IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 002035

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Christina Lackmann
Date of birth:	27 October 1988
Date of death:	22 April 2021
Cause of death:	1a: Caffeine toxicity
Place of death:	105/77 Hawthorn Road, Caulfield North, Victoria, 3161
Keywords:	Caffeine toxicity, ambulance delay, ramping, 000 call triage, welfare check

INTRODUCTION

1. On 22 April 2021, Christina Lackmann was 32 years old when she was found deceased at her home. At the time of her death, Christina lived in Caulfield North.

2. Christina was born in Mona Vale, New South Wales, and grew up with her parents and two brothers. As a teenager, Christina was diagnosed with anorexia nervosa. Her medical history also included ongoing gastrointestinal issues, amenorrhea, and hypercholesterolemia. In May 2014, when Christina was 25 years old, her father died suddenly from a heart attack. His death was a major shock to Christina and her family, and she struggled with depression from this time. In 2015, she took an overdose of caffeine tablets but sought medical assistance in time. In recent years, Christina had been prescribed levothyroxine for hypothyroidism and had reported a significant improvement in her gastrointestinal symptoms.

3. In the months before her death, Christina was studying for her final semester of a biomedical sciences degree and hoped to progress to an honours degree. During a family visit on 17 April 2021, Christina's mother observed her to be looking 'tired and stressed', and Christina mentioned that she had not been getting any sleep.

THE CORONIAL INVESTIGATION

4. Christina's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

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

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

7. This finding draws on the totality of the coronial investigation into the death of Christina Lackmann. Whilst I have reviewed all the material, I will only refer to that which is directly

relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Circumstances in which the death occurred

8. On the afternoon of Wednesday 21 April 2021, Christina attended a university lecture. Her lecturer did not notice anything unusual about her behaviour.

9. At approximately 5:30 pm, Christina called her mother, Beate Lackmann, from her mobile phone, but she was unable to answer the call. Christina sent a text message asking her mother to visit her the following day. Beate stated that it was out of character for Christina to contact her like this, and when she attempted to call Christina back at 6:30 pm, Christina did not answer, but they exchanged some further texts in which Christina stated she was 'ok', and Beate agreed that she would visit the following afternoon.

10. At 7:49 pm, Christina called 000 from her mobile phone and requested an ambulance. She reported to the call-taker (**CT**) that she felt sick, numb all over her body, and dizzy. She said she had lowered herself to the floor, was unable to get up, and was home alone. The CT asked Christina a series of structured questions about her condition and entered her responses into the emergency dispatch software. The CT recorded 'Feels unwell, feels like everything is all numb - all over, dizzy, lowered herself to the floor', and noted that Christina was conscious and breathing. Based on Christina's responses to the questions, the CT further recorded:

    She is completely alert (responding appropriately)

    She is breathing normally

    She does not have any pain

    She is not bleeding (or vomiting blood)

    Her primary problem is dizziness/vertigo

11. On the basis of this information, Christina's call was categorised as a Code 3 (non-acute/non-urgent), event type 26A3 (Sick person – dizziness/vertigo). As a Code 3, the call was deemed

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

to be suitable for secondary clinical triage by an Ambulance Victoria Referral Service Triage Practitioner (**RSTP**), being a paramedic or nurse.

12. The CT attempted to transfer the call directly to an RSTP (known as a 'warm transfer'), but this was not successful as all available RSTPs were busy on other calls. As a result, the CT ended the 000 call and advised Christina to keep the phone line free so that she could be called back, and to call back immediately if anything changed. Christina confirmed that the paramedics would need to buzz the unit number to gain access to the first floor of the apartment complex, but added 'but I can't get up'. When asked whether there was another way to access the building, Christina responded 'I don't think so, I will try'. The CT recorded 'Caller stating unable to get herself off the floor'. Before the call ended, Christina said, 'Please hurry'. The CT told Christina that her condition had been assessed, and that help had been organised. The call was ended.

13. An RSTP attempted to call Christina back 26 minutes after the 000 call was ended. The RSTP called three times, but there was no answer. At 8:17 pm, the RSTP sent a text message to Christina's mobile advising that Ambulance Victoria was trying to call her. AV communications staff continued to attempt call-backs with some frequency, but there was no answer. In all, a total of 14 call-backs were attempted.

