# OFFICE OF THE STATE CORONER

# FINDINGS OF INQUEST

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| CITATION: | **Inquest into the death of Gregory David Van Moolenbroek** |
| TITLE OF COURT: | Coroners Court |
| JURISDICTION: | MACKAY |
| FILE NO(s): | 2010/1554 |
| DELIVERED ON: | **10 August 2012** |
| DELIVERED AT: | **Mackay** |
| HEARING DATE(s): | **25 July 2012, 9 August 2012, 10 August 2012** |
| FINDINGS OF: | John Hutton, Coroner |
| CATCHWORDS: | Coroners: inquest, rural property numbering, ambulance response |

REPRESENTATION:

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| Counsel Assisting: | Mr Chris Minnery, Office of the State Coroner |
| Queensland Ambulance Service: | Ms Kerri Mellifont of Counsel, Instructed by Department of Community Safety |

## Findings required by s45

**Identity of the deceased** – Gregory David Van Moolenbroek

**How he died** – Mr Van Moolenbroek suffered severe occlusive atheroma which caused approximately seventy percent narrowing and calcification on his left anterior descending coronary artery. This narrowing despite a stent, combined with cardiac arrhythmia caused by Mr Van Moolenbroek exerting himself resulted in his death. I find that any delay in the arrival of the ambulance units attending Mr Van Moolenbroek did not contribute to his death.

**Place of death** – Mr Van Moolenbroek died at a property described as lot 2, RP739675, on Devereaux Creek Road, Devereaux Creek, outside Mackay in the state of Queensland.

**Date of death**– 10 May 2010

**Cause of death** – 1(a) Coronary Atherosclerosis (despite stenting)

2 Coeliac Disease (clinical), Diverticular Disease

## Introduction, Background and Factual Circumstances

1. At about 8:30am on 10 May 2010, Mr Gregory David Van Moolenbroek left his home in Rural View, Mackay, to work on a property on Devereaux Creek Road.

2. Mr Van Moolenbroek had a personal and family history of cardiac complaints. He was medicated and had seven stents surgically implanted in his heart and surrounds in 2006 to deal with narrowing and blockages in his coronary arteries.

3. At approximately 12:07pm Mr Van Moolenbroek called his wife to tell her he was at their Devereaux Creek property. At 1:30pm Mr Van Moolenbroek called his wife again and said he did not feel well. They agreed that she would call him an ambulance, and they discussed the appropriate directions to give to the ambulance operator. At or about 1:31pm Ms Van Moolenbroek called “000” and asked for an ambulance.

4. The call was diverted to the Rockhampton Queensland Ambulance Service Communications Centre (referred to as Capcom), and logged at 1:31pm. Emergency Medical Dispatcher Lisa McCabe took this call, Ms Van Moolenbroek provided a number of details about her husband's location and condition.

5. Ms Van Moolenbroek advised EMD McCabe that her husband was having heart trouble, and was at "lot 2, Devereaux Creek Road", indicating it was a new vacant block, and 8.3 kilometres down Devereaux Creek Road. She advised her husband was conscious and alert, and that he had seven stents put in his heart some years prior and felt unwell, and felt it was his heart. She referred to a Toyota Prado vehicle. After obtaining telephone numbers, the operator advised she would dispatch a unit, and the call ended.

6. EMD McCabe used the Queensland Ambulance Service computer-aided dispatch system to enter details of the call. The program allowed her to enter Deveraux Creek Road, with "lot 2" in another field, and she also entered details including "8.3 kilometres down road", reference to the Toyota Prado and Mr Van Moolenbroek's mobile phone number. Due to the way certain medical prompts by the VisiCAD system were answered, the matter was given a code 2A, meaning an immediate dispatch of an advanced care paramedic crew, without lights or sirens being used.

7. The Queensland Ambulance Service system of classification of emergencies includes Code 2, which indicates an urgent response without lights and sirens, and Code 1, which indicates an immediate response with lights and sirens. The primary difference is that in a Code 1 response, drivers are authorised to, where safe, disregard road rules to respond to an emergency, and in a Code 2 response they are not.

8. At 1:35pm this information was transferred to the ambulance dispatchers at the call centre. At 1:36pm EMD McCabe tried to call Mr Van Moolenbroek on his mobile phone, but he did not answer and the call went to message bank. EMD McCabe left a message asking him to call the QAS.

9. The dispatchers responsible for this matter were EMD Jodie O'Dell (mentor/student supervisor) and student EMD Michael Thurman. They dispatched an advanced care paramedic crew at 1:38pm. That crew consisted Advanced Care Paramedics George Fennemore and Mark Saliba.

