# OFFICE OF THE STATE CORONER

# FINDINGS OF INQUEST

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| CITATION: | **Inquest into the death of Peter David Howlett** |
| TITLE OF COURT: | Coroner's Court |
| JURISDICTION: | Mackay |
| FILE NO(s): | COR 33/06 |
| DELIVERED ON: | 25 March 2010 |
| DELIVERED AT: | Mackay |
| HEARING DATE(s): | 13 January, 9 – 12 June, 25 September and 15 December 2009 |
| FINDINGS OF: | Ross Risson, Coroner |
| CATCHWORDS: | CORONERS: Inquest – Adequacy of Queensland Ambulance Service policies and procedures |

REPRESENTATION:

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| Counsel Assisting: | Mr P Cullinane |
| For next of kin: | Mr B Harrison of Counsel |
| For Qld Ambulance: | Ms J Rosengren of Counsel |
| For Ms J Cassidy: | Mr G Handran of Counsel |
| For Ms S O'Connor: | Ms D Callaghan of Counsel |
| For Mr C Benjamin: | Mr R Byrnes of Counsel |

The *Coroners Act 2003* (the Act) provides in s 45 that when an inquest is held into a death, the coroner's written findings must be given to the family of the deceased, each of the persons or organizations who were given leave to appear at the inquest and to various officials with responsibility in the relevant areas. These are my findings into the cause and circumstances surrounding the death of Peter David Howlett and they will be distributed in accordance with the Act.

## INTRODUCTION

On the 21 April 2006, Peter David Howlett died after experiencing back pain earlier that morning at his residence at 156 Jensen's Road, Farleigh. Also present at that time were his wife, Karen Howlett and his family. Mrs Howlett contacted the Queensland Ambulance Service via the Triple 0 emergency service and by the time the ambulance had arrived and medical assistance was rendered to him he had gone into cardiac arrest. Attempts to revive him at his home, on route to the Mackay Base Hospital and at the hospital were unsuccessful and he was pronounced deceased shortly after his arrival there at about 9.10am.

Whilst the sequence of events leading up to Peter Howlett being pronounced deceased at the Base Hospital is clear, how and why that sequence of events unfolded clearly required, by way of this Inquest, examination. Also the response by the Ambulance Service to the incident; what steps, if any, were taken to prevent a repetition in the future also required examination.

These findings

- Confirm the identity of the deceased, the time, place, circumstances and medical cause of Peter David Howlett's death;
- Consider the circumstances of the dispatch of an ambulance and crew in answer to Mrs Howlett's Triple 0 call on the morning of the 21st April 2006;
- Consider what action, if any, was taken by the Ambulance Service to prevent a repetition of a similar sequence of events in the future;
- Consider whether any recommendations or comments can be made that could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

## The investigation

My investigation[1] commenced upon my receipt on the 21 April 2006 of Police Report of Death to a Coroner – Form 1 – prepared by Constable Tina Mackenzie, an officer of the Queensland Police Service.

The medical aspects of the investigation were conducted by Dr. Peter Fitzpatrick, pathologist of Mackay who performed an autopsy on the 24 April 2006 and his report is dated the 24 May 2006.

[1] Section 11(2) *Coroners Act 2003*.

My investigation of this death relied substantially on the investigation report prepared by LKA Management Pty Ltd, dated the 14 July 2006, which was prepared upon the instructions by the Ethical Standards Unit of the Department of Emergency Services. Also the Department provided statements from various employees of the Ambulance Service as well as other relevant documents.

## The Inquest

It was a letter from Mrs Howlett dated the 18 May 2006 which alerted me to her concerns as to the provision of ambulance services to her husband that has ultimately led to this inquest. I was assisted in this inquest by Mr PT Cullinane of Counsel. Mrs Howlett appeared and was represented by Mr BA Harrison of Counsel instructed by Taylors Solicitors.

Also given leave to appear was the Queensland Ambulance Service which was represented by Ms J. Rosengren of Counsel who also appeared for all other Queensland Ambulance Service employees not individually represented.

The employees individually given leave to appear and separately represented were Ms Jennifer Cassidy represented by Mr G Handran of Counsel; Ms Sharon O'Connor represented by Ms D Callaghan of Counsel and Mr C. Benjamin represented by Mr R Byrnes of Counsel.

The hearing extended over a number of days with the first day of evidence being the 9 June 2009.

I record here that all parties co-operated and assisted me in the conduct of the Inquest.

