CORONERS COURT OF SOUTH AUSTRALIA

DISCLAIMER - Every effort has been made to comply with suppression orders or statutory provisions prohibiting publication that may apply to this judgment. The onus remains on any person using material in the judgment to ensure that the intended use of that material does not breach any such order or provision. Further enquiries may be directed to the Registry of the Court in which it was generated.

INQUEST INTO THE DEATHS OF ANNA VINCENZA PANELLA, BERNARD ANTHONY SKEFFINGTON AND GRAHAM HENRY JESSETT

[2025] SACC 21

Inquest Findings of his Honour Deputy State Coroner White

31 July 2025

CORONIAL INQUEST

Examination of the cause and circumstances of the deaths of three South Australians following extended periods of waiting in the care of paramedics outside metropolitan hospitals. The Inquest examined the interactions between the South Australian Ambulance Service and metropolitan hospitals, in particular their Emergency Departments.

Held:

1. Anna Vincenza Panella, aged 76 years of Payneham, died at the Royal Adelaide Hospital on 28 April 2019 as a result of pulmonary thromboembolism due to a left-calf deep vein thrombosis.

2. Bernard Anthony Skeffington, aged 89 years of North Plympton, died at the Royal Adelaide Hospital on 30 September 2021 as a result of aspiration pneumonia secondary to small bowel obstruction.

3. Graham Henry Jessett, aged 64 years of Morphett Vale, died at the Flinders Medical Centre on 22 March 2022 as a result of ischaemic heart disease with cardiomegaly contributed to by hyperkalaemia.

4. Circumstances of death as set out in these findings.

Recommendations made.

Counsel Assisting: MR D EVANS

Interested Party: THE STATE OF SOUTH AUSTRALIA & SA HEALTH
Counsel: MS A DOECKE KC WITH MS J CLARE - Solicitor: CROWN SOLICITOR

Interested Party: SA AMBULANCE EMPLOYEES ASSOCIATION
Counsel: MR P MCCABE - Solicitor: SA AMBULANCE EMPLOYEES ASSOCIATION

Witness: MR S HAMBLING, MR D MCINERNEY, MS K CARTER, MS S WHITE, MS E PANKOKE, MS C WEGENER & MR S GALLAGHER
Counsel: MR D LORBEER - Solicitor: ILES SELLEY LAWYERS

Witness: MS J HEYWOOD, DR S JOLLY, MS S ARAKI, MR C FERNANDEZ, DR E HOPPING, DR M TRUONG, DR J XIAO, MS D WESTON, MS J TOOHEY, MS M CROWTHER & MR S PECK
Counsel: MR J HOMBURG - Solicitor: GILCHRIST CONNELL

Witness: DR M BROOKS
Counsel: MR A KALALI - Solicitor: WALLMANS LAWYERS

Hearing Date/s: 23/04/2024-09/05/2024, 27/05/2024-04/06/2024, 17/06/2024, 21/06/2024, 26/08/2024-29/08/2024, 10/09/2024- 13/09/2024, 29/10/2024, 02/12/2024, 28/01/2025, 03/04/2025

Inquest No: 24/2024 **File No/s: 0847/2019, 2112/2021 & 0662/2022**

INQUEST INTO THE DEATHS OF
ANNA VINCENZA PANELLA, BERNARD ANTHONY SKEFFINGTON AND GRAHAM HENRY JESSETT
[2025] SACC 21

Table of Contents

The tragic deaths of three South Australians 3

Mrs Panella 3

Mr Skeffington 9

Mr Jessett 15

The Inquest 25

Breadth 25

Witnesses 26

The quick fix 27

Ramping understood 27

Aged care 28

Mental health patients 29

Transferring patients 30

24 hours a day 7 days per week v '9 to 5' 31

The consequences of overcrowding 32

Hospital staff 32

Ambulance officers 34

Relative risk 35

The changing nature of demands on the health sector and its services 36

The breadth of the ramping issue and the culture surrounding it 37

Culture and the goodwill conundrum 40

Blood tests for ramped patients 40

Going over capacity on specialist wards 44

Funding for interim solutions, Band aids, Jules Léotard and an unachievable goal 45

What is being done about ramping? 46

The Q-Zone, Lyell McEwin Hospital 52

The fixation with ramping figures 54

Key recommendations to improve safety 55

Offload directions 56

The appropriateness of the Australasian Triage Scale 56

Visualisation at triage 58

Triage distractions and workload ... 61
Triage handovers ... 63
Triage communication ... 64
Blood tests for ramped patients ... 65
Conditions on the ramp ... 65
The environment ... 65
Deteriorations ... 66
Facilities ... 68
The ability to properly care for patients ... 68
Visualisation ... 69
Internal ramping ... 70
The consequence of the inability to ramp internally ... 71
Flinders Medical Centre ... 75
Who has duty of care for ramped patients? ... 77
Responsibility of the media relating to SA Health initiatives to address ramping ... 78
Recommendations which will assist with the effort to reduce ramping ... 80
'Silo thinking' ... 80
Weekend discharge glut ... 81
The fragmented LHN structure ... 82
Mental health catchment areas ... 83
Transit lounges ... 84
The Statewide Interfacility Transfer System ... 85
Extended Care Paramedics ... 85
Issues which arose incidentally ... 85
Adverse incident reviews ... 85
Ambulance advice about demand ... 87
Consultation ... 87
Amalgamation of recommendations ... 88
Input from a nursing organisational perspective ... 88
Counsel ... 88
Condolences ... 88
Annexure – Extracts of family statements ... 90

INQUEST INTO THE DEATHS OF ANNA VINCENZA PANELLA, BERNARD ANTHONY SKEFFINGTON AND GRAHAM HENRY JESSETT [2025] SACC 21

The tragic deaths of three South Australians

1 This Inquest examined the deaths of three South Australians following periods of time waiting on the ramp outside major metropolitan hospitals. The tragedy lies in being so close to the help needed, but being unable to access it. Clinicians involved, as well as leaders of the South Australian health system, gave evidence. A pre-eminent emergency physician, Professor Anne-Maree Kelly, reviewed each patient's case and provided her independent expert opinion to assist me to understand what went wrong for each death.

Mrs Panella

2 Anna Panella was born on 2 January 1943. She migrated from Italy to Australia at 15 years of age and learnt English.[1] She was given employment at San Remo, a South Australian company which supported young migrants. She met her husband, married, moved to Payneham and had a daughter.

3 Mrs Panella took a job working at a private hospital in St Peters. Her dedication and compassion were noted and she was offered a career as a nurse. While initially hesitant because of her English skills at the time, she was able to obtain the necessary qualifications and commence her nursing career which lasted 42 years.[2]

4 Mrs Panella's husband of 45 years passed away unexpectedly in 2007. She struggled to manage her grief but proved to be resilient. In 2015, Mrs Panella became an Australian citizen and returned to visit Italy. In 2019, she was 76 years old. She remained a strong and caring woman. She was a grandmother. She enjoyed cooking, meeting new people, attending exercise classes and celebrating her faith and family.[3] She suffered from hypertension, reflux disease and benign paroxysmal positional vertigo,[4] but was of generally good health. She is one of the many great success stories of immigration in Australia.

5 In the early afternoon of Saturday, 27 April 2019, Mrs Panella's sister-in-law, Nicoletta Delre, visited. Mrs Panella said she thought she had a little virus but would be okay.[5] Later that afternoon a friend of Mrs Panella's visited Ms Delre and told her that she was worried about Mrs Panella because she had been having dizzy spells. The two returned to Mrs Panella's house to check on her.

6 When they arrived, after 4:30pm, Mrs Panella said that she was feeling cold and was having dizzy spells.[6] She appeared pale. At about 5:30pm Ms Delre called the National Home Doctor Service and requested a doctor.[7] At about 8:20pm, Dr Vasant Lagiseti

---

[1] Exhibit C68
[2] Exhibit C68
[3] Exhibit C68
[4] BPPV
[5] Exhibit C3 at [5]
[6] Exhibit C3 at [7]
[7] Exhibit C3 at [7]

arrived. Mrs Panella reported that she was feeling better and Ms Delre confirmed that she looked better than she had earlier.[8] Dr Lagiseti asked about chest pain, heart palpitations, cough and fever. Mrs Panella said she had none of those symptoms. Dr Lagiseti took the usual vital sign observations.[9] Her medical presentation was normal with mild anxiousness. Dr Lagiseti reached a working differential diagnoses of a panic episode in the context of ongoing grief for her husband, or otherwise transient arrhythmia.[10] Dr Lagiseti advised Mrs Panella to see her usual GP on Monday and to monitor herself in the meantime. He advised her to call an ambulance if there was a recurrence of symptoms and confirmed that she had a medic alert button. Professor Kelly had no criticism of what Dr Lagiseti did given Mrs Panella's presentation at that time,[11] and I find that there is no criticism to be made.

7 After Dr Lagiseti left, Mrs Panella asked Ms Delre to stay a little longer as she still felt dizzy and wanted the company. As Mrs Panella walked into the kitchen, she again said she was dizzy and then fell.[12] She did not lose consciousness. Ms Delre pressed the medic alert pendant. Mrs Panella said that she felt fine again, but Ms Delre told her to stay on the floor and wait for the ambulance. She was nauseous and vomited three times.

8 The ambulance request came through at 9:15pm. It was assigned Priority 3.[13] The SA Ambulance Service[14] has target timeframes for dealing with cases in metropolitan Adelaide. For Priority 1, it is that in 60% of cases an ambulance arrives within eight minutes. For Priority 2, it is that in 90% of cases an ambulance arrives within 16 minutes. I made observations about those targets in the Inquest of *Weekes and Files*[15] which I do not repeat here. Data published by the government on SA Health website dashboards, shows that the Priority 1 target is currently being met, and surpassed. The Priority 2 target is on a trend towards being met, after fluctuations.

9 In Mrs Panella's case, a single paramedic response, or SPRINT[16] paramedic, Graham Hambling, was dispatched immediately at 9:15pm, arriving at 9:30pm. Mr Hambling took a history and made vital sign observations which were largely normal.[17] Mrs Panella's oxygen saturation was 98% on room air.[18] Mr Hambling thought that an ECG showed atrial fibrillation. Mr Hambling affirmed the need for an ambulance crew and Mrs Panella's ambulance priority was upgraded from 3 to 2.[19] In the meantime, an ambulance had been tasked at 9:18pm, leaving at 9:37pm and arriving at 9:45pm.[20] The crew dispatched were Darren McInerney and Kristen Carter.[21] At the time of dispatch, these paramedics had worked continuously since 2pm without a break.[22]

---

[8] Exhibit C4 at [5]
[9] Exhibit C14
[10] Exhibit C4 at [6]
[11] Exhibit C49b at 4; T2012.10
[12] Exhibit C3 at [11]
[13] Exhibit C15 at 8
[14] SAAS
[15] Inquest 91/2020, Finding delivered 26 October 2022
[16] Single Paramedic Response and INTervention
[17] Exhibit C26 at [31] and [33]
[18] Exhibit C26 at [32]
[19] Exhibit C23 at [14]; Exhibit C15 at 9
[20] Exhibit C23b
[21] Exhibit C23 at [12]-[13]
[22] Exhibit C23 at [12]-[13], T190.34

10 The ambulance paramedics received a handover from the SPRINT paramedic.[23] Mrs Panella's medical history and recent events were noted. Mr McInerney took Mrs Panella's vital signs again and spoke to her about her symptoms.[24] These vital signs were taken 12 minutes after Mr Hambling's initial observations. Mrs Panella's oxygen saturation was now 86% on room air.[25] She was provided oxygen at two litres per minute and her saturation increased to 93%. Her blood pressure and heart rate were a little high. Her heart was in sinus rhythm, but tachycardic.

11 The ambulance left the house at 10:18pm, arriving at the Royal Adelaide Hospital Emergency Department[26] at 10:33pm.[27] Mrs Panella's case was reconsidered by paramedics and graded back to Priority 3, which is commonly done when lights and sirens are considered unnecessary for transport.[28] Just before they left the house, Mrs Panella's oxygen supply was increased from two litres per minute to four, although she was not displaying any increased work of breathing or respiratory distress.[29] Mrs Panella was sensitive to light and so the ambulance lights were dimmed.[30]

12 SA Health data shows that in the hours leading up to and including Mrs Panella's arrival, the Royal Adelaide Hospital received 15, 13, 13, 13, 13 and 13 new patients cumulatively.[31] Of these, 44 patients arrived by ambulance. Given the timeframes involved in triaging, this represents an almost continuous task of triaging one patient to the next. For the majority of the day, the Department occupancy had been well in excess of its capacity. At 10:40pm specifically, there were 87 patients registered in the Department,[32] against a capacity of 69 patient spaces and eight resuscitation rooms.[33]

13 Upon arrival, Mr McInerney entered the hospital alone. He queued to wait for a triage nurse for about seven minutes.[34] He then provided Mrs Panella's information to the triage nurse, Jenese Heywood.[35] Ms Heywood did not sight Mrs Panella, which is usual practice during busy times,[36] although formal policies mandate patient visualisation.[37] I will return to the topic of patient visualisation later in these Findings. For now, I will just note that Professor Kelly and all other witnesses who commented on this topic clearly accepted best practice is for the triage nurse to see the patient. Mrs Panella's vital signs at that point were a slightly raised respiratory rate, a slightly raised blood pressure (reduced from previous observations), and a slightly raised heart rate (also reduced from previous observations). Her oxygen saturation was at 94%, but only with a high level of oxygen supplied.

---

[23] Exhibit C26 at [44]; Exhibit C23 at [25]
[24] Exhibit C23 at [27]
[25] Exhibit C23 at [27]
[26] the Department, Emergency Department
[27] Exhibit C23b; Exhibit C16 at 16; Exhibit C15 at 11; CCTV footage in Exhibit C6b (as agreed in Exhibit C52)
[28] Exhibit C23 at [46]; T155.6, T822.14
[29] Exhibit C23 at [45]
[30] T157.15, T190.23
[31] Exhibit C34 at 3
[32] T1502.17
[33] T1628.12; Exhibit C43 at [31]
[34] Exhibit C25 at [15]; Exhibit C25d at 7; CCTV footage in Exhibit C6b (as agreed in Exhibit C52)
[35] Exhibit C23 at [53] and [56]
[36] Exhibit C25 at [13] and [20]
[37] Exhibit C25b at 3.4.2; Exhibit C25c at 3.4.2; Exhibit C25a at 3.4.2

14 At 10:40pm, Mrs Panella was assigned Category 3 with a target of treatment commencing within 30 minutes.[38] Professor Kelly reviewed Mrs Panella's treatment by paramedics and by the hospital. There were facts recorded in the triage note identified during the evidence which were not in keeping with Mr McInerney's notes. Neither witness could recall exactly the content of the handover. Ms Heywood's evidence was less than certain about what was handed over. She said her practice was that she would not always record oxygen saturations when handed over.[39] In contrast, Mr McInerney was certain that he would always provide oxygen saturation status during handover.[40] Mr McInerney was described by his colleague as having 'Rain Man'-like qualities, which I took to be a reference to his precision and thoroughness.[41] I find that, on the balance of probabilities, Mr McInerney handed over Mrs Panella's oxygen saturation status and that Ms Heywood either misheard or did not appreciate the significance of the figures (i.e., hypoxia) and hence did not record it. This is explicable, given that Mrs Panella's actual saturation level itself (absent consideration of the level of supplied oxygen required to maintain the sufficient level) was satisfactory at 94% and that Ms Heywood had focussed her mind on a neurological presentation[42] where oxygen saturation would be less relevant. Professor Kelly's opinion was that Mrs Panella's condition was under-appreciated through triage[43] and that hypoxia should have been identified on the information available.[44] In her oral evidence, without conceding that she was advised of the hypoxia, Ms Heywood conceded that on the basis of the information that I have now found was presented to her, Mrs Panella should properly have been assigned Category 2.[45]

15 The State of South Australia urged me not to make any findings about whether information about hypoxia was handed over or not.[46] This was submitted on the basis that improvements to the process of handing over clinical data between paramedics and triage nurses are being made. In my view, that is not a proper basis to refrain from assessing and weighing the evidence presented in order to reach a conclusion about particular circumstances in the lead up to Mrs Panella's death. Whether a systemic issue was at play, or whether improvements are likely to ensure the circumstance does not arise again, are not factors which carry any weight in assessing what was established by the evidence.

