ambulance call-taking crisis which occurred in 2021-2022.

458. For the month of December 2020, ESTA's ambulance call answer speed performance did not meet the performance standard. This was a significant event and indicated that the risks which had been identified at the beginning of 2020 were likely materialising. At this time, if ESTA did not believe it had sufficient funding to undertake additional recruitment, ESTA should have made an urgent request to government for funding to recruit additional ambulance call-taking staff. Not recruiting additional call-taking staff in January 2021 was a missed opportunity to prevent, or minimise, the severity of the ambulance call-taking crisis which occurred in 2021-2022.

459. By March 2021, the degradation in ESTA's emergency call answer speed performance was continuing unabated. By that time, ESTA had no reasonable basis to believe that measures other than recruitment of additional ambulance call-taking staff would correct

non-compliance with the performance benchmark, and the situation should have been regarded as an emergency with corresponding urgency in response.

460. In March 2021, ESTA possessed sufficient organisational knowledge to have recognised that there was an impending crisis in ambulance call-taking delays, and that it did not have the workforce to avoid or fix this. At that time, ESTA should have utilised its legislative powers to raise the issues regarding ongoing ambulance call delays with the Minister for Emergency Services directly, but ESTA may have misunderstood the nature of the assurance role performed by IGEM in relation to IGEM's monitoring of ESTA's performance standards. However, at all times ESTA remained responsible for the performance of its statutory function in relation to ambulance call-taking and dispatch, regardless of the monitoring performed by IGEM.

461. Having regard to the level of concern demonstrated by ESTA in March 2021 in correspondence to both Emergency Management Victoria and Ambulance Victoria, it is unclear why ESTA did not escalate its concerns directly to the Minister at that time. It also remains unclear what was communicated to government at that time, or what was understood by government about the risks posed to the community by non-compliance with the performance standard for ambulance call answer speed.[606]

462. In March 2021, ESTA should have been aware that if the December 2020 request for funding for 43 additional full-time employees was provided in the State Budget, this would not be available until the second half of 2021, and the recruitment and training processes which would follow would take months. There should have been an earlier recognition that the prospect of this additional funding did not sufficiently mitigate the risk posed by ongoing non-compliance with the performance benchmark, and that urgent recruitment of additional ambulance call-takers was needed at that time. This was a missed opportunity to prevent, or minimise, the severity of the ambulance call-taking crisis which occurred in 2021-2022.

463. Between September 2021 and October 2021, ESTA accepted that it needed urgent assistance by way of broader government intervention and utilisation of the emergency management framework. There was sufficient organisational knowledge for ESTA to have reached this position earlier, at any point in time from January 2021. Whilst it is

[606] Matters which are beyond the scope of this coronial investigation.

unclear when the window of opportunity to prevent or minimise the crisis closed, additional recruitment should have occurred or been well advanced before that time.

464. By the time EJAST was formed in October 2021, it was too late to avert the ambulance call-taking crisis, and there was no prospect that it would be resolved without significant adverse impact on the Victorian community for an extended period. It was unsurprising that even with intervention by the Minister for Emergency Services, substantial immediate resourcing from government, and management from the emergency management sector more broadly, it took until August 2022 for the ambulance call-taking crisis to resolve. Whilst other mitigation strategies assisted in suppressing call demand and utilising the current workforce, the resolution of ESTA's ambulance call answer speed performance issue was only achieved when there was a substantial increase in ambulance call-taker numbers.

465. On 16 October 2021, the day of Nick's emergency, ESTA did not have adequate ambulance call-taking staff to meet its forecast of operational staffing hours required for that day, meaning that ESTA did not have enough staff available to service the expected demand. If ESTA had the required number of staff available at that time, the delays experienced in requesting an ambulance in Nick's case would likely not have occurred, and his death could have been prevented.

466. ESTA did not have a workforce of ambulance call-takers sufficient to meet the increased ambulance call demand which was attributable to the COVID-19 pandemic. From December 2020, when ESTA first recorded non-compliance with the ambulance call answer speed performance standard, until August 2022 when it again became compliant, ESTA failed to appropriately perform its statutory function as the authority responsible for ambulance call-taking and dispatch.

467. Acknowledging that ESTA did not request assistance from government and the emergency management sector earlier, and that it should have done so, the occurrence of the ambulance call-taking crisis must be regarded as a broader emergency management sector failure due to the critical role played by ESTA within that sector, and this was attributable to broader deficiencies in ESTA's organisational and governance structure within that sector.

468. It is unacceptable that no significant intervention occurred by ESTA to correct its ongoing non-compliance with the performance benchmark until after the reporting of adverse events related to the delays commenced in late 2021.