## The evidence

Apart from those matters forming the basis of my investigation, the parties produced and tendered various statements and reports during the course of the inquest. This resulted in a substantial amount of information before me and I have made no attempt to even try to include in my findings a summary of all that detail.

In making my findings I only have to be satisfied on the balance of probabilities although "*the seriousness of the allegation, the inherent unlikelihood of an occurrence of a particular description or the gravity of the consequences flowing from a particular finding*"[2] are matters which I must take into account in deciding if a matter has been proved on the balance of probabilities.

## Personal Background

Peter David Howlett was a 44 year old male who was born on the 26 November 1961. He was a married man having married Karen Lee Howlett in 1997 and they have three children – Thomas aged 9, Ryan 6 and Lara aged 2

[2] Brigginshaw v Brigginshaw (1938) 60 C.L.R. 336 at 362 per Dixon J

all at the time of their father's death. He was a self employed engineer who resided at 156 Jensen's Road, Farleigh. In her letter of the 18th May 2006, Mrs Howlett described her husband as "*a young (44 y.o.) strong, fit man*".

## My findings are:

On the 21 April 2006, the Howlett's awoke at about 6.30am. Mrs Howlett went for a shower and came back to the bedroom at about 7.00am to find her husband lying on the floor at the side of their bed. He complained that his back was hurting. Mrs Howlett then went out to make the children's lunches and when she returned to the bedroom Peter Howlett said that he might need an ambulance. He then got up and put on a pair of shorts and complained of having very bad back pains. Mrs Howlett then took him to their car and when in the car he again complained of back pain. When she asked him if he had any chest pain he said that it went from his back into his chest.

Mrs Howlett then got her husband out of the car and took him inside where he laid on the lounge room floor. Mrs Howlett then rang the emergency Triple O number.

This call was made at approximately 7.20am and it was taken by Ms Heather Gibson who was rostered to work as call taker, or one of them, at the Queensland Ambulance Service's communication centre in Rockhampton (CAPCOM) on the 21 April 2006. Briefly the role of a call taker is to receive emergency calls, elicit relevant information, categorise the request, transfer the request electronically to the dispatcher and where appropriate provide the caller with pre-arrival advice.

Mrs Howlett told Ms Gibson that her husband was complaining of back pain and Ms Gibson then asked questions based on protocol 5 which deals with back pain of the Medical Priority Dispatch System ("MPDS") or Pro QA (the electronic version of the MPDS). As the name Medical Priority Dispatch System suggests it is a system so that calls for ambulances can be prioritised so that available ambulances can be dispatched in accordance with a priority rating given to the call by the system. For the system to give a call a priority it required the call taker to follow a script i.e. to ask the caller a set series of questions depending on the nature of the complaint.

Protocol 5 required the call taker to ask the caller in cases where the afflicted party was over 35 years of age, "*Does he/she have any chest pain at all?*" Mrs Howlett asked her husband if he had any chest pain and, before she could relay her husband's response to Ms Gibson, Ms Gibson said "*Just his back.*" What was not heard was Mrs Howlett saying "*In the middle of the back into his chest*". It is accepted that response from Mrs Howlett was difficult to hear on the recording of that telephone call and was not really clear until the recording was digitally enhanced.

Whilst it is accepted that Ms Gibson did not keep strictly to the script, the critical point is that Ms Gibson did not hear Mrs Howlett's response that her husband's pain was *"in the middle of the back into his chest*". That response with other clues such as "*sweating which is like panic*" and *"clammy*" were not

picked up on and Ms Gibson concentrated on back pain. If that response and the other clues had been picked up there is a high probability if not a certainty that Ms Gibson would have gone to protocol 10 which deals with "*Heart Attack Symptoms*". The notes to that protocol state that whilst the symptoms are most common in the chest they may also or only be present in the arm(s), jaw, neck or upper back. If protocol 10 had been referred to the resulting coding for the dispatch of an ambulance in response to Mrs Howlett's call would have been an immediate response with lights and sirens – Code 1C.

Ultimately Mrs Howlett's call was coded 2A which required an immediate response without lights and sirens.

Whilst Mrs Howlett's call was originally coded 2A it was downgraded to a 2B which then required an ambulance on the scene within 30 minutes of the call. This downgrading was done by Sharon Lynn O'Connor who was Communications Centre Supervisor at CAPCOM at the time of Mrs Howlett's calls.