16 I find that on the information handed over Mrs Panella ought to have been assigned Category 2. It is unknown what the practical effect of a higher Category would have been, except that higher priority patients are generally brought in earlier. In any event, Mrs Panella waited on the ramp. Mr McInerney took another set of observations upon returning to the ambulance after triage. Throughout the wait, Mrs Panella continued to indicate that she was not short of breath.[47] Professor Kelly's opinion was that the

---

[38] T264.15; Exhibit C25 at [19]; Exhibit C25d at 7
[39] T268.27, T269.1, T269.7, T377.2
[40] T126.20, T127.12
[41] By virtue of referring to a character played by Dustin Hoffman in the 1988 film 'Rain Man' who is a savant, T147.13
[42] T265.27, T376.28
[43] Exhibit C49a at 10-11; T2030.19
[44] T2121.34
[45] T359.30-T361.20; Exhibit C25f
[46] Written submissions of the State of South Australia dated 28 March 2025 at [11.4.3]
[47] T188.15

concerning part about Mrs Panella's condition during this time was the increasing need for oxygen in order to maintain satisfactory saturation.[48]

17 At around 11:10pm, Mr McInerney took a further set of vital sign observations.[49] He noted that Mrs Panella's condition had suddenly begun to rapidly deteriorate. Her breathing became worse. Her skin became clammy. Mr McInerney asked Ms Carter to notify triage and to request immediate access to the Department while he remained alone with Mrs Panella.[50] Ms Heywood was brought to the ambulance by Ms Carter at 11:11pm.[51] She observed Mrs Panella for about 30 seconds,[52] noting her to be relaxing. This was the first occasion anyone from the hospital had seen Mrs Panella personally. At 11:16pm, Mrs Panella's condition deteriorated. Ms Carter went inside but struggled to find Ms Heywood who was outside visiting another patient on the ramp.[53] She was found and returned to the ambulance to visit Mrs Panella again at 11:18pm. In the meantime, Mr McInerney increased Mrs Panella's oxygen and began to sit her upright. As he was doing this, Mrs Panella said she could not breathe. Mr McInerney noted that her work of breathing had increased and her saturation had decreased to 89%, still with four litres per minute of oxygen being supplied. Ms Heywood said that her view of Mrs Panella was obstructed and the lights were off, but she could see that she had an increased rate of breathing with increased effort and was restless.[54] Ms Heywood directed the paramedics to bring Mrs Panella inside and upgraded Mrs Panella's triage Category to 2.[55] The offload process saw Mrs Panella wheeled into the Department at 11:21pm.[56] Ms Heywood called a 'medical resus' which had the effect of immediately assembling a team of medical professionals to assist Mrs Panella.[57]

18 A registrar on duty, Dr Sean Jolly, received Mrs Panella at 11:30pm in Resuscitation, 50 minutes after she had arrived at hospital. He described her as being 'in respiratory extremis' at that point.[58] About 10 minutes later, Mrs Panella suffered a respiratory, then cardiac, arrest.[59] Ms Heywood called for assistance over the PA system.[60] A Medical Emergency Team[61] assembled, consisting of an Emergency Department Consultant, a circulation doctor and an airway doctor.[62] Another doctor and consultant also assisted.

19 Mrs Panella's oxygen saturation had now dropped to 75%. She was given high flow oxygen with CPAP. CPR was commenced at 11:42pm following the loss of cardiac output. At 11:47pm, a shockable rhythm was found and Mrs Panella was delivered a shock.[63] She had a return of spontaneous circulation at 11:50pm and was intubated by the airway doctor at 11:55pm. She then became bradycardic with her heart rate dropping to

---

[48] T2030.29
[49] Exhibit C23 at [70]
[50] Exhibit C23 at [71]
[51] CCTV footage in Exhibit C6b (as agreed in Exhibit C52)
[52] T83.37; CCTV footage in Exhibit C6b (as agreed in Exhibit C52)
[53] T193.16, T197.23
[54] Exhibit C25 at [21] and [24]
[55] Exhibit C25 at [25]
[56] CCTV footage in Exhibit C6b (as agreed in Exhibit C52)
[57] Exhibit C25 at [24]
[58] T487.33
[59] Exhibit C29a at [7]
[60] T247.13
[61] MET
[62] Exhibit C29b at [3]
[63] Exhibit C29b at [4]

15 beats per minute. She was given adrenaline but lost cardiac output again. CPR was recommenced and she had another return of spontaneous circulation at two minutes past midnight.[64]

20 Throughout the next 40 minutes, Mrs Panella went in and out of cardiac arrest.[65] She was given adrenaline and noradrenaline. She had a final cardiac arrest at 12:38am. At this point, given her condition and the lack of response to efforts, CPR was not recommenced. Mrs Panella was pronounced life extinct at 12:39am on 28 April 2019.[66] Professor Kelly's view was that, with the exception of the under-appreciation at triage, both paramedics and hospital staff gave Mrs Panella adequate care in the circumstances they faced,[67] putting aside the obvious unsatisfactory delay which was out of their hands.

21 A post-mortem examination by forensic pathologist, Dr Karen Heath of Forensic Science SA,[68] revealed that Mrs Panella had extensive bilateral pulmonary emboli and a left-calf deep vein thrombosis. In Dr Heath's opinion, Mrs Panella therefore died of pulmonary thromboembolism due to left calf deep vein thrombosis.[69]

22 Paramedics conducted a reflective review in respect of the case.[70] A formal adverse incident review was conducted by SA Health into Mrs Panella's death.[71] None of the clinicians who provided care to Mrs Panella were involved in this review.[72]

23 Dr Jolly said that treatment for pulmonary embolism must be commenced as soon as possible.[73] Professor Kelly concluded that Mrs Panella's death was not preventable in the circumstances in which it occurred.[74] That is, even if Mrs Panella had been directly admitted to the Department upon arrival, the usual timeframes involved in testing and detecting her condition, then commencing treatment, would not have seen her treatment actually commence before her deterioration and death.[75] Time was likely to have been needed to reach a diagnosis, particularly in light of the fact that Mrs Panella's presentation was atypical.[76] In accordance with Professor Kelly's explanation of the clinical scenario, I find that Mrs Panella's death was not preventable. The delay in Mrs Panella's entry to hospital did not bring about her death. However, Professor Kelly pointed out that this outcome would not necessarily be inevitable in another case for another patient whose condition is not so advanced.[77] I observe that while her death was not preventable, the circumstances in which it occurred were far less dignified than Mrs Panella deserved.

24 I find that Mrs Panella's death was caused by pulmonary thromboembolism due to left calf deep vein thrombosis.

---

[64] Exhibit C29b at [4]
[65] Exhibit C29b at [4]
[66] Exhibit C29b at [5]
[67] Exhibit C49a at 10; T2030.9, T2031.5
[68] FSSA
[69] DVT; Exhibit C2 at 2
[70] Exhibit C15 at 12
[71] Exhibit C24
[72] T230.18, T381.5, T634.36
[73] T511.22
[74] Exhibit C49a at 12-13; T2032.4
[75] T2122.8
[76] Exhibit C49a at 13
[77] Exhibit C49a at 13

Mr Skeffington

25 Bernard Skeffington was born on 3 May 1932. He migrated from Ireland at 18 years of age.[78] He worked across Western Australia in the mining industry until he was injured in an explosion and was brought to Adelaide for treatment. He met his wife and remained in South Australia. He was employed at General Motors Holden and worked his way up in the company. After retiring, he particularly enjoyed spending time with his children, grandchildren and great-grandchildren. In 2021, he was 89 years old. He lived in a retirement village at North Plympton with his wife. He suffered from ischaemic heart disease and had previously had a heart attack resulting in a stent insertion. He had atrial fibrillation which was managed with medication. He was independent; he had his driver's licence. He assisted with charity work and even put bins out for his elderly neighbours. He is yet another successful immigrant to Australia.

26 At 9:53am on Saturday 25 September 2021, Mr Skeffington's wife called an ambulance.[79] She reported that Mr Skeffington had stomach pain and was vomiting. She said that he had previously had a twisted bowel. The request was initially categorised as Priority 5 but was very quickly reviewed internally and upgraded to Priority 3.[80] An ambulance was dispatched from Port Adelaide at 10:04 am, but that did not make it to Mr Skeffington before it was called away to a case of a suspected stroke.[81]

27 An Extended Care Paramedic called Mrs Skeffington back at 10:31am to review the case and determine whether the priority assigned remained appropriate.[82] Mrs Skeffington said that Mr Skeffington had taken an anti-nausea tablet at 8:30am and that his vomiting was now starting to ease. She provided further information that his twisted bowel was about two years earlier, and that Mr Skeffington had opened his bowels that morning with no issue.

28 At 12:06pm, a dispatcher asked the computer system to recommend an ambulance for callout.[83] The system presented 13 options, the nearest being 2.6 km away and the furthest being 8.1 km away. An ambulance was dispatched from Parkside, but that also did not make it before being called away to a patient who was threatening suicide.[84]

29 An Extended Care Paramedic called Mrs Skeffington at 12:29pm to review Mr Skeffington's condition. They advised that the wait time was now 90 minutes. At 12:39pm, another ambulance was dispatched from Fulham which also did not make it to Mr Skeffington before being called away to a patient who was unconscious or had fainted.[85] During a call to Mrs Skeffington at this time, she said that Mr Skeffington had not vomited for a while and that he was sleeping.[86] She said he was tolerating small sips of fluid.

30 At 1:25pm an ambulance was dispatched from the Ashford Hospital which reached Mr Skeffington at 1:36pm, three hours and 43 minutes after being requested by

---

[78] Exhibit C69
[79] Exhibit C17 at 1
[80] Exhibit C17 at 2
[81] Exhibit C17 at 4
[82] Exhibit C17 at 4
[83] Exhibit C17 at 5
[84] Exhibit C65 at 35.2
[85] Exhibit C65 at 35.3
[86] Exhibit C17 at 7

Mrs Skeffington.[87] The paramedics were Stacey White and Erin Pankoke. When they arrived, Mr Skeffington was alert and in bed.[88] He reported pain below the umbilicus, travelling across toward the flanks. His abdomen was noted to be rigid.[89] Physiological observations were taken at the house, and again on departure in the ambulance.[90] Mr Skeffington was given medication for his nausea which eased his dry retching and his pain level.[91] He was able to walk to the stretcher at the end of the path with paramedic support.[92]

31 While paramedics thought that Mr Skeffington required treatment at hospital, they did not consider lights and sirens were necessary and he was transported without, in line with the Priority 3 tasking.[93] I make no criticism of this decision. Mr Skeffington was talkative en route.[94] The ambulance left Mr Skeffington's home at 2:02pm and arrived at the Royal Adelaide Hospital at 2:18pm.

32 SA Health records show that in the hours leading up to and including Mr Skeffington's arrival, the Royal Adelaide Hospital received 9, 10, 7, 20, 14 and 13 cumulative new patients.[95] Of those, 34 arrived by ambulance and the Department went over capacity in the hour of Mr Skeffington's arrival. Dr Katrina Romualdez, Co-Director of the Royal Adelaide Hospital Emergency Department, accessed other data which she considered was more accurate.[96] In that data, 20 presentations were recorded in the same hour Mr Skeffington presented. There were 20 presentations in the hour preceding that, and 22 presentations in the hour previous to that. This represents almost the entire capacity of the Department arriving seeking help in just three hours. Dr Romualdez said that this would challenge any Department and the only possible outcome would be waiting. Triage nurse Sally Araki said that data showing 11 ambulance arrivals in the hour leading up to Mr Skeffington's arrival would practically mean she would be able to do nothing but triage one patient after another.[97]

33 Although it remains unknown, had Mr Skeffington not had to wait so long for ambulance transport to hospital, Dr Romualdez said that he may have been ahead of this crushing demand and may have been seen sooner.[98] The service was obviously busy that day and I do not make any criticism for ambulances being diverted to cases that presented more concerning scenarios. An earlier ambulance appeared to be practically impossible in the circumstances as they existed on the day, evidenced by the multiple attempts at sending one to Mr Skeffington. Although it worked against Mr Skeffington, the continual reassessment of the appropriate use of resources is an important part of the ambulance service. Notwithstanding that, the State of South Australia acknowledged that Mr Skeffington's wait for an ambulance was unacceptable.[99]

---

[87] Exhibit C17a
[88] Exhibit C27 at [16]; T584.28
[89] Exhibit C27 at [25]
[90] Exhibit C27 at [27] and [31]
[91] Exhibit C27 at [28], [29] and [32]
[92] T589.36, T591.33
[93] T590.26
[94] Exhibit C17a
[95] Exhibit C35 at 3
[96] T1507.31, T1628.10, T1629.3
[97] T749.15, T779.18
[98] T1518.12
[99] Written submissions of the State of South Australia dated 28 March 2025 at [18] and [27]

34 When the ambulance did arrive, it had to be parked far away from the Department entrance due to busyness.[100] At 2:24pm, Mr Skeffington was assigned triage Category 4,[101] the target time for treatment being 60 minutes. Professor Kelly said that Category 3 would have been more appropriate.[102] Ms Araki, the triage nurse who conducted Mr Skeffington's triage, explained the reasoning behind the assignment of Category 4 and the comforting factors that were weighed against the concerning factors.[103] In light of the content of the Australasian Triage Education Kit, Ms Araki conceded that Mr Skeffington had features which meant that Category 3 would have been a better classification.[104] Her actual triage of him was limited by the pressures of her workload at the time. Ms Araki explained that she does not necessarily visualise patients being triaged externally unless she has clinical concerns. She considered this normal practice.[105] I find that Mr Skeffington ought to have been assigned triage Category 3 and that Ms Araki's assessment was hampered by the lack of patient visualisation. It will remain unknown whether Mr Skeffington would have been brought into the Department sooner if he had been assigned Category 3, given that the Department was extremely busy.