10. The system operating at the time meant that ACP Fennemore and ACP Saliba received a page on a pager, providing information about the job. They also received a call on a mobile phone they carried providing details. They were told by EMD O'Dell in the phone call that it was a Code 2 job, the location was lot 2 Devereaux Creek Road, it was 8.3

kilometres down that road, and the patient was a 44 year old male unwell or with a heart problem. They were not told the vehicle details, or that the property was on the right hand side, and that it was a vacant block.

11. The dispatchers attempted to call Mr Van Moolenbroek at 2:03pm but he did not answer.

12. At 2:05pm EMD McCabe called Ms Van Moolenbroek, who was by this time on her way to the property. During this call, EMD McCabe was told that the property was across the road from a property owned by Gavin Zillfiech. This was entered into the VisiCAD system by EMD McCabe as Gavins Millfish. EMD McCabe also offered to conference Ms Van Moolenbroek into a call with the QAS unit trying to attend her husband, although this did not actually occur.

13. QAS unit 2148 was dispatched from South Mackay. ACP Saliba was driving and ACP Fennemore was navigating. They proceeded to Devereaux Creek Road, and attempted to locate the property where Mr Van Moolenbroek was.

14. I have attended the scene of this incident, and viewed the access from the road to the property as it is now. I am also assisted by photographs of the scene taken on the day that Mr Van Moolenbroek passed away and the following day, albeit with further flattening of the grass and tyre tracks than confronted the ambulance unit on 10 May 2010. As of May 2010 there was no property number up to mark the entrance to the property, nor was there actually an entrance to the property – anyone attending the land would need to turn off Devereaux Creek Road next to a tree on long grass, drive into a muddy and wet channel and out again and forward a flowing creek, then drive through long grass towards a hill to a flattened area where Mr Van Moolenbroek was working. A view of the scene conducted on 8 August 2012, shows that the scene is significantly changed, but it has enabled me to understand the enormous difficulties which would have confronted the ambulance units responding to this emergency.

15. From dispatch at 1:38pm, the crew consisting ACP Fennemore and ACP Saliba were on Devereaux Creek Road prior to 2:09pm. They drove down Devereaux Creek road trying to locate the property, and counting the distance down the road they travelled to try and locate the property using the descriptions given. At 2:10pm they attended a property signed as lot 2, which had a white Toyota Prado (consistent with the description they had been given), and informed Capcom that they were on scene (as in, they had arrived at the location where the patient was expected to be found). This was incorrect – the crew attended a location which matched at least three of the descriptions they had of the property (lot 2 on Devereaux Creek Road, the approximate correct distance down Devereaux Creek Road, location of a Toyota Prado), but as it turns out this was the wrong property. A man

at that property indicated that this was the wrong location, and they returned searching at 2:13pm, informing Capcom as such. The delay was due to the property being set about 250 metres back from Devereaux Creek Road, and the necessity for the residents to confirm that no-one on the property had called the ambulance.

16. The crew drove the entire length of Devereaux Creek Road, turned around and drove back again, searching in vain for the correct location. They drove slowly enough to visually search for any of the clues they had been given about the location, but could not find the property or Mr Van Moolenbroek. Having attended Devereaux Creek Road as it is now, I appreciate their difficulty.

17. At shortly before 2:17pm Ms Van Moolenbroek attended the property. She arrived using a different entrance to the property to that given to the ambulance officers. She found her husband lying in the trailer that he had used to move the digging equipment. He was not moving, his eyes were open and fixed, and he had no pulse.

18. Ms Van Moolenbroek phoned Capcom at 2:17pm (this was the second "000" call), speaking with EMD Narelle Smith, and told EMD Smith that she thought her husband was dead. She was advised on how to commence Cardiopulmonary Resuscitation (CPR), which she did. During this call she provided some further information to EMD Smith on the location, essentially that the ambulance crew could look up the hill and see her husband's trailer attached to a silver Toyota Prado, the location was on the right hand side of the road near a gum tree at the entrance, and the location was 8.3 kilometres down Devereaux Creek Road, from the intersection with Marion Hampton Road.

19. EMD Smith entered this additional information into the computer system and caused an automatic upgrade of the job to Code 1A (the highest priority).

20. EMD O'Dell and student EMD Thurman were on a fifteen minute break when it came to dispatching this information, so the dispatching of this additional information was handled by EMD Catherine Austin.

21. EMD Austin immediately advised unit ACP Saliba and ACP Fennemore of Mr Van Moolenbroek's condition and the upgrading of the job's code to Code 1A. This caused an Intensive Care Paramedic, Tracey Eastwick, to be dispatched. An Intensive Care Paramedic (ICP) possesses the highest skill of an emergency responder.