Her role as supervisor of the communications centre was to ensure that the day to day operations of the communications room was running smoothly. A supervisor would take any extra Triple O calls; assist with dispatching if it got extremely busy and assist the operators with decision making.

The downgrading took place at 7.22.50 and it is clear that such downgrading was made contrary to Standard Operating Procedure 27 which authorised a down grade of a response code "*when information is available from a reliable source*" indicating that there has been an "*improvement*" in the patient's condition or "*it was not as originally stated*". There was of course no such information from a reliable source – someone who is clinically trained and is with the patient. SOP 27 required that any doubt was to be resolved in favour of the original coding.

Ms O'Connor said that she discussed the call with Ms Gibson before the downgrading. Ms O'Connor also said she discussed the downgrading with Mr Chris Benjamin who was at the time, acting manager of CAPCOM.

Whilst Mr Benjamin was acting manager of CAPCOM, the role of manager of the communications centre was not considered to be an operational one in the sense of having an active role in the actual taking of calls and dispatching vehicles. The supervision of the day to day running of the call centre fell to Communication Centre supervisor in this instance Ms Sharon O'Connor.

Considering that Mrs Howlett's call ended at about 7.22.16 and the downgrading took place at 7.22.50 there seems to have been little time for such discussions. The probability is that there was no or little discussion with Mr Benjamin about the downgrading. Ms O'Connor said that she relied on Mr Benjamin for the medical aspects of the matter; Mr Benjamin's experience was as a paramedic and not in communications. Because he had no background in communications, Mr Benjamin, assuming that he was in fact aware that a response code was being downgraded, would have had no idea

that it was being done in breach of SOP27. As the downgrade was done in breach of SOP27 a coding of 2B was never the correct code as any doubt had to be resolved in favour of the original coding.

Once Ms Gibson had taken the call an ambulance had to be dispatched and the dispatcher for the purpose of Mrs Howlett's call was Ceri Protheroe.

Ms Protheroe was aware of Mrs Howlett's first telephone call as she had listened as Ms Gibson had taken the call. She was aware that the ambulance crew that was on duty at North Mackay when she started at 7.00am was due to finish at 8.00am and that another crew was due to start at 7.30am thereby giving a half an hour overlap. At 7.23.04 Ceri Protheroe contacted the North Mackay Station and spoke to Officer Steve Parker who informed her that only one of the incoming crew had arrived at the station. This was Probationary Student Paramedic Seeona Francis Brown. Ms Brown had just completed six weeks training in Brisbane and had started in Mackay on the 17 April 2006 and the 21 April 2006 was her first day at the North Mackay station.

Officer Parker even though he was due to finish his shift at 8.00am indicated that he was willing and able to take the call. Ms Protheroe was "keen" to use the incoming crew. That course of action was approved by her supervisor Ms O'Connor although she may have been under the misunderstanding that the outgoing crew were to finish at 7.30am and not 8.00am.

Leaving aside for the moment the downgrade, it is clear the decision to use the incoming rather than the outgoing crew was influenced by the fact that all this was taking place at or around a shift change over.

There is no evidence before me that dispatchers are reprimanded, as Ms Protheroe seems to have believed, for sending out an outgoing crew for a Code 2B call at or about shift changeover.

The decision to use the incoming crew also has had, apart from the delay in sending any crew at all, another important effect on the outcome. The incoming crew consisted of John Hinder, who along with Ms Brown, were new to the area and did not have the local knowledge of the outgoing crew. This almost complete lack of local knowledge must have been a factor in their difficulty in finding the Howlett's property.

Ms Protheroe stated that if the call had been coded 2A she would have dispatched an ambulance immediately. That may have been so but unfortunately Ms Protheroe did not dispatch an ambulance within the 20 minutes as required by a Code 2B call.

Ms Protheroe when she spoke to Officer Parker did not ask him to put on notice the incoming crew that there was a Code 2 pending. It seems that she did not raise this pending call with John Hinder when he did his radio check.

Ultimately Hinder and Brown were assigned the call at 7.45.27 and they informed CAPCOM that they were "en route" at 7.48.32. Ms O'Connor, as

supervisor, whilst agreeing to the sending of the incoming crew has failed to ensure that the crew was in fact sent.

The delay could not be attributed to a need, as is often the case, for an incoming crew to make ready the vehicle – to ensure that it was properly equipped with the supplies that they considered necessary for their shift – they were to use. This was not a factor for Mr Hinder as he had the vehicle permanently assigned to him. It is not clear that Ms Protheroe was aware of this.