35 During triage, Ms White inferred that Mr Skeffington had been assigned a lower triage Category and conveyed her concern about him in an effort to 'bump up' his assigned acuity.[106] She said that she did not feel her concern was taken into account.[107] Ms Araki said that she had been reassured by the fact that Mr Skeffington was haemodynamically stable and that he had been given medication.[108] Ms Araki discussed Mr Skeffington's case with another triage nurse, Clarkton Fernandez, during the change of shift.[109]

36 A note was made on the triage record which stated:

> '…The Emergency Department is currently overcrowded and unsafe. Capacity for clinical assessment and care delivery is compromised as a direct consequence of this and may affect this patient. Hospital Executive are aware of the situation.' [110]

Evidence was given that this was an 'acronym expansion' designed to record that the triage had occurred in difficult circumstances.[111]

37 Dr Brooks, who at the relevant time was head of the Royal Adelaide Hospital Emergency Department, gave evidence that, at the time, the Royal Adelaide Hospital was effectively running two Departments; a COVID one and a non-COVID one.[112] There were usually a significant proportion of cubicles occupied by patients who were required to be there because of the inability of anywhere else to provide care to COVID-positive patients, such as patients within quarantine periods who required complex nursing care.[113] This

---

[100] T592.35, T609.23
[101] Exhibit C18 at 108
[102] T2035.7
[103] T773.36
[104] T774.22
[105] Exhibit C32 at [14]
[106] Exhibit C27 at [49]
[107] T633.19
[108] T696.19
[109] Exhibit C31 at [11]
[110] Exhibit C18 at 108
[111] T691.20; Exhibit C32 at [26]
[112] Exhibit C66 at [50]
[113] Exhibit C66 at [51]

was unfortunate, but necessary in extremely unusual times,[114] with only 47.1% of the adult population vaccinated by this date.[115]

38 While waiting, Mr Skeffington was fluctuating between comfortable and distressed.[116] Ms White said that in those episodes, he appeared to be in more distress than his physiological observations revealed.[117] A second dose of anti-nausea medication was administered at 3:10pm.[118] Ms Pankoke went into the Department to speak to the triage nurse about Mr Skeffington looking uncomfortable and becoming increasingly unwell.[119] Mr Fernandez came outside to see Mr Skeffington. At this time, Mr Skeffington had settled and was sitting upright, with his hand across his abdomen, and grimacing,[120] although he was chatty.[121] Mr Fernandez could only see Mr Skeffington from behind and to the side.[122] Mr Fernandez said he would try to bring Mr Skeffington in, but also said that if there was another deterioration, to draw his attention to the situation.[123] Mr Fernandez returned to the hospital to check whether there was any available space in the Department or whether there were any pending discharges. There were not.[124] Mr Skeffington continued to wait. As a result of Mr Fernandez's visit, Mr Skeffington's triage was upgraded to Category 2, processed later at 3:45pm.[125]

39 I should note here that, after receiving various pieces of evidence on the topic, I find that while waiting in the ambulance outside hospital, Mr Skeffington was either not seat belted to the barouche or the seatbelts were loosened.[126] On either situation, this was not a contributing factor to his cause of death. This was appropriate. There were periods when he was noticeably less chatty than he had been previously.[127]

40 While waiting, Mr Skeffington began vomiting again. By this time he was having no periods of being settled.[128] Ms Pankoke said that she thought she was watching him deteriorate in front of her eyes.[129] At 3:40pm, Ms Pankoke again went inside to advise of the situation and escalate the process while Ms White stayed with Mr Skeffington alone.[130] This was an appropriate step to take in the circumstances as they existed at that time. Ms Pankoke's intention was to have Mr Skeffington admitted but needed the triage nurse's permission to bring him in.[131] Back in the ambulance, Mr Skeffington was given more anti-nausea medication which did not assist. Paramedics were not able to give Mr Skeffington any further antiemesis treatment within their scope of practice at the

---

[114] Exhibit C11 at 90
[115] Exhibit C12
[116] Exhibit C27 at [52]
[117] T424.32
[118] Exhibit C17a; Exhibit C27 at [55]
[119] Exhibit C27 at [57]
[120] Exhibit C31 at [15]
[121] Exhibit C27 at [58]
[122] Exhibit C31 at [15]
[123] Exhibit C27 at [58]
[124] Exhibit C31 at [19]; T649.6
[125] Exhibit C18 at 108; T651.19
[126] Exhibit C27a at [15]-[16], [19] and [23]; T634.33, T837.32
[127] T594.24
[128] Exhibit C27 at [60]
[129] T599.26
[130] Exhibit C27 at [61]
[131] T599.20, T618.18, acknowledging that if Mr Skeffington's condition had been worse, they could have brought him directly in without seeking permission

time.[132] Mr Fernandez says that Ms Pankoke rushed into the Department and that he told her to bring Mr Skeffington in.[133]

41 While Ms White was alone with Mr Skeffington, he had an explosive vomit, which she thought to be faecal vomit.[134] He became unresponsive and rigid. He became bradycardic. Ms White struggled to sit him forward to prevent aspiration.[135] She could not feel a radial pulse but found a carotid pulse.[136] Ms White struggled to reach the radio to contact Ms Pankoke. She sought help by banging on the ambulance windows.[137] She gave harrowing evidence about the impact this experience had on her. After hearing this evidence, I formed a strong view that measures must be taken to minimise the risk of this situation happening again. A paramedic from another ambulance, also waiting on the ramp, came to assist. They began unloading Mr Skeffington to take him inside.[138] Ms Pankoke was exiting the Department when she encountered Ms White bringing Mr Skeffington in.

42 Mr Skeffington was taken into the Department at 3:48pm after an unload process of a couple of minutes.[139] Transfer of care was achieved at 4:01pm; one hour and 43 minutes after arriving at hospital. By that time, he was noted to have a blue/grey appearance.[140] He was not conscious.[141] The paramedics advised that they were confident Mr Skeffington had aspirated. His oxygen saturation was at 70% and his pulse was weak. He was now in peri-arrest. He was taken directly to the resuscitation area.[142]

43 Mr Skeffington was given oxygen at 15 litres per minute. His colour improved over the next 30 minutes, but he deteriorated when the oxygen was reduced.[143] After he had been stabilised, he experienced another episode of vomiting and a nasogastric tube was inserted to drain the contents of his stomach.[144]

44 Mr Skeffington was diagnosed with a small bowel obstruction, however his primary issue became the aspiration consequent upon vomiting. A CT scan revealed bilateral pulmonary infiltrates.[145] The following day, Mr Skeffington developed a strong cough. His breathing was wheezy. He continued on high-flow oxygen.[146] By the morning of 27 September 2021, Mr Skeffington's small bowel obstruction had resolved.[147] His respiratory issues continued. His airways began to suffer trauma from coughing. During the night of 29 September 2021, Mr Skeffington had worsening respiratory failure and needed 90% supplied oxygen at 50 litres per minute at times.[148] On 30 September 2021, Mr Skeffington reached the maximum level of respiratory support. Medical staff had a

[132] T447.20
[133] Exhibit C31 at [21]
[134] Exhibit C27 at [63]
[135] Exhibit C27 at [63]
[136] T462.20
[137] Exhibit C27 at [63]; T427.33
[138] Exhibit C27 at [64]
[139] T401.32
[140] Exhibit C18 at 110
[141] Exhibit C31 at [21]; T652.15
[142] T603.9
[143] Exhibit C18 at 114
[144] T555.12, T555.31
[145] Exhibit C18 at 122
[146] Exhibit C18 at 135 and 141
[147] Exhibit C18 at 153
[148] Exhibit C18 at [76]

conversation with him, advising him that if he worsened from that point, it would indicate he was dying.[149] This was particularly upsetting for Mr Skeffington's family.[150] Mr Skeffington said he would 'push on'.

45 By early afternoon he was recorded to have continued to deteriorate. Later in the afternoon he reported feeling exhausted. He was tachypneic and uncomfortable. He decided to transition to comfort care.[151] He was transitioned to medications to alleviate his distress and died within a couple of hours.[152]

46 A pathology review by Dr Alexandra Yuill of FSSA concluded that Mr Skeffington's death was brought about by aspiration pneumonia secondary to small bowel obstruction.[153] I accept Dr Yuill's conclusion and make a finding acordingly.

47 An adverse incident review was conducted into Mr Skeffington's death at the program-level, involving multiple specialities.[154] The review documents, as well as evidence from most clinicians, established that none of the clinicians who directly provided care to Mr Skeffington were involved in the review,[155] although they may have been 'debriefed' by those actually involved in the review. Dr Brooks requested that a cluster event be declared in order to better understand the systemic issues involved in Mr Skeffington's death alongside others who had died after being ramped.[156] This was declined by the then-management of the Central Adelaide Local Health Network which administers the Royal Adelaide Hospital. It is unclear what this might have specifically achieved given that the review conducted did span multiple cases, although a formal 'cluster review' would have drawn in the Safety and Quality Unit of the Department for Health and Wellbeing.[157]

48 Professor Kelly's opinion was that the care provided to Mr Skeffington, including the way in which his aspiration event was managed, was the best that could be achieved in the circumstances.[158]

49 Professor Kelly's opinion was that, had Mr Skeffington had measures to reduce his risk of aspiration such as the timely insertion of a nasogastric tube to remove potential aspiration material, his death would likely have been prevented.[159] She said that Mr Skeffington's condition was not life-threatening prior to the aspiration event. Dr Eve Hopping, who treated Mr Skeffington, agreed.[160] She said that conservative management would have been preferred[161] and that intensive care would not have been required if Mr Skeffington had not aspirated.[162] Dr Hopping cautioned that it is not possible to be absolutely certain of avoiding that, given that a person with a bowel obstruction can vomit

---

[149] Exhibit C18 at [196]
[150] Exhibit C69
[151] Exhibit C18 at [202]
[152] Exhibit C18 at [203]
[153] Exhibit C8 at 1
[154] T1517.5
[155] T1624.21
[156] T2543.9
[157] Exhibit C47g at 2 and 4
[158] T2034.27
[159] Exhibit C49e at 9 and 10; T2044.19, T2099.18
[160] T564.21, T564.34, T565.7
[161] T551.2
[162] T551.26

at any point. She pointed out that a number of assessments would ideally have been conducted prior to the insertion of a nasogastric tube.[163]

50 The Inquest explored the appropriateness of the insertion of a nasogastric tube early in the care of a patient in Mr Skeffington's condition. The clear evidence of the clinicians was that there are risks with the procedure, and the insertion of a nasogastric tube on a conscious patient is best left for doctors rather than paramedics.[164] Given this evidence, I do not propose to advance a variation for paramedics to be permitted to do this as a realistic proposal for SA Health to consider.

51 Professor Kelly's assessment of the medical care provided by the paramedics was that it was appropriate.[165] Professor Kelly made no criticism of the care Mr Skeffington was afforded once he was able to enter the Department.[166] I find that there is no criticism to be made of the care actually provided to Mr Skeffington by the paramedics and hospital staff.

52 In circumstances where the evidence is that Mr Skeffington's condition was not life-threatening until the aspiration event, that there was a delay in his assessment by doctors, and that a treatment to reduce the risk of aspiration was available, I find on the balance of probabilities that Mr Skeffington's death, caused by aspiration pneumonia secondary to small bowel obstruction, was preventable. I make that assessment based on the timeline of events as I have found that they occurred, including that Mr Skeffington's aspiration event occurred about one hour and 21 minutes after he was triaged. The fact that Mr Skeffington was in the back of an ambulance did not itself bring about his aspiration event, but the fact that he was made to wait without any hospital assessment other than triage allowed it to happen before any treatment was commenced.

53 Mr Skeffington's age and ability of his body to recover from an aspiration event is not relevant to an assessment of whether the aspiration event itself could have been prevented. It is of no moment to observe that a younger healthier patient may have survived notwithstanding experiencing an aspiration event.

54 I consider that it is not speculative to suggest that a nasogastric tube could have been inserted earlier. I consider that if Mr Skeffington had been fully assessed earlier, he would have had the device inserted earlier. I consider that the scenario of Mr Skeffington being taken into the Department, assessed and having a nasogastric tube inserted prior to his aspiration event is not a theoretical possibility, it is a scenario that was open and, if occurred, would likely have prevented his death.

Mr Jessett

55 Graham Jessett was born on 20 September 1957. He lived at Morphett Vale with his wife. He was Type 1 diabetic and had previously had two heart attacks with an AICD implant fitted. He had hypertension, hyperlipidaemia, renal impairment and gout. He had coronary artery disease, congestive cardiac failure, ischaemic heart disease and ischaemic cardiomyopathy. He suffered from chronic pulmonary obstructive disease. Mr Jessett's

---

[163] T566.15
[164] T469.37, T553.9, T2035.25
[165] Exhibit C49e at 10
[166] Exhibit C49e at 10

mother had a history of heart disease and Mr Jessett's brother passed away after a sudden cardiac event. In 2022, Mr Jessett was 64 years old.

56 In mid-February 2022, Mr Jessett was diagnosed with shingles. On 11 March 2022 he tested positive for COVID-19 with a PCR test, which I will discuss in more detail shortly. He had a week of feeling unwell and lethargic, with intermittent nausea and coughing. On 19 March 2022 he was not sure why he was still unwell, and given his complex medical history, his wife called an ambulance. Paramedics had Mr Jessett perform some sit/stand tests and found his respiration rate raised then lowered appropriately afterwards. His oxygen saturation dropped to 97% and then returned to 99% within 30 seconds.

57 Paramedics told Mr Jessett to take paracetamol, drink fluids and to rest. They said he should see his GP to obtain antiemetics for the nausea. They said if there was a worsening of his symptoms, then he should see a GP after 10 days had passed since his COVID test, or otherwise call an ambulance.

58 At 10:48am on Tuesday 22 March 2022, Mr Jessett's wife rang triple zero. She reported that he was full of fluid, was not very lucid, that he looked bad, had chest pain, was pale and clammy, lethargic and not breathing normally. She said that he had previously had a heart attack and had taken his usual medications that day. It was recorded that he had tested positive for COVID in the last 14 days but had been cleared by SA Health.[167] He was assigned a Priority 2 response.

59 An ambulance was dispatched from Morphett Vale at 10:57am and arrived at 11:01am. The crew consisted of paramedic Caitlin Wegener and then-intern paramedic Stuart Gallagher.[168] Ms Wegener read the dispatch information and immediately became concerned that Mr Jessett may have been experiencing a potentially serious cardiac-related event.[169] Upon arrival, Ms Wegener recorded the history 'Has been lethargic [with nausea and vomiting]. Last 2 [days, patient] has had worsening lethargy'.[170] She noted a distended abdomen and mild shortness of breath when Mr Jessett was sitting up. Mr Jessett was able to move himself to the stretcher without any apparent difficulty.[171] He reported being uncomfortable rather than being in pain.[172] In contrast to records held by SA Health, Mr Jessett reported that he had tested COVID-positive by Rapid Antigen Test 10 days prior and did not appear to mention any PCR test, nor the significance of the SA Health clearance.[173] Ms Wegener formed an impression that Mr Jessett may have been experiencing exacerbation of his congestive cardiac failure due to the recent COVID infection.[174] The ambulance left at 11:30am and arrived at Flinders Medical Centre at 11:46am.

60 SA Health data shows that in the hours leading up to and including Mr Jessett's arrival, the Flinders Medical Centre received 6, 5, 15, 15 and 17 cumulative newly arriving patients.[175] Of these, 22 arrived by ambulance. Of all arrivals in those hours, at least

---

[167] Exhibit C19 at 3
[168] Exhibit C37 at [7]
[169] Exhibit C37 at [11]
[170] Exhibit C19a at 1
[171] Exhibit C37 at [29]
[172] Exhibit C37 at [16]
[173] Exhibit C37 at [15]
[174] Exhibit C37 at [30]
[175] Exhibit C36 at 1

16 were assigned triage Category 2, requiring admission within 10 minutes.[176] The Department exceeded its capacity in the hour prior to Mr Jessett arriving. At 1:46pm, a 'Code Yellow' was declared, which records an internal disaster, on this occasion due to the inability to cope with demand which is putting patients at risk.[177] Acting Nursing Director Steven Peck described the data as demonstrating the Department operating at 'absolute capacity'.[178] Co-Head of the Flinders Medical Centre Emergency Department, Dr Matthew Wright, said that his review of the data established that 38 of the 67 treatment spaces in the Department were occupied that day by admitted patients waiting for a bed on the wards.[179] Dr Wright said that the Department was exceptionally busy on this day.[180]

61 The Flinders Medical Centre was operating within a health system that was dealing with 26,431 active cases of COVID on that day.[181]

62 Ms Wegener recalled having to wait to speak to a triage nurse for about 12 minutes,[182] which Dr Wright said suggested that the triage area was busy.[183]

63 At 11:58am, Mr Jessett's case was assigned triage Category 3, that is the 30-minute category. He waited in the ambulance outside the hospital. A COVID assessment indicated 'no' to all symptoms except fatigue.[184] It recorded an onset date of 13 March 2022 and noted 'COVID Day 9'. The triage nurse, Mariah Crowther, noted the history of congestive cardiac failure and of his symptoms. She noted that Mr Jessett's observations were within normal ranges. Ms Crowther was not able to visit Mr Jessett in the ambulance.[185] Mr Jessett's details were entered onto an 'offload log' which was used to monitor the number of patients on the ramp.[186] Ms Crowther checked with the shift coordinator, Mr Peck, about Mr Jessett's isolation requirement and this was confirmed.[187]

64 The manner in which Mr Jessett's COVID condition was dealt with was unfortunate. The ambulance dispatch system recorded that Mr Jessett had been cleared by SA Health in relation to COVID.[188] The significance of this is unclear. It is also unclear whether this text would have appeared on the mobile data terminal in the ambulance. In any event, the paramedics did not see it and they acted on what Mr Jessett said himself.[189] Given that it cannot clearly be said that they were presented this fact, I do not criticise them for acting on what Mr Jessett told them, nor for not querying his self-reported test date further. I accept that it is not their role to double-check everything they are told by a patient. In any event, the self-reported date of his positive test was then relayed by the paramedic to the triage nurse. This was again taken at face value.[190] It was wrong. I am satisfied it was wrong because clear medical records of a specialist COVID clinic