14. Eleven entries in the Computer Aided Dispatch (**CAD**) software system specifically recorded Christina's geographical area as 'an area of resource need', meaning that there were no local ambulances available for dispatch. A Communications Support Paramedic (**CSP**) identified that Christina's case could not be resourced and flagged the timeframe risk with the Communications Centre Clinician. This clinician also attempted to call Christina back, but again there was no answer. At 9:13 pm, Christina's call priority was upgraded from a Code 3 to a Code 2 to improve the likelihood that an ambulance would be dispatched.

15. On two occasions between 9:14 pm and 1:46 am, an Advanced Life Support (**ALS**) paramedic ambulance was assigned to Christina's case, but on both occasions the ambulance was diverted to higher priority cases before reaching her. AV records show that these cases related to patients with severe breathing difficulties and chest pains.

16. At 2:05 am on 22 April 2021, an ALS paramedic ambulance was dispatched from 9.5 km away and arrived at Christina's address at 2:23 am. Access was hindered because she resided alone on the first floor of the secured apartment complex but was ultimately achieved with the help of a neighbour. Christina's dog, a Rhodesian Ridgeback, was also agitated and barking

when paramedics arrived. The attending paramedics called for police assistance and climbed from a neighbour's first floor balcony to Christina's balcony, where they could see Christina lying on the floor in an apparently unconscious state. Attending police managed to secure the dog, and paramedics finally gained access to the apartment shortly before 3:00 am, a total of 7 hours and 11 minutes since Christina's 000 call.

17. Christina was found on the floor in her ensuite bathroom. She was cyanosed and very cold to the touch. No resuscitation was attempted as the paramedics assessed that she had been deceased for a prolonged period. Christina was formally pronounced deceased at 3:00 am.

18. Attending police found no suspicious circumstances. They located a nearly-full packet of levothyroxine 200 x 200 mg tablets in the refrigerator with approximately 10 tablets missing. Pharmaceutical Benefit Scheme records indicate this medication had been supplied on 3 February 2021.

19. Christina's mobile phone was found in the lounge room of her apartment. An email found on Christina's phone showed that at 10:26 am on 21 April 2021, an iHerb order of 90 x 200mg caffeine tablets had been delivered to her apartment. Despite subsequent searches of Christina's apartment, neither the caffeine tablets nor their packaging were found.

Identity of the deceased

20. On 22 April 2021, Christina Lackmann, born 27 October 1988, was visually identified by her mother, Beate Lackmann.

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

Medical cause of death

22. Specialist Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 23 April 2021 and provided a written report of his findings dated 14 July 2021.

23. The post-mortem examination revealed a low Body Mass Index of 17.4 with minimal fatty tissue. There was no evidence of cardiac disease, pulmonary embolism or intracranial haemorrhage, and no internal or external injuries likely to lead to death.

24. Vitreous fluid biochemistry was unremarkable other than elevated potassium.

25. Toxicological analysis of post-mortem blood samples identified the presence of caffeine[2] at a very high and potentially fatal concentration (~290 mg/L). Supplementary analysis of Christina's stomach contents revealed caffeine at a concentration of ~940 mg/L.

26. Dr Bedford explained that caffeine toxicity can lead to seizures and fatal heart arrhythmias and provided an opinion that the medical cause of death was "1(a) caffeine toxicity".

27. Associate Professor (**A/Prof**) Dimitri Gerostamoulos, VIFM Chief Toxicologist and Head of Forensic Sciences, provided further expert evidence about caffeine toxicity. A/Prof Gerostamoulos explained that the concentration of caffeine detected in Christina's blood could not be achieved by drinking excessive amounts of coffee.[3] He added that it was not possible to estimate the amount of caffeine Christina consumed to achieve the concentration found in her blood and stomach contents but it was consistent with excessive consumption of caffeine, equivalent to at least 10 x 100 mg caffeine tablets.

28. I accept the opinions of Dr Bedford and A/Prof Gerostamoulos.

EXPERT OPINION

29. As part of the coronial investigation, an expert opinion was obtained from A/Prof Narendra Gunja, a specialist medical practitioner in clinical and forensic toxicology and emergency medicine. A/Prof Gunja reviewed all the available evidence in Christina's case and provided his expert opinion as to the causes and effects of caffeine toxicity and whether earlier medical intervention could have prevented Christina's death.