Whilst she contacted North Mackay station at 7.23am when she spoke to Officer Parker she did not assign the call until 7.45.27. It was therefore impossible to have an ambulance on the scene within 30 minutes of the call being made. Clearly Ms Protheroe has failed to make reasonable efforts to ensure an ambulance was dispatched in accordance with the requirements of a Code 2B call.

With about 30 minutes having elapsed since Mrs Howlett made her call, which ultimately turned out to be the first of three calls she made and an ambulance not having arrived, Mrs Howlett again called Triple 0. This second call was logged by the system as being received at 7.52.10.

In this second call Mrs Howlett was advised that an ambulance had been dispatched – Mr Hinder had informed CAPCOM that they were en route at 7.48.32 – that of course was correct. Ms Cassidy took that call in which Mrs Howlett advised that her husband was in a lot of pain – in agony - there was no change in his *condition.* Whilst the condition of their husband and father as they waited for an ambulance would have been extremely upsetting for Mrs Howlett and her family, pain of itself did not justify an upgrade of the call's coding.

It is Ms Cassidy's evidence that she advised Ms O'Connor as supervisor, of the second call and suggested an upgrade of it because of the time lapse since the first call. It is Ms O'Connor's evidence that she was unaware of the second call and as such there was no discussion as to any upgrade. Whilst Ms Protheroe as the responsible dispatcher, was aware of the second call there is no evidence clearly supporting either version.

Both of the crew Hinder and Brown were new to the area and they became lost on the way to the Howlett's residence. Added to the unfamiliarity with the area was the fact, as Mr Hinder saw it that he was positively misled by the map from the telephone book that he was using. As he read the map he considered that Wainai Road continued on and became Jensen's Road when in fact, as a later map shows, Jensen's Road joins Wainai Road at right angles on the right as one travels north on Wainai Road.

Whilst Mrs Howlett first rang Triple 0 at 7.20.33 no ambulance had arrived by 8.14.42 when she made her third Triple 0 call. By that time there was a drastic change in her husband's condition - he was blue and not breathing.

Mr Hinder advised CAPCOM at 8.16am that the Howlett's residence had been located. This was after CAPCOM had been contacted for directions at about 8.06am. This necessitated a call to Mrs Howlett at about 8.08am. From Mrs Howlett's first Triple 0 call at about 7.20am it had taken just short of an hour. The journey from North Mackay Ambulance station to the Howlett's residence, a distance of about 7.3 kilometres, should have taken less than 15 minutes. A back up unit arrived and it was dispatched from the South Mackay station in Archibald Street and it had taken about 17 to 18 minutes to get there although it was attending a Code 1 call. The back up unit consisted of advance care paramedic Jeremy Lee Wickham and student Natalie Pickering. Mr Wickham who was navigating considered that the map showed Jensen's Road as continuing northwards. Because the Jensen's Road street sign was noticed they did not continue on northwards as did Mr Hinder. Peter Howlett was transported to the Mackay Base Hospital where he arrived after having arrested on the journey. Despite all efforts he could not be revived.

I also heard evidence from two cardiologists, namely Dr Mark Dooris and Dr Adam Cannon who had differing views as to the prospects of Mr Howlett's survival if there had been timely arrival of an ambulance to the Howlett's residence on the 21st April 2006. Whilst they have differing views it is clear that as the events unfolded Mr Howlett's chances of survival diminished. That of course says nothing about what his chance was – Did he have a real chance of survival? Or was it more hope than real?

I accept that this inquest is not the appropriate forum to determine that question.

Mrs Howlett was of the view that she had informed the Ambulance Service that her husband was having chest pains. She indicated that to Intensive Care Paramedic Hinder and also Constable McKenzie who prepared the Form 1 Police Report of a Death to a Coroner and also in her letter to me although she was mistaken as to which call she said that in.

During her interview with Mr Zsombok and Mr Cunnington on the 5 May 2006 she was advised that only back pain had ever been mentioned by her in her telephone calls. Ultimately Mrs Howlett was found to be correct in that she had mentioned chest pains although in her first call and not the second. Unfortunately, that she was correct was not ascertained until this Inquest. I accept that she has for a considerable period spent time blaming herself for contributing to the delay because she was told that, contrary to her belief, she had not mentioned back pain.

Also I accept that Mrs Howlett experienced some concern that her perceived "calmness" in her first call to Triple 0 had influenced the response to her husband's condition.