---

[176] Exhibit C45 at Annexure MDW2
[177] Exhibit C39 at [40]; Exhibit C45 at [26]
[178] T1366.5, T1371.2
[179] T1657.33
[180] Exhibit C45 at [26]
[181] Exhibit C13
[182] T803.2
[183] Exhibit C45 at [5]
[184] Although mild shortness of breath was also recorded at the time
[185] Exhibit C37 at [41]
[186] Exhibit C39 at [23] and [31]; Exhibit C39b; T1074.30
[187] T1309.36, T1342.5, although Mr Peck could not recall this occurring
[188] Exhibit C19 at 3
[189] T843.22, T889.20
[190] T1341.35

establish the date of Mr Jessett's COVID test by PCR. These are precisely the details that I would expect a COVID clinic to record reliably; it was their very role at the time and I observe the seriousness with which COVID clinicians carried out their roles. It also fits with the fact that SA Health issued some form of 'clearance', indicating the passage of a critical timeframe, such as an isolation period which was in force from time to time during the pandemic. I note Professor Kelly's evidence that confusion was a symptom Mr Jessett would have experienced.[191] I am therefore faced with an official record of a specialist clinic on the one hand and the self-report of a man experiencing confusion (who provided a date which is repeated in multiple places, but coming from the same source) on the other. I am prepared to rely upon the clinic record as an accurate reflection of Mr Jessett's test date and method of testing. The unfortunate aspect is therefore that if a simple search of Mr Jessett's medical history, held electronically by SA Health, had been conducted, it would have revealed his attendance at the Flinders Medical Centre's COVID Care Clinic on 14 March 2022 where it was recorded that he had a positive PCR test on 11 March 2022.[192] This information was readily available on the Sunrise system used by the Department.[193] There was a practice of looking at recent COVID test results, but only sometimes.[194]

65 Given how busy a triage nurse is, I do not criticise the triage nurse for not conducting a search of Mr Jessett's history to verify the clear information that had been handed over. It is for this reason that I have concluded that the manner in which the COVID condition was dealt with was unfortunate for Mr Jessett and not anything more serious. It was unfortunate, for example, that he had not been more vague or uncertain about his test date which might have brought about further investigation and potentially revealed the earlier date, prompting further enquiry. My finding that this circumstance was unfortunate is a reflection of the manner in which the scenario played out, not a reflection on the decisions of those involved or the reasons for their actions. I consider that a series of events can be within protocols and procedures and nonetheless unfortunate. That is where this circumstance sits.

66 The Court heard evidence about differing ways of calculating COVID timeframes. It can be charted as follows:

Date	Scenario A	Scenario B
11 March 2022 – *Positive PCR*	Day 0	Day 1
12 March	Day 1	Day 2
13 March	Day 2	Day 3
14 March	Day 3	Day 4
15 March	Day 4	Day 5
16 March	Day 5	Day 6
17 March	Day 6	Day 7
18 March	Day 7	Day 8

[191] T2059.6
[192] Exhibit C21 at 71
[193] T1341.23
[194] T1341.25

Date	Scenario A	Scenario B
19 March	Day 8	Day 9
20 March	Day 9	Day 10
21 March	Day 10	Day 11
22 March	Day 11	Day 12

67 As this chart makes clear, if Mr Jessett's true COVID PCR result date was known, he might not have been earmarked as requiring COVID positive precautions, which as I will explain below, only applied within 10 days. The result being that there would have been more options for his admission to the Department, instead of, in effect, only one appropriate cubicle potentially being available that could accommodate him. This might have seen him enter the Department earlier,[195] or might at least have presented more options to be considered for his placement. Mr Peck conceded that there was a possibility that earlier entry might have been facilitated.[196] It might have had no impact at all, and I heard evidence of the opinions of the clinicians involved that Mr Jessett's COVID status did not actually deny him earlier entry. I have merely observed that more options may or may not have been beneficial. Knowing that he was further along in his COVID journey, or that SA Health had issued him a 'clearance', might have had the potential for the Department not to have been so strict about him requiring isolation. It will never be known what shuffles might have been considered appropriate if isolation was not considered mandatory.

68 It was suggested in evidence and submissions that COVID measures at the time might have been applied only within a period of 14 days, however that evidence was given with hesitation,[197] and without any specific supporting documentation.[198] It is contrary to the effect of the clear note made on the offload log. There was criticism of that note because the author of it is unidentified. In my view, the author of the note is less important than the clear import of it, combined with the fact that a person saw fit to specifically record that he was within that period. That is what Ms Crowther who was using the offload log on that day interpreted the note to mean in her evidence.[199] One of the procedural documents tendered were not of direct application to patients arriving at the Department.[200] In respect of the other, it provided no isolation timeframe and the evidence was it was not followed in any event.[201] I observe that COVID procedures changed often. It is therefore unsurprising that a formal document may not have been drafted for a specific timeframe within which to deal with COVID positive patients in the Department. I observe that isolation timeframes reduced over time through the pandemic and that Mr Jessett's presentation was about two years after a biosecurity emergency was declared by the Australian Government,[202] and only seven months before all isolation requirements were removed entirely.[203]

---

[195] T1426.16
[196] T1426.13
[197] For example, T1161.7, T1330.29, T1338.20
[198] Exhibit C41 at [17]; T1395.17
[199] T1309.11
[200] Exhibit C41g
[201] Exhibit C41f; T1447.5
[202] Exhibit C11 at 82
[203] Exhibit C11 at 83

69 In the Chief Public Health Officer's report dated June 2022, Professor Spurrier explained that when the Omicron wave commenced in January/February 2022, the eastern states moved to a seven day isolation period with South Australia '…continuing with a 10 day isolation period…'.[204] Mr Peck gave evidence that the Department was essentially following the State's advice.[205]

70 In the end, I consider that the clear picture of what regime was in place emerges from a combination of all of the evidence. This includes the Chief Public Health Officer's report, the handwritten note on the offload log,[206] which a staff member with access to the offload log has gone to the effort to record, combined with the fact that SA Health had issued some form of COVID 'clearance' which, whatever its full nature was, fits neatly with the end of a mandatory isolation period having been reached, as well as the fact that the paramedics who initially visited Mr Jessett on 19 March 2022 advised him to visit his GP 10 days after testing.[207] I consider that, on the balance of probabilities, the health system was operating on a 10 day isolation regime at the time of Mr Jessett's presentation. If that was not the case, what cause would a person have for writing 'Day 9 COVID ISO' and 'Reason: In High Risk 10 days' on the offload log? What reason would SA Health have to issue a COVID clearance? Why would paramedics advise Mr Jessett to visit his GP 10 days following his test? Evidence of general COVID practices which changed over time was not sufficient to persuade me that the clear handwritten note was based on a regime that was not in force at the time. Once again, this is not something for any person to be criticised for, it is simply part of the unfortunate circumstances that Mr Jessett found himself in on that day.

71 Another unfortunate event was that Ms Wegener was not advised that Mr Jessett had been marked as requiring a negative pressure room.[208] If that had been advised, it might have prompted further thought about the cause of the delay and potentially prompted further enquiries of Mr Jessett himself about his actual test date. Again, this may not have had any impact on his entry to the hospital and is not something that I criticise any individual clinician for in the circumstances.

72 The triage nurse who assessed Mr Jessett's case, Ms Crowther, was new to the triage role.[209] She was being supervised by, and ran her assessment of Mr Jessett past, Nurse Educator Jessica Toohey, who was supporting her through the shift.[210] Ms Toohey reviewed Mr Jessett's records in preparation for the Inquest. Her opinion was that it would have been prudent for Ms Crowther to have made a record of Mr Jessett's diabetic status in the triage note, and that he suffered from chronic obstructive pulmonary disorder, but that these things would not have altered the appropriate triage score for his condition.[211] It is unclear whether these conditions were conveyed to Ms Crowther. Ms Wegener believes she did.[212] Professor Kelly's view was that Ms Crowther should have undertaken an in-person assessment of Mr Jessett, then regular reassessments where

---

[204] Exhibit C11 at 88
[205] T1425.8
[206] Exhibit C39b
[207] Exhibit C21 at 51
[208] T844.1
[209] T1080.6, T1128.36, T1301.31
[210] Exhibit C39 at [12] and [20]
[211] Exhibit C39 at [28]-[29]
[212] T815.38

indicated, but that the triage score assigned was reasonable.[213] Ms Crowther assessed records of Mr Jessett's actual health status while giving evidence and said that she could not recall being advised that he had Type 1 diabetes, that he had had a prior heart attack and that he suffered chronic obstructive pulmonary disorder, although she accepted that it was possible that some of these things were told to her.[214] It is possible that she may not have appreciated the combined significance of these conditions which led to her not recording them. I find that, on the balance of probabilities, Mr Jessett's diabetic status and his chronic obstructive pulmonary disorder were handed over to her but not recorded. She said on the basis of an assessment of the complete picture (without the pressures of the Department that were occurring on the day) she would have assigned Mr Jessett triage Category 2.[215] Ms Toohey said that Ms Crowther was largely operating on her own. I do not consider it likely that Ms Toohey would have disagreed with an assignment of Category 2 if the full circumstances were known to both Ms Crowther and Ms Toohey. That is, I consider it unlikely that she would have 'downgraded' Ms Crowther's assessment if it had been made in that manner in the first place when Ms Crowther had progressed to an independent level.[216] I find that Mr Jessett should have been assigned triage Category 2. It is unclear whether this would have made any practical difference, given that Mr Jessett had been identified as requiring isolation, something hard to achieve at the Flinders Medical Centre. It was a requirement that was not flexible depending on Category.[217] Indeed, it might have made no practical difference. A resuscitation room might have been considered appropriate,[218] although capacity is required to be kept available in this area because of the Flinders Medical Centre's designation as a Level 1 Trauma Centre.[219] In any event, consideration of these potential options was not made because Mr Jessett's true COVID test date was not known to anyone involved in his care.

73 While waiting on the ramp, Mr Jessett had a sudden onset of epigastric pain.[220] He was able to get some relief by sitting up and belching.[221] Ms Wegener left Mr Jessett in Mr Gallagher's care and entered the hospital to report this to the triage nurse on shift at the time, Danielle Weston.[222] Ms Weston did not visit Mr Jessett,[223] but noted on his record that the ECG continued to be 'OK'.[224] He was given paracetamol at 1pm and did not complain of any further pain.

74 At 3pm, Ms Wegener recorded a further set of physiological observations which were generally normal.[225] Ms Wegener then turned the cardiac monitor off as Mr Jessett had been stable for three and a half hours and she wanted to allow him to be more comfortable on the stretcher.[226] In the circumstances, I find that this was a reasonable action.

---

[213] Exhibit C49g at 11; T2048.2
[214] T1327.33, T1329.27
[215] T1327.28, T1328.2, T1328.12, T1329.15, T1330.6, T1343.13
[216] T1080.14
[217] T1369.29
[218] T1419.19
[219] T1715.33
[220] Exhibit C37 at [45]
[221] T879.29
[222] Exhibit C37 at [46]
[223] Exhibit C37 at [48]
[224] Exhibit C21 at 36
[225] Exhibit C37 at [50]
[226] Exhibit C37 at [51]

75 While waiting, one patient also on the ramp was transferred to the waiting room.[227] No other patient was taken from the ramp into the Department.[228]

76 As I have said above, there was only one cubicle in the entire Flinders Medical Centre Emergency Department that was suitable and likely to become available to accommodate Mr Jessett upon his arrival due to his COVID-positive status; cubicle South-16.[229] South-16 was occupied at the commencement of Mr Jessett's wait by a patient who had died and was waiting for family to visit.[230] Shortly after Mr Jessett's arrival, a patient was placed in the cubicle who had sudden onset shortness of breath with crackles audible and a fast respiratory rate of 36 with a low oxygen saturation level, requiring eight litres of oxygen per minute using CPAP. Over the hours that Mr Jessett waited, this patient was able to be weaned to nasal specs and was moved to a ward (via another cubicle) about eight minutes prior to Mr Jessett's entry to the Department.[231] Another space which would potentially have been appropriate, South-01, had been occupied since 11am by a suspected COVID-positive patient who had a fever and shortness of breath with low oxygen saturation.[232]

77 On the face of the respective conditions as they were known at the time, these other patients appeared to be more urgent than Mr Jessett. I find that no criticism can be made of treating those patients while Mr Jessett waited.

78 At about 4:47pm, paramedics were advised that Mr Jessett could be brought into the Department.[233] They wheeled him from the ambulance into the Department.[234] They asked him whether he would be comfortable taking a few steps himself to get onto the hospital bed and he agreed.

79 When Mr Jessett was transferring, he became unsteady.[235] When he sat down, he collapsed onto the bed and went into cardiac arrest. CPR was commenced immediately. Mr Jessett was transferred into a negative pressure room at 4:50pm and CPR continued. A Medical Emergency Team was assembled. Mr Jessett had a return of spontaneous circulation after two minutes. He was intubated at 5:05pm. At 5:22pm, Mr Jessett's oxygen saturation worsened and he was found to have no carotid pulse. CPR was recommenced. He was given seven shots of adrenaline along with amiodarone while CPR continued for more than 45 minutes. Dr Joel Xiao, who participated in the resuscitation effort, said that Mr Jessett's comorbidities made resuscitation more difficult because he had a lower baseline functioning.[236]

80 At 6pm Mr Jessett was found to have non-shockable rhythm and the decision was made to cease resuscitation efforts. He was then declared life extinct.[237]

---

[227] Exhibit C39 at [41]
[228] T1078.28, T1092.27, T1125.26, T1153.18
[229] Exhibit C41 at [18]
[230] Exhibit C41a, T1359.3
[231] Exhibit C41a; T1359.34, T1428.5, T1360.21
[232] Exhibit C41a
[233] Exhibit C37 at [53]
[234] T797.30, T881.27
[235] Exhibit C37 at [54]
[236] T1017.38
[237] Exhibit C21 at 57

81 Professor Roger Byard AC of FSSA conducted a post-mortem examination and concluded that Mr Jessett's death had resulted from ischaemic heart disease with cardiomegaly.[238] He found that there had been a narrowing of all three major epicardial coronary arteries. Professor Kelly gave evidence that hyperkalaemia played a role in Mr Jessett's death.[239] Professor Byard explained that hyperkalaemia is not something that is detected during post-mortem procedures, but he agreed that Mr Jessett's blood test results in the Department suggest he was in a state of hyperkalaemia. Professor Byard was prepared to modify his medical advice about Mr Jessett's cause of death to include hyperkalaemia as a contributing factor.[240]

82 The role of Mr Jessett's diabetes was explored during the Inquest. Professor Kelly explained that a person with poorly managed diabetes will be at increased risk of diabetic ketoacidosis.[241] This occurs because of the use of fat cells for energy rather than glucose, causing the production of ketones which make the blood acidic. If insulin is administered, it moves sugar inside the body's cells and takes potassium with it, which can reduce hyperkalaemia,[242] hence reducing the risk of arrhythmia. Dr Xiao said that Mr Jessett had an abnormally high potassium reading which was potentially the result of Mr Jessett's underlying kidney impairment.[243] Professor Kelly agreed that it is unknown whether Mr Jessett's abnormal blood results were the consequence of diabetic ketoacidosis, or merely an exacerbation of diabetes due to illness and worsening renal function but without diabetic ketoacidosis. Professor Kelly also explained that confusion is caused by diabetic ketoacidosis which would have confounded the proper self-administration of insulin.[244]

83 Ultimately, Professor Kelly's opinion was that if Mr Jessett's insulin level was appropriate on the basis he had taken or been administered a correct amount of insulin for his state, it would have slightly decreased his potassium level which would have put him at lesser risk of arrhythmia due to hyperkalaemia, but it was unlikely to have made enough of a difference to have prevented his death.[245]

84 Evidence from Mr Lemmer established that paramedics are trained to ask patients about whether they need to bring insulin.[246] Professor Kelly considered that the administration of insulin to patients who are unwell carries with it significant risks which can only really be weighed and assessed by a doctor who has a full suite of blood tests.[247] Mr Lemmer agreed.[248] If a recommendation was made that paramedics be trained in administering insulin, there is a risk of causing deaths unintentionally. On the basis of that, while diabetes may have played a role in Mr Jessett's death, I will not make any recommendations regarding it.