469. Whilst IGEM was not responsible for ESTA's performance of its statutory functions, one if its functions included advising the Minister for Emergency Services that there were issues with ESTA's performance. It did not do so until October 2021, following ten months of non-compliance with the ambulance call answer speed performance standard. The timing of this advice was due to the assurance nature of IGEM's role and this reveals that the monitoring of performance benchmarks by IGEM was not protective in these circumstances. It was reflective of the reactive nature of the assurance role performed by IGEM.

FINDINGS

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

   a. the identity of the deceased was Nick Panagiotopoulos, born 24 April 1974;

   b. the death occurred on 16 October 2021 at [redacted], Preston, Victoria 3072, from 1(a) acute myocardial infarction; 1(b) thrombotic occlusion of the right coronary artery; 1(c) coronary artery atherosclerosis; and

   c. the death occurred in the circumstances described above.

CONCLUSION

471. The crisis in emergency ambulance call answering which occurred as result of the COVID-19 pandemic was unprecedented, but it was not unforeseeable. In Nick's case, the system that was designed to save him failed, and his death could have been prevented.

COMMENTS

472. I make the following comments connected with the death under section 67(3) of the Act.

473. I acknowledge the commitment to improvement which was evident in both the Ashton and IGEM reviews. The IGEM review was of great assistance to the coronial investigation, enabling broad understanding as to how and why the call-taking crisis occurred. This was important in understanding the circumstances which led to Nick's

death. The large-scale reforms which arose from the recommendations in these reports will ensure Victoria is better served in the future in relation to emergency call-taking and dispatch, particularly in relation to emergency ambulance call answer performance.

474. The narrative and findings which have been made about the potential for improvement, or the nature of the role performed by IGEM, or the decision-making of ESTA (now Triple Zero Victoria) are made in accordance with the statutory obligation to make findings regarding the circumstances in which the death occurred, and by reference to the Coroner's broader prevention function. The narrative and findings arise from voluminous evidence regarding the performance and structure of those organisations as entities, and no assessment has been made of any individual's performance. The coronial investigation was directed to identifying why the death occurred and any remaining systems improvements. It was beyond the scope of the coronial investigation to undertake an account of individual decision-making involved in the call-taking crisis, or to enquire into what was known to government, particularly, government decision-making regarding funding decisions and appreciation of risk.

475. Neither the IGEM review nor the Ashton review specifically examined or accounted for the extent and nature of the monitoring by IGEM which occurred regarding ambulance call answer performance in the lead-up to the crisis. This was likely due to the terms of reference of the Ashton review, and the nature of the IGEM review. By way of comment, any future review of Triple Zero Victoria's performance in relation to an adverse event should ideally include an account of any relevant internal and/or external monitoring and oversight of performance standards. Such analysis should also ideally include:

    a. an explanation of the relevant escalation pathways and reporting requirements which applied;

    b. an assessment of whether these were appropriate in the circumstances; and

    c. an assessment of whether they served the purposes for which they were intended.

476. Finally, I wish to acknowledge the work of the emergency call-takers (including Telstra operators), their managers, and other staff impacted by the call-taking crisis, particularly those who provided these essential services throughout the COVID-19 pandemic. It is apparent from the evidence that the call answer delays potentially impacted the mental

health and wellbeing of those staff members. Operators and call-takers stayed on the phone with distressed members of the community who were facing unacceptably long delays waiting for assistance in very difficult circumstances. Managers and other staff did what they could to effectively utilise a grossly under-resourced workforce, but they could not adequately address call volume demand no matter what strategies were employed. The stress of those circumstances continued from December 2020 until August 2022. I acknowledge their ongoing efforts to maintain ESTA's critical call-taking service during that difficult time.

RECOMMENDATION

477. I make the following recommendation connected with the death under section 72(2) of the Act:

> That the Minister for Emergency Services considers reviewing the nature of the assurance role of the Inspector General of Emergency Management relating to its monitoring of performance standards applicable to Triple Zero Victoria, to assess whether this monitoring is sufficiently protective in nature, whether it adds sufficient value, and whether it is in accordance with best practice in emergency management.

ORDERS

Pursuant to section 73(1) 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:

Belinda Nicolazzo, Senior Next of Kin

The Hon. Vicki Ward, Minister for Emergency Services

Triple Zero Victoria (c/- Victorian Government Solicitors Office)

The Inspector-General for Emergency Management Victoria

Telstra Ltd (c/- Gilbert & Tobin)

Ambulance Victoria (c/- Lander & Rogers)

Emergency Management Victoria

Leading Senior Constable David Torrelli, Coronial Investigator

Signature:

Catherine Fitzgerald
Coroner

Date: 30 April 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 inquest. 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.