Caffeine toxicity

30. A/Prof Gunja explained that caffeine is a stimulant drug which has adrenaline-like effects on the heart and brain (central nervous system). The dose of caffeine required to cause toxicity varies from person to person, but the majority of patients with levels above 80 mg/L would be expected to display signs of severe to life-threatening toxicity.

31. Toxicity begins with tachycardia, vomiting and electrolyte disturbances in the blood, the main one being hypokalaemia (low blood potassium concentration). As the body begins to suffer

[2] Caffeine (1,3,7-trimethylxanthine) is a central nervous system stimulant present in cocoa beans, coffee, guarana berries, holly leaves, kola nuts, and tea leaves. Secondary physiological effects include cardiorespiratory stimulation, coronary vessel dilation, and diuresis. A 350 mL cola drink has 18-48 mg of caffeine, and a 180 mL regular coffee or tea has 40-150 mg.

[3] Baselt RC. Disposition of toxic drugs and chemicals in man. 11th ed. Seal Beach, Ca.: Biomedical Publications; 2017. pp. 335-8.

low oxygen transport around the body and breakdown of glucose and fat, this leads to elevated lactate production and acidaemia (acid built up in the blood). This progresses to cardiac arrhythmias, seizures and shock. Unless medical intervention is provided, caffeine toxicity from overdose usually leads to death within 8 hours of ingestion.

32. In relation to treatment pathways, A/Prof Gunja explained that death from caffeine overdose is rare if the patient presents to hospital and is treated with intensive life-saving therapy. Treatment of caffeine overdose includes early assessment, administration of activated charcoal to bind caffeine in the gut, and preventing deterioration from toxicity. When life-threatening toxicity develops, treatment involves fluid and electrolyte management, haemodialysis and inotropic support for shock. The stimulant effects of tachycardia and hypertension may be treated with beta-blockers, and cardiac arrhythmias can be managed with anti-arrhythmic agents and electrical cardioversion. Because caffeine is a small molecule with a small volume of distribution in the body, it is also amenable to haemodialysis (artificial kidney elimination), and this may be instituted in intensive care units where a patient presents with severe caffeine toxicity. A/Prof Gunja opined that if a patient presents to hospital early with caffeine toxicity, prior to the onset of irreversible damage, and expert clinical management is enacted, the chances of survival are good.

33. A/Prof Gunja agreed with A/Prof Gerostamoulos that the concentration of caffeine detected in Christina's blood far exceeded therapeutic levels or those found in recreational coffee drinkers and was consistent with caffeine toxicity and excessive caffeine intake.

Could Christina's death have been prevented with earlier medical treatment?

34. A/Prof Gunja confirmed that death from overdoses is largely preventable when treating clinicians know what they are treating. He added that prompt medical attention and appropriate expert management often relies on the overdose patient stating the identity of the toxicant and timing of ingestion.

35. In Christina's case, A/Prof Gunja opined that if she had been in hospital immediately after making the 000 call, it is likely she would have received early medical attention with questioning about any drug ingestion. This would likely have led to appropriate management with the use of antidote therapy and haemodialysis. If these management strategies were followed, A/Prof Gunja considered it likely that Christina would have survived, even with a large caffeine overdose.

36. However, in the absence of information about the time Christina ingested the caffeine, or the length of time between ingestion and the making of the 000 call, A/Prof Gunja was not able to pinpoint a specific time at which Christina's death was still preventable. If Christina ingested the caffeine tablets several hours before the 000 call and collapsed soon after the call ended, he considered it likely that she would not have survived. However, if she ingested the caffeine tablets an hour before the 000 call, early medical attention within a few hours could have prevented her death. In short, he opined that the earlier Christina received medical attention, the higher her chances of survival.

37. I accept A/Prof Gunja's opinions.

FAMILY CONCERNS

38. In correspondence to the Court and in her statement dated 17 September 2021, Christina's mother expressed significant concerns about the categorisation of Christina's 000 call and the extended delay between the 000 call at 7:49 pm and ambulance attendance at 2:23 am. She also questioned why the repeated unanswered calls to Christina after her 000 call did not prompt AV to re-categorise her case or arrange a welfare check by another authority.