Obviously these issues would have caused her additional emotional upset on top of the emotional trauma that she would have experienced on the 21 April 2006 with the death of her husband and the knowledge of the errors that occurred in the Ambulance Service responding to her call for help.

A great deal of time has passed since Mr Howlett died on the 21 April 2006 and I accept that the Queensland Ambulance Service has introduced a number of changes since then.

STAFF

- Increased staffing levels and improved rostering practices in CAPCOM which have provided additional staff during peak periods;
- Improved recruitment practices have been adopted;
- A professional development officer has been appointed in CAPCOM to provide on the job training, supervision and recertification;
- A position of Operations Supervisor has been created to ensure that a qualified and experienced intensive care paramedic is rostered in CAPCOM during peak periods to provide clinical assistances to call takers and dispatchers;

POLICIES AND PROCEDURES

- Comprehensive regular random audits (including feedback) of all Triple 0 calls in CAPCOM, which audits are conducted centrally and regionally to ensure compliance with performance criteria;
- Reinforcement of the downgrade policy and procedure through monthly team leader meetings, email correspondence and the creation of a separate standard operating procedure (SOP 089) which clearly explains when cases can be downgraded and emphasises that the team leader must authorise the downgrade; and
- Reinforcement to CAPCOM staff and on road officers of the requirement to respond to a dispatch request at any time prior to the conclusion of a shift;

EQUIPMENT

- Four plasma computer screens, which can be readily seen by all staff in the room, have been mounted on the walls in the CAPCOM room. These screens display pending cases and provide a visual reminder (flashing mechanism) in circumstances where there has been a delay in dispatching an ambulance,

NAVIGATIONAL AIDS

- All QAS Mackay ambulances now have a colour street directory from the Mackay Phone Directory, UBD local street directory maps showing both urban and regional areas and maps provided by the Mackay Regional Council that are updated on a quarterly basis;
- CAPCOM staff are provided with MAPINFO – an electronic street directory and MIMAPS provided by the Mackay Regional Council to enable them to assist on road staff find locations; and
- GPS devices installed in all ambulance vehicles within the Mackay area.

DEBRIEFS

- Guidelines have been developed for the conduct of operational debriefs in selected cases. This process is a formal and coordinated one in which all QAS personnel involved in a particular case participate in a structured and detailed analysis of every aspect of the case.

INVESTIGATIONS

- Clinical Audit and Review Tool (CART) – All cases which involve a death in care or a cardiac arrest are automatically filtered and reviewed within 24 hours of the case. A score is assigned to the case and a score which denotes a significant variation in the standard of services provided. Where that occurs a number of notifications have to be sent;
- Root Cause Analysis (RCA) – This is appropriate where systemic issues may be involved; and
- Open Investigations are most appropriate where human error or any non-systemic issues may be involved.

INVOLVEMENT OF FAMILY

- Documented investigation procedures require investigations to be conducted in an open and transparent manner keeping the patient/family appraised of the investigation, its progress and its outcome.

Obviously all policies and procedures of themselves cannot guarantee that errors such as occurred in this case will not be repeated. Obviously if those policies and procedures are complied with they can reduce the likelihood they will be repeated.

I accept that staff at CAPCOM would be under a great deal of pressure dealing with Triple O calls which involve life and death situations. I accept that those involved in this incident with Mr Howlett were affected emotionally by it. Obviously the emotional trauma caused to Mrs Howlett and her family was much greater. It would only be natural for her to believe that, but for the delay in the arrival of an ambulance to which she believed for a considerable period she may have contributed by not mentioning that his back pain went into his chest, her husband would have survived.

My findings pursuant to section 45 of the Act are: -

> The deceased person was Peter David HOWLETT and he died on the 21 April 2006 at the Mackay Base Hospital, Bridge Road, Mackay in the State of Queensland and the cause of his death as found at the autopsy was acute myocardial ischaemia due to coronary artery occlusion due to thrombosis and atherosclerosis.

I make only one comment pursuant to section 46 of the Act: -

> That the Queensland Ambulance Service use actual case studies such as this matter involving Mr Howlett including

playing the actual tapes, with the consent of those involved, in training all staff.

I extend my condolences to Mrs Howlett and family.

I order that the EMD Protocol board be returned to the Queensland Ambulance Service.

This inquest is now closed.

Ross Risson
Coroner
Mackay
25 March 2010

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