85 An adverse incident review was conducted into Mr Jessett's death. None of the clinicians who provided care to Mr Jessett were involved in the review,[249] although again they may

---

[238] Exhibit C9 at 1
[239] T2107.33
[240] T2570.34
[241] T2058.35
[242] T2059.30
[243] T1007.15, T1017.29
[244] Exhibit C49h at 7
[245] Exhibit C49h at 7; T2059.30, T2060.10, T2100.33
[246] T2466.26
[247] T2061.36, T2063.6
[248] Exhibit C65 at [41]
[249] T847.35, T884.18, T1019.8, T1031.6

have been 'debriefed'. Ms Toohey was involved. The review queried Mr Jessett's venous blood gas results on the basis that they may have been haemolysed. A corrected potassium level was calculated. A review of Mr Jessett's results shows that there was a blood sample that was haemolysed, but others that were not, with consistent potassium levels across tests, suggesting that the concerning results were correct.[250] Professor Kelly said that the conclusion in the report was 'ill informed'[251] and that there was no basis for calculating a corrected potassium level.

86 A further review was conducted by the Clinical Review Committee, with recommendations for improvement being made on 1 September 2023.[252] The recommendations were:

a. develop a protocol to govern the frequency of physiological observations to be performed by paramedics;

b. introduce point-of-care testing to be used by the ambulance service;

c. mandate visualisation as part of triage;

d. prioritise the use of resources to reduce ramping and improve flow; and

e. work with the ambulance service to front load care for selected patients.

The State of South Australia indicated that many of the recommendations were, or are still being, pursued.[253]

87 Professor Kelly's assessment was that the care provided to Mr Jessett by paramedics on the ramp was reasonable and consistent with their scope of practice.[254] She considered that the care provided to Mr Jessett once he was inside the hospital was reasonable and appropriate.[255] I find that there is no criticism to be made of the medical care actually afforded to Mr Jessett by paramedics and hospital staff.

88 Professor Kelly's view was that Mr Jessett's death would potentially have been prevented if his hyperkalaemia had been identified earlier.[256] Dr Wright agreed that Mr Jessett's hyperkalaemia could have been reversed.[257] Professor Kelly pointed out that hyperkalaemia is rarely associated with symptoms, but can lead to cardiac rhythm disturbances which can be fatal.[258] Dr Xiao gave evidence of treatments available in the hospital that would have reversed Mr Jessett's hyperkalaemia, some which were actually given, but too late to be effective.[259] Professor Kelly explained how hyperkalaemia can be reversed in minutes and how the heart can be protected from arrhythmias during that process.[260] It was not suggested that these treatments are not available until the underlying

---

[250] T2051.36
[251] T2052.12
[252] Exhibit C45 Annexure MDW1
[253] Written submissions of the State of South Australia dated 28 March 2025 at [29.9.4]
[254] Exhibit C49g at 11; T2047.29
[255] T2048.7
[256] Exhibit C49g at 12; T2064.15, T2066.26
[257] T1672.23
[258] Exhibit C49g at 12; T2106.24
[259] T1029.15, T1020.6
[260] T2066.11

cause of the hyperkalaemia is known and so I am not required to be certain of that cause in order to conclude that treatment would have assisted him to avoid death.

89 I find that Mr Jessett's cause of death was ischaemic heart disease with cardiomegaly complicated by hyperkalaemia. It was potentially preventable. I am not limited to making findings of preventability only where things could be done within present practices or policies. I consider that it is not appropriate to conclude that Mr Jessett's death was not preventable because, for example, there was no policy in place at the time to take blood samples from a patient on the ramp or other practices and procedures in place which might have identified the seriousness of his condition sooner, or that resourcing and infrastructure did not allow for more patients to be taken into the Department that day. This Court frequently explores issues of policies which, while correctly followed, lead to death. The Court is not bound to find these deaths not preventable because a policy did not facilitate the steps required. So it is that I am not bound to find that Mr Jessett's death was not preventable because there was no isolation space available in the Department, or because there was no policy of taking blood samples early in a patient's journey.

90 Further, I am not introducing innovative or novel approaches to medicine which did not exist at the time; I am confronted with the possibility of a simple blood test being used to detect a serious health issue invisible to observers. I acknowledge that Mr Jessett faced a number of difficulties with his health and that the picture of his prognosis is not perfectly clear. However, I consider that removal of a key factor which is known to contribute to arrhythmia and cardiac arrest[261] would at least potentially have prevented his death. I am not required to be satisfied that Mr Jessett was guaranteed to survive in order to make a finding of this nature.

The Inquest

Breadth

91 The Court heard a broad and comprehensive body of evidence which explored the depth of the ramping issue. An enquiry of that depth was necessary in order to ensure that I had a full grasp of the factors at play and to ensure that any avenues which might present a simple fix could be revealed. There were no such avenues identified. In fact, the scope of the ramping issue presented as much more complex and wide-ranging than appears to be commonly understood in the community.

92 In order to have proper regard to the coronial jurisdiction, I must use the broad evidence I heard to identify the cause and circumstances of the deaths investigated and whether there are any recommendations which might assist to prevent future deaths. With due respect to others who may think otherwise, I believe an aspirational recommendation to end ramping would be unhelpful and do little to comfort the families of Mrs Panella, Mr Skeffington and Mr Jessett, not to mention the families of other people who have died, or have nearly died on the ramp, of which these three South Australians are representatives. I will take into account this effect in a general sense in determining which circumstances are appropriate matters on which to make a recommendation. There is no greater attunement to the true issues and genuine solutions than directly dealing with the loss of these South Australians to their families and friends. I will also take into account

[261] T2100.1

the effect of any recommendations on the health system. My recommendations must be tailored to the issues at hand and what combined to bring about the deaths under examination.

93 Another reason why aspirational recommendations are not called for is that they would add nothing to the enormous effort already put into addressing the ramping issue daily. It is therefore the practical reality of ramping to which I must address my key recommendations.

Witnesses

94 When Counsel Assisting gave his opening address, he said that the tragedy of ramping is that a patient has to sit and wait, at their time of most need, with world class medical equipment just inside the hospital which is full of medical professionals with all of the necessary skills and the best intentions. I would like to focus on that last part. That has been absolutely proven without any doubt in this Inquest. Over the weeks of the clinical evidence, as well as the overarching corporate evidence that followed from witnesses who stand outside the day-to-day stress of providing healthcare, the Court was treated to evidence from a cavalcade of excellent medical professionals. Each, to varying degrees, appeared to care about not only the health system as a whole, but the patients who progress through it each day. Many appeared to care very deeply about the problems posed by ramping. The upper echelons of the South Australian health system were particularly impressive, namely; the Chief Executive of SA Health, Dr Robyn Lawrence, the Commissioner for Excellence and Innovation in Health, Professor Keith McNeil, Co-Director of the Flinders Medical Centre Emergency Department, Dr Matthew Wright, Co-Director of the Royal Adelaide Hospital Emergency Department, Dr Katrina Romualdez, Clinical Partnerships Lead for the State Health Coordination Centre, Dr Megan Brooks, Southern Adelaide Local Health Network Nurse Educator, Jessica Toohey and Flinders Medical Centre Acting Nursing Director Steven Peck.

95 Each of the clinicians involved who gave evidence attended with clear goodwill, sharing their involvement in these cases and their wider work in order to assist me to gain a full understanding of the issues. Many witnesses spoke about a high level of goodwill in the health sector toward dealing with ramping. That was evident amongst the witnesses who presented their evidence.

96 An issue that I will therefore not spend time on is assessing the credibility of witnesses. I heard oral evidence from 24 witnesses and received affidavits from others. I find that each was credible and gave largely reliable evidence. In fact, I was impressed by the quality of the evidence given by each of them. The overall quality of the professionals who came and spoke gives a great deal of reassurance that the future of the health system is in good hands. It is the system that needs the attending, including maintaining the wellbeing of the medical professionals who keep it functioning.

97 I observe that there are always going to be things that could be done differently, or better, but that is not where I consider that I need to focus my attention. It cannot be said that anyone involved in the treatment of Mrs Panella, Mr Skeffington or Mr Jessett had anything but the best intention and applied their skills as best they could in the circumstances they faced. So it is that that is where I will focus my attention; the circumstances that these staff were, and are, placed in and what brought about disastrous consequences in each case. This can be done without attributing blame.

The quick fix

General comments

98 It is tempting to try to answer the problem of ramping by recommending the expansion of the size of the Emergency Departments. While Department access should naturally expand in line with a growing population, the addition of beds within the Department itself beyond population growth is unlikely to achieve any meaningful reduction in ramping. As witnesses described, should there be more beds in the Department, more patients will be taken in. This would then create a higher level of demand for beds in wards and exacerbate the access block issue that already exists.

99 An analogy is a take-away drive through. Where a drive through is considered particularly popular, a second lane might be added. This has the result of allowing a greater intake of diners ordering at once. Without an expansion of the number of burger-makers, those diners will wait for their burgers and hot chips. The pressure placed on the burger-makers might lead to stress, mistakes and delays. The product might be substandard. Once diners receive their meals, they need to exit the premises through the exit lane which can only accommodate so many cars, the same number it could before the second intake lane. Very quickly, the drive through will be backed up as it was before, or potentially worse. The point of this analogy is to highlight that without greater capacity for users to flow out, increasing capacity within the front end of the system is unlikely to decrease waiting.

100 Another problem that would be faced with the quick fix of larger Emergency Departments is a phenomenon similar to the Jevons paradox. This is effectively where the better something is, the more it will be used. Dr Lawrence described it as '…the more we can do, the more we will do and the more people will want'.[262] Dr Lawrence spoke of a phenomenon of new bigger Emergency Departments having an increased patronage after opening, without any reduction in patronage elsewhere.[263]

101 This quick fix would be a quick path to more problems.

Ramping understood

102 The Court heard that ramping is the chosen method of dealing with overcrowding due to previous incidents of patient deaths in corridors that led to coronial Inquests.[264] The Court heard that ramping was well-entrenched at the Flinders Medical Centre in about 2011[265] and the Ambulance Employees Association[266] records show industrial action was taken about ramping at the Lyell McEwin Hospital in 2010.[267]

103 At its most basic, ramping simply refers to the practice of having patients wait in ambulances outside the Departments of hospitals until there is enough space inside to allow them entry. That simple concept masks a much more complex scenario which is unveiled by asking the question 'what causes ramping?'. All witnesses were quick to explain that, while ramping occurs at the door of the Department, it is actually caused

---

[262] T1923.3
[263] T1935.18
[264] T1900.2; Exhibit C47 at [51]
[265] T1677.23
[266] AEA
[267] Exhibit C50 Annexure LW1

initially by access block, which is contributed to by exit block, which itself is caused by resource issues spread across the entire health system.

104 The Court heard about the factors which contribute to ramping. Helpfully, Professor Kelly provided a chart prepared by Professor Simon Craig which sets out the complex interplay of issues which brings about overcrowding in the Department.[268] Professor Kelly said that most Departments can operate efficiently enough if they achieve 25% of arriving patients flowing out within four hours.[269] That this cannot be achieved demonstrates the depth of the flow issue.

105 Ramping is a symptom of different issues arising in the complex, interconnected and adaptive health system. Given the evidence, it is beyond doubt that the most significant mechanisms which bring about ramping are access block and exit block. Access block is the inability to move patients from the Department into hospital wards, resulting in patients simply waiting in the Department long after they have been stabilised and treatment commenced, and they are no longer in need of emergency-level care. Exit block is the inability to move patients from wards out into the community,[270] resulting in patients simply waiting in hospital wards well after they no longer need hospital-level care. Exit block contributes to access block which causes overcrowding in the Department. With all suitable treatment spaces taken up by patients, newly arriving patients cannot progress into the Department. They will therefore wait either in the waiting room or in an ambulance outside the hospital.

106 Access and exit block issues themselves appear to be exacerbated by deficits in residential aged care and disability care facilities in the community, as well as the limited number of mental health treatment spaces in hospitals. The consequence of mental health limitations is that patients in need of acute mental health care end up sitting in the Department waiting for a space. The consequence of community placement limitations is that patients who would otherwise be released from hospital wards into the community end up waiting in hospital for placement, taking up a bed with a level of care that exceeds their requirements.

Aged care

107 In respect of aged care, witnesses spoke about the difficulty in having elderly patients access the residential care facilities they require. Dr Lawrence observed that high-needs aged care is a high-risk endeavour and the profit margins expected are low. She has perceived a downtrend in availability as providers close high-needs facilities on the basis of the risk versus reward assessment.[271] Professor Kelly was not surprised to hear of these issues,[272] identifying that the aged care deficit is a national problem.[273] Professor McNeil said that the issue had been drawn to the attention of the Commonwealth Government.[274] Dr Lawrence also highlighted particular issues on the weekend, with aged care facilities not being able to accept new residents on the weekend, meaning that any patient who is ready for discharge to a facility for the first time on a weekend must wait until Monday.

---

[268] Exhibit C49j
[269] T2242.31
[270] T1816.8
[271] 1818.13
[272] T2080.5
[273] T2240.29
[274] T2365.1

Dr Lawrence pointed out that a significant proportion of the long-term hospital population are elderly patients waiting for placement in a residential aged care facility. Of course, these patients who occupy hospital beds are not suitable for discharge elsewhere as they require a specific level of care. The result is that actual hospital bed capacity is less than figures show as many beds are occupied on a longer-term basis.

108 Data shows that South Australia has the highest proportion of older people on mainland Australia with more than 37% of the population over 50 years of age and 44% of all hospital admissions over 70 years of age.[275]

109 SA Health data shown reveals that on 9 January 2023,[276] there were 90 patients across South Australian hospitals who were waiting for an aged care placement but were otherwise suitable for discharge. By 8 July 2024, that number had escalated to 184 patients. On 27 August 2024, there were 220 patients. This data demonstrates that if these patients could be released to aged care facilities, there would be a significant reduction in access block and therefore ramping. SA Health has been working with the aged care sector to better understand the barriers involved and has implemented some initiatives to facilitate the transition from hospital to aged care.[277]

110 Aged care is a Commonwealth funded sector largely outside the control of SA Health. In that light, I can only suggest that the Minister for Health continue to advocate to the Commonwealth Government for increased investment in the local aged care sector as a direct measure to address ramping and prevent deaths. It does not rise as high as a recommendation. I have assumed the Minister has made many representations to the Commonwealth on this topic and will continue to do so.

111 In respect of disability care, the issues are similar to aged care. Dr Lawrence observed that a lot of work has been done in conjunction with the NDIS and that the number of long-term patients waiting for disability care in the system has reduced.[278] In that light, I also need not make any recommendations about this aspect.

Mental health patients

112 I turn to mental health. The issue of the role that mental health patients play is complex. The first aspect is the use of resources placed on the Department itself by patients in acute mental health crisis. Over two days in May 2024, I attended each of the major metropolitan Emergency Departments, including the Flinders Medical Centre. While at the Flinders Medical Centre, a patient in an apparent mental health crisis was waiting on the ramp in the care of two police officers. Later, I observed the patient in the Department, guarded by a security guard and two police officers, all in cramped quarters.

113 Witnesses explained that these patients are often intoxicated. Where there is a mental health concern mixed with intoxication, it is clinically necessary to wait for detoxification, essentially for the patient to ‘sober up’ to determine whether there is an underlying mental health issue or whether it was merely drug induced.[279] Given the unknowns, and the high safety concerns posed in the situation, this waiting must occur in

[275] Exhibit C47 at [68.1]
[276] Exhibit C47a
[277] Exhibit C47 at [201]
[278] T1819.19, T1952.24
[279] T1674.22, T1731.32, T1947.25

the Department. The result is the occupation of an emergency bed for a patient sobering up who may or may not turn out to have an independent mental health issue. Given the clinical need for this process, it is unfortunately unavoidable. Some hospitals have constructed areas with less stimulation for mental health patients as accommodation in the hustle and bustle of a working Emergency Department has the potential to overstimulate these patients and exacerbate their symptoms. These areas appear to be useful and contribute to the safety of the patient as well as the safety of staff and other patients.