FURTHER INVESTIGATIONS

Ambulance Victoria review

39. I directed that further information be obtained from Ambulance Victoria (**AV**) and Emergency Services Telecommunications Authority (**ESTA**)[4], now Triple Zero Victoria, regarding the management of Christina's 000 call and ambulance dispatch over 21 – 22 April 2021.

40. Mr Andrew Keenan, AV Director of Patient Safety and Experience, provided statements on behalf of AV with detailed information about 000 call triaging processes and the ambulance resourcing pressures on the evening of 21 April 2021.

41. In relation to the categorisation of Christina's call as a Code 3, Mr Keenan explained that when a person calls 000, the call is initially accepted by Telstra and the caller is asked whether they require the services of police, fire or ambulance. Based on the caller's response, the Telstra 000 operator will transfer the call to an ESTA call-taker (**CT**) trained in the relevant

[4] From 15 December 2023, the Emergency Services Telecommunications Authority Act 2004 (Vic) was repealed and replaced by the Triple Zero Victoria Act 2023 (Vic). The change in legislation abolished ESTA and established a new entity, called Triple Zero Victoria (TZV).

emergency service. What happens next depends on how the call is coded. The ESTA CT asks the caller scripted key questions, following which the call is triaged and designated a code. A defined matrix/grid is used to work out the appropriate coding for each call. For example, a caller who requires urgent paramedic and hospital care will be designated as Code 1. The CTs do not obtain a caller's next of kin details, nor do they have access to a caller's past medical history.

42. In Christina's case, her call was classified as a Code 3, which meant it was deemed suitable to be first transferred to the AV Referral Service for secondary triage, where callers are able to speak to a health practitioner about their condition. The purpose of the secondary triage is to gather further pertinent clinical information from the 000 caller to determine whether the incident should be upgraded or may be suitable for an alternative disposition, such as self-presenting to an emergency department. A Code 3 is of lower acuity but may be upgraded or deemed suitable for an alternative service provider following further discussion between the caller and the Referral Service's health practitioner.

43. In relation to the suggestion that a welfare check should have been arranged when Christina did not answer the repeated calls to her mobile, Mr Keenan advised that Victoria Police are sometimes used for this purpose, but that because AV receive approximately 15,000 calls per year where contact is not made on call-back, this additional demand on Victoria Police resources means that this is not always possible.

44. In relation to ambulance resourcing, Mr Keenan advised that on the evening of 21 April 2021, the ambulance service was under extreme demand pressure, resulting in long delays and significantly reduced fleet availability across AV's emergency ambulance resources.

45. At the time of Christina's 000 call at 7:49 pm, the Melbourne metropolitan region had been in 'Code Green' escalation (denoting a medium impact on normal operations) due to increased workload demand since 7:00 pm. Over the next few hours, the demand for ambulances escalated significantly and by 10:50 pm, triggers were met to escalate to a 'Code Orange' (denoting a major impact on normal ambulance operations), and there were up to 70 cases which were unable to be immediately resourced. Of these:

    a) approximately 35 to 40 were Code 3, where there is an expectation of ambulance arrival within one hour under normal driving conditions. Usually, most Code 3 cases would be assessed first by Triage Services for secondary triage, and with some, an alternative disposition is reached meaning an ambulance is no longer required;

b) approximately 20 to 25 were Code 2. Code 2 events are acute, but not time critical and do not require a 'lights and sirens' response. The expectation for a Code 2 response is that ambulance arrival will be within 25 minutes under normal driving conditions; and

c) approximately 5 were Code 1. Patients who require urgent paramedic and hospital care are designated as Code 1. Ambulance response to Code 1 incidents has an official response time target of 15 minutes for 85% of incidents Statewide. These incidents are responded to under emergency 'lights and sirens' driving conditions. The response time for Code 1 incidents in centres with populations greater than 7,500 is 15 minutes for 90% of incidents.