22. ACP Saliba and ACP Fennemore continued to search up and down Devereaux Creek Road. They were stopped by a passing car and sought assistance, without further information of assistance being gathered. They stopped and sought assistance from another local resident who was a council worker, but did not gain any further useful information. They used their vehicle's flashing lights and used the

sirens intermittently to signal their location in the hope they would be heard and signalled back by Ms Van Moolenbroek (using the sirens continuously can interfere with hearing information over the radio in circumstances such as this one). They searched for properties matching all or any of the descriptions they had been provided without success.

23. ICP Eastwick was dispatched from North Mackay Station, via an automated page, at 2:20pm. ICP Eastwick operated in a vehicle by herself.

24. Communication continued to flow between ACP Fennemore and ACP Saliba on Devereaux Creek Road and Capcom. Operators at Capcom used mapping software to measure out 8.3 kilometres down Devereaux Creek Road and determined this would be between rural property number 791 to 823. This information was given to ACP Fennemore and ACP Saliba by EMD O'Dell immediately.

25. A series of landmark references were given to both units, driving up and down Devereaux Creek Road searching for Mr Van Moolenbroek, between 2:07pm and 2:45pm. These landmarks were sourced during phone calls with Ms Van Moolenbroek, and the information was passed on to the two units on the ground. The provision of this information was hampered by difficulties with signal on both the unit's mobile phones and radios, given this was a relatively remote location.

26. Ms Van Moolenbroek was able to hear the sirens of one of the units, and indicated this over the phone. She went to a place visible from the road, and waved to the crews as they approached. Both units located her and the property at 2:44pm and informed Capcom of this.

27. Further difficulties were encountered as the ambulance vehicles could not traverse the muddy ground from the road to where Mr Van Moolenbroek was. They drove as close as they could, and ran with their equipment approximately a hundred metres to his location. They took over the CPR performed by Ms Van Moolenbroek, but unfortunately Mr Van Moolenbroek could not be revived.

28. At 3:03pm the ambulance crews advised the Queensland Police Service via communications that Mr Van Moolenbroek was deceased.

## Discussion of the evidence

29. There is no basis for any criticism of any of ACP Fennemore, ACP Saliba or ICP Eastwick. They acted appropriately, and responded as quickly as they could. The delay in their location of Mr Van Moolenbroek can in no way reflect upon them.

30. I find the actions of the dispatch personnel in this matter appropriate and timely. Their actions were reviewed by QAS as well and I do not propose visiting upon the results of that review in any more detail, except to say that there is no evidence to support any suggestion that anything done in the receiving of calls, the dispatching of ambulance units or the provision or receipt of information contributed in any way to Mr Van Moolenbroek's death.

31. There are no matters which could be or should be implemented in terms of improvements to the Queensland Ambulance Service. This is largely because any such matters, few as they may be, have already been identified and rectified by the Queensland Ambulance Service.

## Discussion of recommendations and commendations

32. The evidence in this case suggests that Mr Van Moolenbroek may well have been deceased as at 2:17pm when his wife informed Capcom that he was unmoving, with no pulse and fixed pupils. It may well be that he was deceased earlier, given he was unable to answer calls to his phone at 1:36pm and 2:03pm.

33. Despite this, the circumstances of this case require consideration of methods to improve the ability of emergency responders to locate properties quickly, especially rural properties.

34. I sought and have received responses from the Local Government Association of Queensland, and the Department of Local Government on the issue of mandatory fitting of property numbers on all properties in Queensland, and monitoring and enforcement of this process by local governments. This was not a suggestion which was supported, largely on the issue of cost in circumstances of severe financial restrictions, and the abrogation of responsibility for property numbering from the property owner.

35. In attending the view of the incident scene I was encouraged to observe rural property numbers placed at virtually all of the properties in the area of this incident. I am informed this has occurred since this incident, not necessarily as a direct result of this matter. The numbering enables emergency responders to locate a property quickly, given they reference distance from important cross-roads, and are displayed prominently near the entrance to a property, angled for maximum visibility and on reflective signs. These signs are provided to the land holder by the Mackay Regional Council at no charge.

36. On the basis of this implementation, for which I commend the Mackay Regional Council, I find it inappropriate to make any further recommendations, save and except that other regional councils adopt the sensible and possible life saving approach taken by the Mackay Regional Council. I note it is incumbent upon property owners to assist emergency responders in every possible way to respond to their properties, but I make no formal recommendations.