114 Waiting mental health patients are a strong contributor to Department overcrowding. For example, Dr Romualdez said that it was not uncommon to have 20 patients in the Royal Adelaide Hospital Emergency Department waiting for mental health care.[280] Dr Brooks said there were 20 admitted mental health patients in the Royal Adelaide Hospital Emergency Department the weekend before she gave evidence.[281] Dr Hopping said that it was not uncommon to deal with these patients, leave hospital and return for her next shift only to see the same patients still waiting.[282] Mr Peck said the Department is a very busy, high-stimulus environment.[283] Dr Brooks described this as 'deeply counter-therapeutic'.[284] Professor Kelly said the practice is 'terrible health care'.[285] Dr Lawrence said that the data shows that the number of mental health-related Emergency Department presentations had doubled from 2005-06 to 2020-21, with the second highest overnight occupancy rate in the country.[286]

115 Another contributory aspect of mental health patients is access block. Witnesses spoke of particular difficulties in moving mental health patients to mental health wards 'after hours'.[287]

116 Given this evidence, it may be argued that SA Health would see quicker improvements in ramping if efforts were focussed on encouraging the expansion of aged care and mental health support services in the community. That is not to say that SA Health has not been working on those issues. In fact, as Dr Lawrence made clear, a great deal of effort has been made in these areas. For example, new Urgent Mental Health Care Centres have been opened.[288] These are designed to take the brunt of mental health presentations. Ideally these would leave the Department to deal only with mental health patients who have concurrent medical issues or are sobering. If these Centres achieve that, then in accordance with Dr Romualdez's evidence, up to 20 beds might be freed up in the Royal Adelaide Hospital Emergency Department alone. Given the capacity of the Department, that would be a remarkable increase in capacity.

Transferring patients

117 Another component which contributes to overcrowding are transfer patients; usually those coming from rural and regional facilities to metropolitan facilities. As these patients

---

280 T1512.25
281 T2529.19
282 T575.2
283 T1436.11
284 T2533.7
285 T2077.32
286 Exhibit C47 at [77]
287 For example, T1435.20
288 Exhibit C47 at [114]

have been assessed by an emergency physician, they are usually not in need of urgent care and so they assume a lower priority than incoming patients who have received no medical assessment or treatment.[289] They end up waiting for inordinate amounts of time for entry into the Department to be briefly assessed and then sent to a ward. This is an area where SA Health has made dramatic improvements, through the introduction of the Statewide Inter-Facility Transfer system.[290] The result has seen data about a patient's assessment shared between hospitals in advance of moving the patient, which has resulted in a high number of patients bypassing the Department in the receiving facility and being admitted directly to a ward into the care of a medical team which is comfortable with their condition and plan.[291] I commend SA Health on this project, which would have been undoubtedly more difficult than it might appear.

24 hours a day 7 days per week v '9 to 5'

118 Another component which exacerbates exit block is the concept of the '9 to 5' hospital.[292] All public hospitals in metropolitan Adelaide provide a 24 hours a day, 7 days a week service.[293] However, the level of services provided across those seven days varies.[294] Witnesses spoke of there being a glut in patient discharges over the weekend.[295] Professor McNeil spoke of personal experience of a patient who was ready to be discharged on a Sunday waiting until Monday morning for a senior doctor to attend work and order their discharge.[296] Dr Hopping said that observations and discussions with patients during ward rounds are a key component leading to discharges.[297] Dr Lawrence spoke of limitations in the industrial agreement which covers consultants. While consultants in the Department are required to work to a roster which spans seven days, those in other areas of hospitals are not.[298] Professor McNeil considered that the proper approach to the issue is to empower less-senior doctors with the knowledge, skills and ability to make these discharge decisions themselves.[299] Professor Kelly said that it is not only about consultants. As she explained, weekend discharges also rely on the availability of medical imaging, allied health and operating rooms.[300]

119 An innovative solution to the weekend discharge glut has been implemented at the Lyell McEwin Hospital; the Supportive Weekend Interprofessional Flow Team or 'SWIFT'. Dr Aman Anand explained that this is a multi-disciplinary team which assembles on weekends and identifies bottlenecks in discharges to keep them happening over weekends.[301] Dr Lawrence described it as a coordinated use of resources and gave an example of a patient that needs to pass a physio assessment in order to be discharged.[302] She explained that artificial intelligence is used to review ward round notes and produce a list of patients that SWIFT might be able to help.[303] The SWIFT will identify that and

---

[289] T310.12
[290] SIFT
[291] Exhibit C47 at [167]-[168]
[292] T2083.29
[293] T2306.35, T2308.10
[294] T1893.30, T1894.17
[295] T1732.17, T2086.28
[296] T2307.23
[297] T577.31
[298] T1897.9, T1898.16, T1900.20, T2084.3
[299] T2307.8
[300] T2233.12
[301] Exhibit C58 at [11]
[302] T1901.22
[303] Exhibit C47 at [225]

send a physio to that patient to achieve the discharge instead of the patient waiting for the usual hours of the physio service.[304] Dr Anand roughly estimated that the SWIFT was achieving 20-30 more discharges on weekends.[305] Dr Lawrence said that an evaluation identified a 34% increase in discharges.[306] Professor McNeil observed that the existence of SWIFT has brought about a cultural shift across the hospital.[307]

120 Additional contributors involve an escalating prevalence of chronic health conditions in the community which require specialised and coordinated care,[308] combined with a reduction in access to GPs by virtue of a reduction in bulk billing and the number of doctors practising as GPs.[309] South Australia must also deal with a significantly greater proportion of people living in areas of socio-economic disadvantage (39% compared with the national average of 28%) which carries greater incidence of poor health, chronic illness and disability, as well as creating barriers to access to healthcare.[310]

121 This summary of the main factors contributing to ramping demonstrates something Professor Kelly said; that ramping is a sector-wide issue, not a hospital-wide issue.[311] It is also a phenomenon experienced throughout Australia and the developed world.[312]

The consequences of overcrowding

Hospital staff

122 The clearest evidence of the consequences of ramping was given by Dr Brooks. She said that there is a wealth of evidence which shows that patients who receive care in an overcrowded Emergency Department have an increased risk of morbidity and mortality, which carries even after they leave the Department.[313] A concerning part of this is that the negative health impact is not limited to the actual patients who wait on the ramp, but extends to all those who receive care in the high pressure environment of an overcrowded Department. Patients are also put at increasingly higher risk to their ongoing wellbeing as their waiting time extends.[314] Professor Kelly spoke of shorter off-stretcher times resulting in less mortality.[315] Professor McNeil pointed out that patient flow affects both patient safety and quality of care.[316]

123 It is not just patients who suffer. Dr Brooks identified five groups who are directly affected by ramping; patients in the waiting room, patients on the ramp, potential patients in the community waiting for an ambulance, patients receiving care in the Department and health staff.[317]

---

[304] T1901.13
[305] Exhibit C58 at [11]
[306] Exhibit C47 at [226]
[307] T2311.1
[308] Exhibit C47 at [46.1]
[309] Exhibit C47 at [46.2] and [68.4]; T1825.8
[310] Exhibit C47 at [68.2]
[311] T2072.8
[312] Exhibit C47 at [27]; Exhibit C66 at MRB3; T1810.30, T2072.14, T2309.15
[313] T2494.1, T2538.18
[314] T1838.33
[315] T2073.6
[316] T2310.1
[317] T2493.32, T2539.7

124 The process of dealing with patients is more cognitively difficult when the Department is overcrowded, which results in fatigue.[318] Dr Brooks identified a swathe of senior nursing staff, with 20 or 30 years of experience, who have left the health system in recent times.[319] Mr Peck said that while some nurses cite overcrowding as their reason for leaving, others simply find other employment and do not specifically cite overcrowding.[320] Dr Romualdez said that it is often reported that staff are moving on because the Department is too stressful.[321] Ms Heywood said that ramping was one of the reasons she left the Royal Adelaide Hospital.[322] Dr Lawrence said that there has been a rise in staff attrition and that SA Health is increasingly reliant on overtime and agency or locum staff to keep up with demand.[323]

125 It takes approximately 300 nurses to operate the Flinders Medical Centre Emergency Department 24 hours a day, 7 days a week.[324] Dr Brooks described nursing staff as the 'backbone' of Emergency Departments.[325] She identified a vicious cycle where staff leave because of the pressure of overcrowding, which results in a less experienced workforce, which brings about more overcrowding.[326] This evidence supported my view that efforts must be made to reduce the stress around the issue of ramping, contributed to by the safety issues it causes.

126 Dr Wright spoke of a reduction in levels of doctors, with vacancies at all levels.[327] Dr Brooks spoke of multiple shifts where an entire wing of the Royal Adelaide Hospital Emergency Department, about 20 cubicles, is staffed only by herself and an intern with nursing support.[328] She spoke of 'being flogged' through COVID[329] which contributed to her resignation from formal leadership.[330] She spoke of an incredibly concerning situation in 2021 where the decision was nearly made to close The Queen Elizabeth Hospital Emergency Department overnight due to the unavailability of sufficient staff.[331]

127 Dr Brooks said that South Australia has a substantial deficit in senior decision-makers in the public health system when compared to the eastern states.[332] Professor Kelly said that there has been 'an exodus' of nurses and doctors from emergency practice following the COVID pandemic.[333] Dr Lawrence agreed that there are workforce shortages across the entire health sector.[334] She gave evidence that there has been a recent turnaround and the number of health service staff has been increasing beyond attrition in recent years.[335] This

---

[318] T1433.2
[319] T2539.7
[320] T1433.26
[321] T1519.35
[322] T382.13
[323] Exhibit C47 at [86]
[324] T1049.12, T1085.28
[325] T2539.7
[326] T2539.26
[327] T1654.1
[328] T2550.9, T2551.31
[329] T2554.33
[330] T2556.8
[331] Exhibit C66 at [57]; T2549.16
[332] T2550.2
[333] T2040.31
[334] T1827.34
[335] Exhibit C47 at [194]

improvement has not yet rectified the staffing issue, as established by Dr Brooks' experience working at the coal face recently.[336]

128 A reduced workforce in the context of continued high demand takes its toll on the clinicians who remain.[337] Dr Wright spoke of the difficulty of trying to run an Emergency Department for patients arriving today when yesterday's patients are still occupying a large portion of the treatment spaces.[338] Professor Kelly said that ramping causes wellbeing and retention issues[339] and that clinicians take on a lot of moral distress when things go wrong.[340]

129 Dr Hopping spoke of a particular moment of frustration of having patients that she could not see because 'every cubicle and every chair and every corner' had been used to bring patients in and there were still patients waiting.[341] Dr Xiao spoke of limitations to the level of care that he hoped to deliver.[342]

Ambulance officers

130 Another group significantly affected by ramping are ambulance officers. A lot of evidence was heard about paramedics being required to miss meal breaks and working through their shifts to deal with demand in the community that cannot be addressed by paramedics waiting on the ramp.[343] This has obvious potential to make an already stressful job harder.

131 The AEA suggested in its written submissions[344] that paramedics join the ambulance service due to a passion for helping those in need. That appears to me to be well established. The AEA went on to say that the problem of ramping prevents them from doing this. I do not accept that these submissions can be linked to each other. It may be readily accepted that ramping hampers the organisation's ability to help all the people that seek its help each day. However, the individual clinicians who are treating a patient on the ramp are helping those in need; the patient in their ambulance. These are patients who the individual clinician has determined needs admission to the hospital. The hospital has, for complex reasons, not been able to accept them immediately. The individual clinicians are therefore taking on an important role in monitoring and assisting the ramped patients to get through the wait unharmed. It may be that they reasonably have a desire to drop the patient into the Department and return to the community to be of more assistance to others. Understandably, frustration builds when this cannot occur. However, that is a different concept to asserting that they have been prevented from helping those in need. As I have said, every clinician needs to play their role. In the context of the current state of the health system, including the expansion of the ambulance service, at this time it must be the paramedics who take on a wider role of care than they traditionally have. Submissions from the AEA to the effect that paramedics caring for patients on the ramp are not doing their job are perilous.[345] It is true to say they are

---

[336] T2549.21
[337] T1368.10
[338] T1657.26
[339] T2073.26
[340] T2083.4
[341] T574.13
[342] T1035.9
[343] For example, T2433.13
[344] Written submissions of the Ambulance Employee Association dated 18 March 2025 at [4]
[345] Written submissions of the Ambulance Employee Association dated 18 March 2025 at [4]

prevented from helping more South Australians who need them as the system is designed to achieve. The patient waiting with them is no doubt grateful and comforted that they have an advocate in a high-risk situation as I explain below.

Relative risk

132 A topic that was explored thoroughly was the concept of assessing relative risk across the healthcare system. A simplified explanation of the proposition put is that patients in wards are at low risk because their condition is known, their treatment is underway and they are surrounded by medical supports. Patients in the Department are more at risk because their condition might not yet be identified or, if it has, their treatment may not have commenced, although they are still surrounded by health professionals. Patients on the ramp are at a higher risk because they have not been assessed by a doctor yet. Patients in the community waiting for an ambulance are at the highest risk because they have not had any medical assessment, their condition is unknown and they are generally not surrounded by health professionals or medical equipment.

133 Some witnesses agreed with this concept.[346] As it turns out, like so many aspects of the health system, it is not that simple.

134 Although Dr Brooks was not asked to differentiate between risk of preventable death and a general risk to patients' health,[347] she revealed a fundamental issue with the proposition. She said that it is impossible to make any reliable assessment of relative risk across the continuum of the health care system.[348] She explained that statistics show that only two out of every three people that call triple zero are transported to hospital.[349] Not every patient that is transported to hospital requires admission. Seen in this way, the patients who progress through the system further and further are more certain to be seriously unwell. It is possible, therefore, that the cohort of patients awaiting admission to the Department could be at an overall higher risk than the group of patients who are waiting for an ambulance.

135 It is perhaps for this reason that Professor McNeil said that the highest risk is firmly at the front door of the Department,[350] where emergency healthcare has been identified as necessary, but is yet to be provided.

136 I consider that it has not been established in evidence that the greatest risk of preventable death exists in the community as distinct from on the ramp or in the hospital. Given that there has been a generous expansion of the ambulance service, it cannot be said that expending every possible resource to prioritise admission of ambulance patients in order to release all ambulances back into the community the moment they arrive at a hospital should be the only goal. I say that in the context of there being finite resources available in the health care system which must be factored in. I also say that particularly in light of the fact that it is not always the case that patients arriving by ambulance are more unwell than patients arriving by their own transport.[351] There is yet a further context of there being a rapid offload process in place which can see patients of lower acuity being

[346] T1126.34, T1683.17, T2304.20
[347] See T2494.29-T2498.26
[348] T2494.35, T2498.12, T2498.30
[349] T2496.9
[350] T2304.20
[351] T1147.27, T1608.34, T1741.33, T1921.8

taken from ambulances into the Department ahead of sicker patients where there is identified high demand in the community. I acknowledge that this 'rapid' process is not responsive to momentary demand, but it is nevertheless a mechanism to deal with sustained high pressure and increasing community risk that is available in crises.

137 In light of the finite resources available, decisions need to be made about the best use of those resources. These decisions must be agile and responsive to the actual scenario in place, rather than always favouring one group. In my view, it cannot be that in every scenario an ambulance patient must be offloaded so that the ambulance can be released.

The changing nature of demands on the health sector and its services

138 The Court heard evidence about the changing nature of the demand for services in the South Australian health system. Triage Category 4 and 5 patients have reduced, with an increase in Category 2 patients.[352] Anecdotal evidence was given from multiple witnesses about patients presenting with more complex health pictures and more chronic conditions, or 'comorbidities'.[353] It was identified that the population is ageing which contributes to this phenomenon.[354] Dr Lawrence observed that the growth in number of undifferentiated patients with geriatric or medical classification between 2023 and 2024 exceeded the 2-4% annual growth which is used for modelling.[355]

139 Another factor which is altering the level of healthcare required, specifically in the Department, is the rise in hospital avoidance techniques and services. Dr Wright gave evidence that the increasing number of diversions of lower-acuity patients means that there are less quick-turnaround patients and the figures for overall time spent in the Department has risen.[356] Dr Romualdez said that not being able to take a break from high-acuity case after high-acuity case results in more mental pressure for all doctors and less training opportunities for junior doctors in the Department.[357] Professor Kelly said that lower-acuity patients do not meaningfully contribute to access block as they are not often competing for a bed on the ward.[358] Hospital avoidance will nevertheless reduce overcrowding in Emergency Departments.