46. Additionally, on this evening, decreased ambulance availability (as distinct from increased 000 demand) significantly influenced the ambulance response delays and was the major factor leading to the excessive delay in reaching Christina. Ambulance Victoria records indicate that only 14 ambulances were in 'available mode' at 7:49 pm within the metropolitan ambulance boundaries. A further six ambulances had Code 1 or Priority 0 dispatch warnings (meaning they could only be dispatched to Code 1 or Priority 0 events), four were Mobile Intensive Care Ambulance (**MICA**) resources (also preserved for Code 1 and Priority 0 events), and only one Advanced Life Support (**ALS**) single officer staffed ambulance was available to be dispatched to Code 2 or 3 cases. This resource was in Craigieburn, over 47 kilometres away from Christina's home. The remainder of the fleet were assigned to cases and were either en route to high priority cases, on scene with a patient, loaded to hospital, or already arrived at a destination health service.

47. The public hospital system's capacity to clear ambulance resources was also extremely challenged. On this evening, there were significant delays at Monash Medical Centre (Clayton), and the Royal Melbourne, St Vincent's, Sunshine, Austin and Northern Hospitals. Health services have a Key Performance Indicator (**KPI**) to offload 90% of ambulance patients within 40 minutes of arrival at the hospital. On 21 April 2021, this benchmark was achieved only 57.3% of the time. On 22 April 2021, the benchmark was achieved 59.2% of the time. Metropolitan hospital presentation data reveals that at the time of Christina's 000 call, there was a large volume of ambulance arrivals at hospitals. Between 6:00 pm and 10:00 pm, presentations (both ambulance arrivals and self-presentations) were at their peak.

48. Following Christina's passing, AV reported her case to Safer Care Victoria as a sentinel event[5] and undertook a Root Cause Analysis in accordance with its statutory obligations. AV also conducted an internal In-depth Case Review.

49. The findings of the RCA included the following:

a) When Christina's call to 000 was received, a confluence of factors had occurred which created excessive and unacceptable delays in ambulance response times. Specifically, due to 'ramping'[6] having affected 80% of AV's metropolitan fleet, requests for ambulance assistance were not able to be responded to in a timely manner.

b) At the time of Christina's call, there was no standard process in place to enable AV to trigger a welfare check from another agency, or to provide any other non-ambulance response to a 000 caller who did not respond to attempted telephone contact.

c) Although Christina was advised that 'help [was] being organised' as per ESTA scripts then in place, this did not adequately describe the situation, namely the type of response she would receive, including that an ambulance would not be immediately dispatched. Having not been adequately informed, Christina was unable to make any subsequent decisions in relation to seeking further assistance.

d) the inability to provide a warm transfer to an AV RSTP from the ESTA CT affected the ability to elicit further pertinent clinical information from Christina and constituted a missed opportunity to establish a connection between Christina and a health practitioner. This connection potentially would have allowed for the transfer of important clinical information which would have enabled a different prioritisation of response.

50. The RCA also concluded that in the context of an unsuccessful warm transfer, the policy of completing three unanswered phone calls to the patient before sending an SMS informing them that the incoming calls were from AV was suboptimal. Sending an SMS earlier in the call-back protocol could result in better awareness by the patient that incoming calls are to be

[5] A sentinel event is a particular type of serious incident that is wholly preventable and has caused serious harm to, or the death of, a patient: Australian Commission on Safety and Quality in Health Care, *Australian Sentinel Events List (version 2)* (April 2020).

[6] Ambulance ramping, also known as offload delay or patient off-stretcher time delay, occurs when paramedics are unable to transfer a patient from the ambulance to the ED within a clinically appropriate timeframe due to the ED being at capacity. This means ambulances are stuck at the hospital entrance, unable to unload patients and potentially delaying care for other patients.

expected and need to be answered. The RCA recommended that alternative strategies also be explored, including consideration of placing callers on hold rather than ending the call when warm transfers cannot be made.

51. The following seven recommendations were made to address the findings and learnings arising from the RCA:

    a) That the Department of Health signal significant patient safety risks associated with prolonged transfer of patients from AV to EDs and to increase the visibility and accountability of health services and AV in relation to the meeting of transfer time KPIs.

    b) That a health system review be commissioned, led by the Department of Health, to identify the barriers to effective patient flow through EDs and their impact on hospital transfer times and ambulance availability.

    c) That a government funded package be implemented to address the changing demand across ambulance services, EDs and hospitals.

    d) That AV and ESTA improve the provision of information to 000 callers at the conclusion of the call.

    e) That AV identify and implement technological support for clinicians to monitor and manage cases pending dispatch.

    f) That AV investigate with Emergency Response partners the capacity for dispatch/welfare checks in circumstances where there is a high demand for ambulance services.

    g) That AV and ESTA explore the feasibility and efficacy of workflows and technical systems to allow real time transfers of 000 callers to Triage Services.

Implementation of RCA recommendations

52. I sought an update from AV in relation to any changes made as a result of the RCA findings since the time of Christina's passing.

53. In a statement dated 21 May 2025, David Allan, Acting Director of Patient Safety and Experience, reported that all seven RCA recommendations have been implemented:

a) The Department of Health has communicated with Health Services Board Chairs and CEOs to increase visibility of ramping as a significant patient safety risk, and promote greater accountability through performance monitoring frameworks.

b) The Department of Health commissioned a review of the causes of ramping, which has since been undertaken and an action plan developed to implement system-wide changes.

c) Funded initiatives have been implemented to improve transfer times and Code 1 response times.

d) Exit scripts used by ambulance call-takers have been updated to include the expected time of ambulance arrival, and ESTA has updated workflows to require earlier SMS messaging when attempting call-backs to a 000 caller.

e) Alternative technology options have been investigated to enhance visibility for clinicians in identifying and prioritising review of cases where there is a delay in ambulance dispatch.

f) Standing arrangements with alternate emergency service providers and community responder groups have been updated regarding the capacity to conduct welfare checks.

g) AV has examined the feasibility of workflows and technical systems to allow real time transfer of 000 callers who are unable to be transferred directly to a secondary triage practitioner. Discussions with ESTA have concluded that the telephone system does not currently have the capability for callers to be placed 'on hold' in situations where a Triage Practitioner is not immediately available.

54. In response to my further questions about the capacity of AV to enable welfare checks by other services, Mr Allan advised that the decision to request a welfare check in cases where there is difficulty in allocating an ambulance resource is considered on a case-by-case basis. For example, AV may, from time to time, request Victoria Police to attend to conduct a welfare check following AV's arrival at a patient's residence if there is no answer at the door, no answer on call back, and/or the case information indicates concerns for the patient's welfare.

55. Mr Allan added that since 21 April 2021, AV has added to its 'Work Instruction – Management of Response Delays' a special note which states:

'Delayed response increases the potential for patient deterioration. Held events should be regularly reviewed and reassessed for dispatch solutions.

Where concerns for patient welfare exist (such as an inability to make contact via a welfare call back), consider requesting assistance from other agencies for the purposes of a physical welfare check'.

56. Reflecting on Christina's case, I consider that the updated exit scripts, (d), may have assisted by alerting Christina to the possibility that an ambulance might be delayed, potentially empowering her to seek other help. It is also possible that the updated Work Instruction would have prompted consideration of a welfare check to be performed by another agency, given the recognised delay prior to ambulance dispatch.

57. Whilst I note the information that measures have been put in place to address the system-wide problem of ramping, (a)-(c), and to enhance the triage system, (e), it is not clear what, if any, positive impact this has had on the problem of ambulance ramping/ambulance resourcing.

58. I note that the Ambulance Victoria Annual Report includes data on both the percentage of patients transferred from the ambulance to the ED within the percentage target, and the average ambulance clearance time target, as part of its reporting on Key Performance Indicators for "Timely access to care". The most recent Annual Report for 2023-2024 recorded that the target percentage of patients transferred from ambulance to ED within 40 minutes is 90%. However, the actual percentage of patients transferred within this measure was just 65%. The average ambulance hospital clearing time target is 20 minutes, with the actual average clearing time being 29.8 minutes.

59. Any measures which reduce the overall strain on the health system and shortage of available ambulance resources are welcome, but I am unable to determine what real progress has been made on achieving these objectives since the recommendations were accepted and additional measures were put in place, or what the planned improvement in the KPIs are. It is also unclear what plan exists to evaluate what impact the changes made to date have had in improving these actual performance measures, whether the pace of improvement is regarded as acceptable, and whether any alternative or additional measures are necessary to achieve the targets set.

FINDINGS AND CONCLUSION

60. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities.[7] 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.

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

    a) the identity of the deceased was Christina Lackmann, born 27 October 1988;

    b) the death occurred on 22 April 2021 at 105/77 Hawthorn Road, Caulfield North, Victoria, 3161, from 1(a) caffeine toxicity; and

    c) the death occurred in the circumstances described above.