140 Another aspect of change is that brought about by government initiatives. Following the most recent change of government, an enormous number of resources were deployed to expand the ambulance service.[359] This has had the effect of greatly reducing delays in ambulance callouts, which are now nation-leading.[360]

141 Dr Brooks gave evidence about the very significant increase in the ambulance service. It is without any doubt a positive initiative. Getting ambulances to those in need quickly is critical to the efficacy of a modern health service and to engender public confidence in it. Recent data published by the government on SA Health website dashboards suggests that ambulance targets are largely being met or are on a positive trend towards being met.

---

[352] T1403.30
[353] T1403.30, T1663.21, T1825.8
[354] T1725.1
[355] T1822.28, T1970.15; Exhibit C47B
[356] T1663.7
[357] T1533.29
[358] T2076.28
[359] T2546.3, T2547.32
[360] Exhibit C47 at [211]

The AEA agreed that this initiative has gone a very long way to ameliorating the effects of ramping in terms of community safety.[361]

142 While the increase in the size of the ambulance service is a very good safety initiative and results in people in need of urgent care being put under the care of paramedics quickly, one might have predicted the inevitable result; an increase in ramping figures. As a matter of logic, if there are more ambulances on the road, responding to emergencies quicker, they will collect more patients. They will therefore bring more patients to hospitals which will put even more pressure on the Departments than there were with less ambulances. The increase in ramping figures is therefore the natural consequence of a larger more-responsive ambulance service providing a safer level of service to the community. In other words, a consequence of the changing structure of the health system to be more ambulance-intense is that the ambulance service has a greater capacity to overrun Emergency Departments which have not been correspondingly increased. The additional ambulances add to access and exit block issues. What the public see is an increase in ramping figures. What the public may not see is that the situation overall is a safer one.[362] While waiting on the ramp in the back of an ambulance is a bad circumstance, it is preferrable to waiting at home in a medical crisis without any medical professionals at all. With more ambulances, more people get an ambulance quickly when they need one. They then wait in the care of the paramedics for longer, but they will have been stabilised or otherwise identified as needing urgent care and progressed into the Department.

143 The overall situation is something that must be taken into account when assessing the proper approach to the ramping issue within a system of finite resources, and in particular whether abolition at any cost is the only correct approach.

The breadth of the ramping issue and the culture surrounding it

144 The Court heard much evidence about the frequency of ramping. It was described as 'an everyday phenomenon that is unrelenting'.[363] Ms Weston observed that ramping occurred more often than not at the Flinders Medical Centre.[364] Dr Wright spoke of a specific Category 1 patient who could not get into the Department for 30 minutes.[365] That represents a patient who needs an extremely urgent high-level of care having to wait. He said that ramping of Category 2 patients is becoming increasingly frequent.[366] Mr Lemmer said that in times of peak demand in July 2024, there was a day when seven ambulance Priority 2 patients were ramped at the Flinders Medical Centre and two were ramped at the Royal Adelaide Hospital.[367] Paramedics reported having to hand over patients to incoming crews at the end of their shifts due to extended ramping, and often starting their own shifts by taking over care of patients already on the ramp.[368]

145 Professor Kelly made it plain that ramping is an international phenomenon[369] that is an everyday occurrence in most metropolitan Emergency Departments in Australia.[370] She

[361] Written submissions of the Ambulance Employees Association dated 18 March 2025 at [59]
[362] T2547.32
[363] T1519.18
[364] T952.15; Exhibit C38 at [11]
[365] T1654.34, T1681.7
[366] T1692.30
[367] T2451.15
[368] T637.11, T478.12, T135.1
[369] T2072.14
[370] T2072.28

believes that it will be incredibly hard to fix and probably impossible to eliminate.[371] Dr Lawrence said that delayed transfer of care occurs throughout the world and across Australia.[372] Professor McNeil suggested that ramping should not be tolerated, but then acknowledged that, even in the best circumstances, the health system will experience delays.[373] He acknowledged that, even if hospitals achieved a flow of 85% of patients within four hours, there would still be ramping, although it would be reduced.[374] The ambition of the task is clearest in that figure. Dr Brooks said that she does not see ramping being solved any time soon.[375]

146 I heard about the impact ramping has on those involved in the system. There were two levels; first, the staff working in that environment, but at least equally importantly the impact on the patients who present to the hospital for help. Mrs Panella, Mr Skeffington and Mr Jessett, presented for help and had to wait, with tragic consequences.

147 Potentially due to the enormous amount of community and media attention to the issue of ramping, there is a pervasive attitude amongst clinicians, which I observed at times in some of the witnesses who gave evidence, that ramping should not occur; that ramping is a sign of failure and that *all* efforts should be directed toward its eradication.

148 The foundational question that needs to be addressed, and I take as a starting point, is; why is ramping bad? This was a topic addressed by numerous witnesses during the Inquest. There were various explanations given about the desire to end ramping. Many simply said that it is not good healthcare, or not good practice. In the end, I accept on the basis of the evidence as a whole that ramping is bad because it puts patients and healthcare providers in a risky situation. If I adopt that as a starting point, then my task is clear. I must take into account the circumstances which faced Mrs Panella, Mr Skeffington and Mr Jessett who represent occasions where the risks of ramping turned out in the worst way. I must try to address those safety risks so that others who are waiting on the ramp are not put at the same risk.

149 The current response to the issue of overcrowding may be seen to represent a lack of imagination. Too many patients arrive at once, so they will simply sit in the back of the ambulances they arrived in. I heard evidence of various strategies that have been tried over time; the doctor on the ramp, or the triage nurse on the ramp with a ‘workstation on wheels’ for example. Still, the essence of the solution is that the patient remains in the back of the ambulance, experiencing anything from frustration compounded by pain, to anxiety about their immediate future if they are not seen promptly by an Emergency Department doctor.

150 I heard a number of times from witnesses during the Inquest that introducing ‘this’ improvement or ‘that’ improvement or doing ‘this’ or ‘that’ in a new way would not actually address the root of the ramping problem; access block, and so will not prevent ramping. In all instances that was said, those witnesses are of course likely correct. However, I pose a rhetorical question; if ramping is a daily occurrence and addressing the root cause is an enormous issue which will take many years and enormous resources and

---

[371] T2038.1
[372] Exhibit C47 at [27]
[373] T2292.9
[374] T2309.20
[375] T2545.27

might actually be impossible, then why would better ways of dealing with the consequences not be a worthwhile exercise? To give a medical example, a patient with catastrophic leg injuries requiring amputation would not be left to bleed while awaiting the amputation surgery. Bandages and torniquets will not deal with the root problem, but they are nevertheless a valuable exercise. Respectfully, to do nothing of a serious nature about safety on the ramp because it will not actually address the root problem is an unacceptable approach, particularly where it occasionally results in the loss of life.[376] If expenses are put into developing a better way of dealing with ramping, and in years to come those better facilities or procedures are not needed because all incoming patients go directly to a bed in the Department, but lives have been saved in the meantime, then I believe the people of South Australia would be not see it as a waste of valuable public money. This is particularly relevant for South Australians who may have been, or were at risk of facing, life-threatening delays under the current stressful, undesirable, and unsafe conditions.

151 There is an irrationality about declaring ramping unacceptable, and because of that stance, declining to deal with it directly to make it a less dangerous situation. In this situation, it would be an error to only focus on the enormous task of preventing it happening in the first place. It results in a situation where those patients who face being ramped are in a worse situation than they could have been because those involved are dedicated to preventing ramping, not making it a less dangerous situation when it does happen. This approach completely overlooks the overall goal of the Emergency Department and indeed hospitals and the entire healthcare system; namely to take care of people in the safest way possible in the circumstances in which they present.

152 The first half of the dangerous situation which ramping creates, and potentially the most serious, has been drastically reduced; the inability to get an ambulance to people who need it. Dr Lawrence gave evidence that SA Health is pursuing 255 additional ambulance employees, 36 additional ambulances, five new ambulance stations, four station rebuilds and 10 ambulance station upgrades,[377] as well as other ambulance efficiency projects. As I have already observed, a lot of this has been realised already. The increase in the size of the ambulance service, which has increased ramping hours, means that people in the community who need the care of paramedics receive it quickly. It is trite to say that as many ambulances should be free as much as possible, however to have every ambulance deliver a patient to hospital and leave immediately would put those patients and others at extreme risk until the hospital has capacity to take them. The patient is actually safer in the care of the paramedics than they are alone in the airlock or corridor or at home without any medical attention. There appear to be sufficient ambulances and paramedics to achieve low response times and still deal with ramping. Therefore, it is the next part of the dangerous situation that now needs to be addressed; the safety of those patients while they inevitably wait in the care of the paramedics during times of peak demand.

153 In order to address this aspect, SA Health and its clinicians need encouragement to be imaginative, and a redirection of their enthusiasm. The State of South Australia submitted

[376] I do not mean to suggest that SA Health has done nothing of a serious nature in relation to ramping, I am responding to the attitude of those that see safety improvements as a misdirection of resources
[377] Exhibit C47 at [207]

that there has more recently been a focus on efforts to mitigate the risks arising from ramping at the same time as continuing work on the reduction/elimination effort.

154 During the Court view to the Lyell McEwin Hospital, I saw what can only be described as a breath of fresh air. The contrast between that and the two other major hospitals was stark. The Lyell McEwin's approach to overcrowding represents thinking from the ground up about better ways. Not minor adjustments, an entirely new way. Of course, the Lyell McEwin Hospital's Emergency Department recently underwent renovations and it was freely acknowledged during the view that the ability to design a new Emergency Department was a luxury.

Culture and the goodwill conundrum

155 The Court heard evidence of serious culture issues within SA Health under previous leadership. It was most concerning to receive a copy of Dr Brooks' and Dr Soulsby's letter to Central Adelaide Local Health Network leadership in which they raised concerns about safety on the ramp.[378] It was particularly concerning that no response was ever received to such alarming correspondence. I say that in light of the fact that the correspondence spoke of specific adverse incidents that were never queried. It raised a concern that the government insurer ought to be made aware of, which appears never to have been done. Dr Brooks said she was not surprised that she never received any response to such a serious letter.[379] Dr Brooks spoke of occasions of being called into meetings to be told that she was spending too much money on overtime without any consideration being given to the requirement to properly staff the Department.[380] Dr Brooks gave evidence about her request for a cluster review into multiple ramping incidents being denied, notwithstanding that it met the criteria.[381] There were clearly issues at that time. Dr Brooks said that the situation is better now, although there is still improvement to be made.[382]

156 I heard from many witnesses currently serving in the South Australian health professions. There was a palpable sense of goodwill in addressing ramping, its causes and its effects. However, at the very same time there was evidence on occasions of resistance to trying new things and resistance to any individual component of the health system changing its practices. While the State submitted that this has been changing, there were clear examples of this attitude persisting.

Blood tests for ramped patients

157 An example of this was an issue which took some prominence during the Inquest; taking blood samples on the ramp. There are obvious benefits in doing so. In particular, I highlight Mr Jessett's case. Professor Kelly said that Mr Jessett's death was potentially preventable if his hyperkalaemia was identified earlier and reversed. She said that hyperkalaemia is a potentially deadly condition which is rarely associated with symptoms.[383] Identification would occur through a simple blood test, which for Mr Jessett was not conducted until it was too late. The idea behind blood tests on the ramp is to

---

[378] Exhibit C66 Annexure MRB2
[379] T2542.2
[380] T2564.32
[381] Exhibit C66 at [36]; T2543.9, although a cluster review was subsequently conducted (T1517.5, T1536.16)
[382] T2565.29
[383] Exhibit C49g at 12

identify these cases of extreme emergency which are not readily apparent on the basis of the patient's visual presentation and physiological observations.[384]

158 Clinical witnesses spoke in support of the idea.[385] Dr Wright said that in an earlier trial of blood tests for waiting room patients, 8-10% were sicker than initially appreciated.[386] Some of these may have had their deaths avoided.

159 There were issues raised about the practical implementation of the proposal, such as identifying who would be responsible for reviewing the results as the patient will not yet be assigned to a clinician. Those issues are reasonable to raise and I make no criticism of those who raised them. There are obviously things to work through as part of implementation.

160 However, there was active resistance to the very idea of the paramedic scope of practice being extended to taking a blood sample.[387] The resistance was described in evidence on the basis of there being the potential for comforting results meaning a patient is left on the ramp longer. That concern has an easy fix; you have a policy that it cannot be used by those determining patient prioritisation. You have a procedure where the results of ramped patients' blood samples are not reviewed by the triage nurse or any doctor involved in intake processes unless highly abnormal. This is actually a simpler model of implementation because it does not require anyone to be assigned to reviewing ramped patients' blood samples. Instead, it relies on the process already in place where highly abnormal results are flagged by the pathology unit. Professor Kelly gave evidence of certain abnormal results being phoned through to the Department to alert them immediately of a patient in an extremely concerning condition.[388] Through this process, a patient with a serious condition simmering away under the surface, like Mr Jessett, would be identified and treated, but others without will simply have a blood test result available to doctors when they are eventually seen. Intake staff continue to treat the patient on the ramp according to their triage Category and presentation upon initial triaging. Mr Lemmer's evidence was that this was how the initiative is designed to work.[389]

161 In reality, this is merely an issue of implementation that needs to be worked out. However, instead of working towards an appropriate manner of trying this initiative, the response to this proposal was to 'strongly disagree[d]'.[390] The enormous benefit of potentially picking up a patient who is about to lose their life on the ramp is lost amongst argument about scope of practice, the traditional role of paramedics and ramping figures. That is unfortunate.

---

[384] Exhibit C47 at [148]
[385] T449.18, T819.29, T1025.36, T1391.27
[386] T1653.15, T1664.22
[387] For example, Exhibit C50a
[388] T2066.3
[389] Exhibit C65 at [16]
[390] Exhibit C50a

162 Ms Watkins spoke in her oral evidence of the AEA's concerns about blood samples being taken from patients waiting on the ramp. Her concerns were not focussed on any scope of practice, training or skills concerns. She said:

> '…in an example where there may be three, say, ATS score 3 patients on the ramp, and three ATS score 3 patients in the waiting room, they all have bloods taken, and say the waiting room patients have more concerning blood levels, that will then reasonably lead to a decision by the ED clinicians that whilst their ATS score is all the same priority, the ones with the concerning blood results have a higher treatment priority and they will all be seen sooner.' [391]

163 With respect, Ms Watkins' concern has a fundamental flaw. Her position amounts to a complaint that a patient who is sicker will be treated before a patient who is less sick. While SA Health policies require ambulance patients to be prioritised over waiting room patients, this is always subject to both patients being of equal clinical risk.[392] To raise concerns in the manner that Ms Watkins did in her evidence perhaps reflects a lack of clinical experience.[393] Her concern was based solely on the industrial situation of paramedics, consistent with her duty to AEA. It has no regard to clinical care required or the welfare of the individual patient that paramedics have in their care weighed up against the welfare of the patient who drove themselves to hospital. Dr Wright said that even if a few patients ended up waiting longer because of their comforting results, but one patient who cannot wait for hours is discovered, then the greater good is served.[394]

164 Of course, Ms Watkins' concern would have more merit in a circumstance where there were cases in the community of higher concern than both cohorts of patients spoken of in her example. If that was the situation, it would readily be accepted that both ramped patients and waiting room patients should yield to the urgency of the patient in the community who is sicker than both. In that scenario, the Ambulance Transport Policy[395] should be implemented and the less sick ambulance patient would be taken into hospital to allow for the ambulance to be released to return to the community to deal with the emergency there. This should occur as quickly as possible, but not prior to there being any actual known inability to respond to community demand. Absent actual demand for higher patients in the community, it cannot be that less-sick patients must always be offloaded just in case a sicker case might arise in the community.