62. Having considered all the circumstances, I am satisfied that Christina's death was the consequence of the ingestion of caffeine tablets. However, I am not satisfied to the requisite standard that Christina intended to take her own life, although this remains a distinct possibility. I have noted her history of depression, previous overdose involving caffeine tablets, and the excessive amount of caffeine she must have ingested on this occasion. The fact that Christina called 000 for help suggests that, at a minimum, she had decided to seek medical assistance at a point in time when she felt seriously unwell. Her call to 000 also included directions about how paramedics could access the apartment which indicated she wanted medical intervention and intended to avail herself of medical care when it arrived. Whilst it is possible that Christina intentionally took a deliberately excessive quantity of the caffeine tablets, I cannot rule out that she ingested an excessive quantity without intending to cause herself harm and did not realise at the time of her 000 call that her symptoms were due to caffeine toxicity. I note that she did not leave any written document or other indication that she intentionally took her own life.

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

63. As acknowledged by Ambulance Victoria, the delay in ambulance assistance reaching Christina was unacceptable, and a result of a confluence of factors, including the following:

a) Christina's 000 call was coded as a non-acute, non-urgent event based on the symptoms she reported and in the absence of information from Christina that may have alerted the ambulance service to the possibility of drug toxicity;

b) The CT was unable to provide a warm transfer to an AV Referral Service practitioner, which meant that further clinical information was not able to be elicited from Christina at a time when the evidence establishes that she was still conscious. Further clinical information at this point in time may have included information which prompted a higher prioritisation of her call. The inability to transfer her call was a resourcing issue as all AV Referral Service practitioners were engaged on other calls.

c) As at 21 April 2021, there were no standard processes in place to enable AV to initiate a welfare check by another agency, such as Victoria Police, or to provide any other non-ambulance response to Christina when she did not respond to attempted call-backs.

d) The ambulance service was under significant demand pressure on the evening of 21 April 2021 and was operating with reduced fleet availability, largely due to ambulance ramping at major hospitals.

e) On two occasions, assigned ambulance resources were diverted to attend cases coded as higher priority.

64. I accept that the difficulties paramedics encountered in gaining access to Christina's apartment caused some further delay, but I am satisfied that this was a relatively minor contributor to the overall delay, and non-causative, as the evidence suggests Christina had already been deceased for some time.

65. The available evidence does not establish the precise time that Christina ingested the caffeine, or the quantity ingested. In the absence of this information, I am not able to reach a definitive conclusion as to whether her death was preventable with earlier ambulance attendance. If Christina made the 000 call within an hour of ingestion and had received medical care a short time later, it is possible that she would have survived, but this remains speculative. If Christina ingested the caffeine several hours before making the 000 call and collapsed soon after the call ended, it is likely she would have died before ambulance arrival. I note that her failure to

respond to the RSTP callbacks indicates she may have been non-responsive within 26 minutes of her 000 call, and this lends some support to the theory that her condition had significantly deteriorated within a short period of time.

COMMENT

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

66. I note the efforts of Ambulance Victoria and the Department of Health to address the problem of ambulance ramping and improve the triage and dispatch system. However, considering the reported statistics regarding the percentage of patients transferred from the ambulance to the ED within the percentage target, and the average ambulance clearance time target, there is clearly more work to be done.

67. I note the ongoing Inquiry into Ambulance Victoria being undertaken by the Legislative Council Legal and Social Issues Committee. The Committee, which will soon be holding public hearings, is tasked with examining:

> *the core issues impacting the management and functions of Ambulance Victoria including issues involved with call taking, dispatch, ambulance ramping, working conditions and workloads of paramedics, procurement practices, allegations of fraud and embezzlement, governance and accountability and the workplace culture within Ambulance Victoria.*

68. I have determined to make this finding available to the Committee to highlight the very real potential human consequences of ambulance ramping in Victoria, as it may assist in informing the work of the Committee on this important issue.

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

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

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

Beate Lackmann, Senior Next of Kin

Ambulance Victoria (C/- MinterEllison)

Triple Zero Victoria

Legislative Council Legal and Social Issues Committee

Leading Senior Constable Anthony Reid, Coronial Investigator

Signature:

Coroner Catherine Fitzgerald

Date: 02 June 2025

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