165 While the goal of returning ambulances to the community as soon as possible to deal with emergencies, or to ensure there is capacity to deal with potential emergencies, is extremely important, the health system cannot prioritise that over an objective assessment of clinical urgency in the cases actually presented for care. With respect, Ms Watkins' concern merely shifts the risk from a potential case in the community to a known case in the waiting room. The ability to identify serious risks to known patients cannot be cast aside in favour of the desire to be available for potential patients. That is an unacceptable approach and represents silo thinking.

---

[391] T2156.5
[392] Exhibit C33; Exhibit C47c
[393] T2172.30, T2182.25
[394] T1734.37
[395] Exhibit C33; Exhibit C47c

166 There was another difficulty to Ms Watkins' position about blood samples; that she, and the AEA, support the idea of nurses being required to visit patients on the ramp at set intervals to check on progress. Objectively, this carries the same potential that was raised in respect of blood tests. That is, nurses visit the patient and deem them to be stable and so they are considered less and less urgent the longer they remain stable. When this was raised with Ms Watkins, she suggested that paramedics could instead visit triage nurses at set intervals to report on progress.[396] This returns to the initial conundrum which arises as a result of triage nurses not having direct visualisation, single paramedics being left inside ambulances alone with patients and crowding the triage desk. What I consider is more likely is that clinicians would put patient care first and use all information available to them to bring in patients as quickly as possible in the order of most need. Risks of perverse uses of blood test results can be managed with policy and procedure.[397] An amount of trust would need to be placed on clinicians to do the right thing, with ample evidence that they would do just that. A firm policy about the proper use of ramped blood samples would ensure that it does not result in unfair outcomes. I cannot accept that triage nurses would take into account that a highly abnormal notification was not made in carrying out their duties, especially given that they would not know if the test had been completed or not and the Australasian Triage Scale does not accommodate such considerations. They are simply too busy during periods of ramping to be able to make efforts to find out whether testing has been completed in order to downgrade a waiting patient. Ms Watkins' suggestion of mere ongoing visualisation by triage nurses carries a risk of under-appreciation of concealed illness[398] which is less pronounced with blood testing. There are compelling reasons to explore blood testing on the ramp as a tool used to prevent death. Professor Kelly gave compelling reasons why these results should be interpreted by hospital staff rather than paramedics.[399]

167 The AEA took issue with these criticisms of Ms Watkins' positions when they were raised by Counsel Assisting. It responded with information about Ms Watkins' achievements as Secretary of the AEA. With respect, Counsel Assisting made no criticism of Ms Watkins personally, I understood his submissions to be directed at the logic of her positions in respect of this particular issue. I agree with his submissions.

168 Dr Lawrence advised that the Australian Nursing and Midwifery Federation also opposed the initiative on grounds that it did not address the core issue of ramping and that there may be additional work for nurses in following up blood tests.[400] I will address the first aspect shortly. The second aspect is illogical, as these patients will need blood tests in any event, they are merely being conducted earlier.

169 I observe that in this example of blood tests on the ramp, the enormous show of goodwill about ramping seems to be tempered by resistance to change of individuals' practices and silo thinking. There must be a balance struck between the very desirable goal of having ambulances on the road and initiatives which may prevent death. In circumstances where the ambulance service is currently able to adequately manage its demand and

[396] T2170.8
[397] T2253.37
[398] I do not intend to suggest that patient visualisation is anything other than essential
[399] T2063.25
[400] Exhibit C47g at [30]

hospitals are not, the balance should properly fall in favour of this initiative to mitigate risks to patients.

170 If a process such as that was in place in 2022, Mr Jessett's life may have been saved. He is a clear example of the kind of patient that such a process would identify and act on. In order to give meaning to Mr Jessett's death, SA Health should not entertain any arguments about the undesirability of saving a life in this manner, whatever the potential drawbacks. It is a simple tool which has the capacity to prevent tragedy. I have carefully considered the AEA's intense opposition to this initiative in its written submissions and I do not accept their arguments. If implemented in a manner of a safety check to identify patients with extreme underlying conditions that are not outwardly visible, the proposal is not akin to diagnosis and does not blur the boundaries of triage and admission. In any event, as I have set out, some disruptions are called for in the name of patient safety.

Going over capacity on specialist wards

171 Another cultural issue raised was the complete opposition to wards taking patients beyond their capacity or going 'over census'. On its face, opposition to this practice seems reasonable; nurses should not have to care for more patients than there are conventional treatment spaces. However, when one takes a whole-system view, it is clear that the Department frequently goes over capacity and finds every possible space to house a patient. While the usefulness of comparative risk assessments is low, some of the patients in the Department may be at a higher comparative risk than those on wards as their diagnosis may not yet have been made and their treatment is unlikely to have commenced. Professor McNeil spoke about efficiencies that can be achieved through having wards pull in patients that are within their specialisation.[401] Wards could accommodate patients who are the lowest known risk in the Department within their specialisation. If one is to try to reduce the risk posed to patients in an overcrowded environment, it would be differentiated patients with treatment underway that would be the obvious selection to be made to share hospital resources.[402] Professor McNeil said that a cultural shift is required towards an appreciation that at certain agreed trigger points, wards being over census is less risky to patients than extremely overcrowded Emergency Departments.[403]

172 Yet another example of a cultural issue was the evidence of a hospital not wanting to request load levelling be instituted to reduce the number of ambulance arrivals to their own Emergency Department at a time of peak demand. This is for the reason that it might then be used on another occasion to support a different hospital which would result in this hospital receiving more patients on the subsequent occasion.[404] This disregards the overall patient risk benefit to using load levelling techniques and needlessly puts patients at risk today to avoid being busy on another day that might have otherwise been quieter. It is a concerning example of a lack of collaboration.

173 Dr Brooks spoke of the health system being a 'team sport' which relies on collaboration.[405] All clinicians working in the public health system need to recognise that

---

[401] T2311.26
[402] T1683.17
[403] T2304.29
[404] T1678.2
[405] T2541.8

it is only with a group effort where everyone gives something, that actual improvements will be realised. Anyone who has an attitude that ramping should be reduced should look to their own area to identify what they can reasonably do to assist that effort and what they might do in the meantime to improve the safety of the situation.

Funding for interim solutions, Band aids, Jules Léotard and an unachievable goal

174 I turn to the attitude that directly addressing the plight of ramped patients is a misdirection of resources.

175 The Band-Aid was invented in the United States in 1920 as a means for members of the community to treat themselves without requiring medical assistance. What is unclear is whether, at the time, the new invention was referred to as a 'band aid' solution and frowned upon because it did not represent full health care. It would appear unlikely.

176 However, the Macquarie Dictionary has now included a second definition of the term 'Band-Aid', that is, an adjective which means 'palliative; superficially helpful and short-term'. While it is understandable how the term came to be used in this way, it fundamentally undermines the usefulness of the device. In circumstances where there are risks of infection, or bleeding, a band aid may be used to avoid further harm or prolong the time a person has before they need professional healthcare. Some people will use a band aid and not need any formal medical treatment at all.

177 Various witnesses described initiatives addressed at the symptom of ramping as band aid solutions. In many respects the witnesses were oversimplifying the positive effects of the proposed initiatives and undervaluing their potential benefits. Dismissing efforts at improving safety as band aids is reductive and unhelpful. I discourage it.

178 In 1859, Jules Léotard invented the flying trapeze, a risky spectacle. Today, a highly skilled acrobat performing on a flying trapeze for a crowd of paying spectators will not accept missing their cue and falling. It is not the aerialist's intention, desire or plan. It is not what the spectators have paid to see. The aerialist would view it as a failure. Nevertheless, beneath the trapeze there is invariably a net. The net is a representation of the recognition that everything does not always go perfectly, despite best intentions. The net prevents catastrophic consequences of problems that can arise when doing something as complex and technical as flying through the air trying to catch a swinging bar. With great respect to flying trapeze artists, the health system is more complex than their performance. There are more moving parts, more points of potential failure, there are more interactions, there are more variations. Like flying trapeze, there is the potential for catastrophic consequences.

179 The approach of clinicians who are resistant to addressing issues created by ramping is akin to telling the trapeze artist not to use a net, that they should instead put their efforts into becoming better at the trapeze so that they do not ever miss. No one would suggest it. No one should resist safety improvements for ramped patients on the basis that they inherently despise the practice of ramping itself. This position does not follow the logic of the situation and does not engage with the level of risk involved.

180 While the idea of ending ramping is an admirable goal, it cannot be the only solution pursued. To do so creates a situation which continues to put the lives of those that endure the wait on the ramp at risk. While South Australia is a leader in many fields, it

seems unlikely to me that we will be the first jurisdiction in the world to put an end to entrenched ramping once and for all. Once this is recognised, superficial complaints about the use of 'band aid measures' fall away and the focus on safety nets seem more desirable. Mr Lemmer said that he has observed this attitude to be changing with a growing understanding that new approaches are required.[406] Professor Kelly pointed out that safety issues with ramping can be addressed by accepting that ramping is inevitable, without endorsing ramping as acceptable.[407]

What is being done about ramping?

181 The Court heard about some initiatives that have been tried over the years to address the risks posed by ramping, but which have not continued. Examples were having nurses and doctors from the hospital stationed on the ramp,[408] having a consultant sit at triage[409] and financial incentives for ramping reduction.[410] Each has issues.

182 Successful solutions to ramping are likely going to be multi-system based and made up of many partial solutions which contribute together.[411] I received a great deal of evidence about efforts which are being made to address ramping. Those efforts are commendable. They are broad and meaningful. They will contribute to a stronger more robust health system in South Australia. Dr Lawrence appears to be well-equipped to manage such significant work which is being carried out amongst current health system governance models that are designed to meet requirements of the National Health Reform Agreements.[412]

183 A formalised central governance structure was introduced to deal with the ramping with an overall approach; the 'Ramping Taskforce' or 'Health Chief Executive's Committee: Ramping'.[413] Subsequently, a Ramping Taskforce Clinical Expert Committee was created which guides the Minister for Health on ramping initiatives.[414] Individual Local Health Networks established their own structures in order to implement directions from the Taskforces.[415] These structures were established in an attempt to diagnose the problem and to implement strategies to progress actions for sustainable improvement.[416]

184 Efforts are being made away from the hospital:

a. An enormous investment has been made for the expansion of the ambulance service which I have detailed above.[417]

b. Efforts have been made at diverting demand from Emergency Departments where other services can provide an adequate level of care.[418] A group of paramedics, Extended Care Paramedics, were empowered to make higher level clinical

---

[406] Exhibit C65 at [14]
[407] T2072.34
[408] T222.1, T304.1
[409] T220.36
[410] T1983.11
[411] T1576.30
[412] T1909.8
[413] Exhibit C47 at [88]
[414] Exhibit C47 at [92]
[415] Exhibit C47 at [95]
[416] Exhibit C47 Annexure RAL5 at 129
[417] Exhibit C47 at [207]
[418] Exhibit C47 at [103]

decisions and treat patients rather than transporting them.[419] Mr Lemmer described this process as highly effective, although some improvements to their utilisation could be explored.[420] If patients do not really need tertiary care then the hospital and the patient are better served by avoiding it. In March and April 2024, the ambulance service achieved a 30% rate of Emergency Department avoidance.[421] Public campaigns were released asking people to think about the many ways to get better.[422] As I have said earlier, Professor Kelly's opinion is that lower-acuity patients do not meaningfully contribute to access block as they are generally not admitted to hospital.[423] The utility in these initiatives is likely to be of limited value in dealing with root causes of ramping, but will reduce overcrowding in the Emergency Departments.

c. Virtual Care Services have been introduced to provide patient access to clinicians of various specialisations through video calling.[424] This includes access to GPs after hours. Ms White said that this service is beneficial.[425] These services are complemented by a Health Navigator, a paramedic who provides advice about the paramedic scope of practice and ability to deal with particular patients.[426] The Health Navigator also provides advice to paramedics on the road about alternate care options.[427]

d. Primary Care Centres have been introduced which are operated by GPs in locations with auxiliary services (pathology, radiology and pharmacy) with support from emergency and acute care trained nurses.[428] Importantly, these Centres are not GP clinics and can only receive patients by referral from an Emergency Department, a Virtual Care Service clinician, a paramedic and other clinicians and services. There are five of these Centres in Adelaide.

e. Mental health patients can be diverted to an Urgent Mental Health Care Centre in Adelaide which has a focus on urgent interventions.[429] Dr Lawrence cautioned that these patients might not be patients who would have necessarily added to access block,[430] but again, their absence will reduce overcrowding in the Emergency Department. In addition, mental health specialists have been embedded in ambulances, with three crews across the metropolitan area seven days a week during peak demand.

f. Three pharmacies were extended to 24-hour services.[431]

g. The Commonwealth Government has established five Urgent Care Centres using existing facilities, which provide care for walk-in patients unable to wait for their usual GP.[432]

---

419 T1885.3
420 T2430.18
421 Exhibit C47 at [104]
422 Exhibit C47 at [105] and [107]
423 T2076.28
424 Exhibit C47 at [109]-[110]
425 T464.21
426 Exhibit C47 at [123]
427 T433.26
428 Exhibit C47 at [112]
429 Exhibit C47 at [114]
430 T1988.38
431 Exhibit C47 at [117]
432 Exhibit C47 at [116]

h. SA Health is also planning further initiatives away from the hospital. A new 'Older Persons Emergency Review and Assessment Service' will open with an aim of keeping those over 65 years of age in their home and out of Emergency Departments.[433] Nurse practitioners will also be paired to GP clinics in areas of high demand.[434]

185 It is important to recognise that many of the issues that bring about or exacerbate ramping are not within the control of SA Health and rely on Commonwealth funding and management.

186 At the end of the day, the approach of the clinicians was that patients who arrive at the Emergency Department obviously consider that they need that level of care and so they are triaged and queued for assessment.[435] The Emergency Department is always going to be a place that is in high demand.

187 To that end, initiatives are being pursued at the hospital:

a. At the Lyell McEwin, a Q-Zone was introduced. I will discuss this initiative in detail below. In response to the idea of rolling out Q-Zone type areas in other hospitals, Dr Lawrence advised that there are no immediately accessible fit-for-purpose spaces. In compromise, the Royal Adelaide Hospital and The Queen Elizabeth Hospital introduced specific beds that are kept vacant, so that they can be available for immediate offload upon demand and when decompression of the Emergency Department into wards is not possible.[436] Also in compromise, the Flinders Medical Centre has expanded its Transitional Care Unit with a transportable ward in the hope of indirectly assisting ramping by improving flow.[437] This area identifies, amongst other things, geriatric patients who might be offloaded from ambulances and redirected to alternative care pathways outside of the Department. While these initiatives are to be commended, they fall far short of the benefits realised at the Lyell McEwin Hospital with its Q-Zone, potentially with a similar staffing model.

b. Hospital Ambulance Liaison Officers ('HALO' paramedics) are stationed at the triage area of five of the six major metropolitan Emergency Departments to support and facilitate communications between hospital and ambulance staff.[438] In times of very high demand, HALO paramedics can be moved out onto the ramp to have more direct visibility and involvement in management of patients.[439] Multiple witnesses spoke about the usefulness of this role.[440] HALO paramedics are complemented by a Hospital Relationship Manager who liaises at a system-level.[441]

c. Multi-disciplinary teams have been established at major metropolitan hospitals with an aim of reducing avoidable hospital admissions from within the Emergency

---

433 Exhibit C47 at [118]
434 Exhibit C47 at [119]
435 T1152.10
436 Exhibit C47g at [33]
437 Exhibit C47g at [33]
438 Exhibit C47 at [136]; T437.31, T475.20, T629.12, T820.38, T2394.4
439 T2461.32
440 T849.2, T865.7, T899.13
441 Exhibit C47 at [136]; T922.5

Department.[442] This reduces the number of patients competing for access to hospital wards.

d. There has been a shift recently towards active consideration about the best way to manage mental health patients in the hospital setting, with a workshop involving 45 clinicians and consumers producing five workstreams that are actively seeking to improve processes.[443]

e. As a result, SA Health is undertaking a project aimed at understanding the factors involved in mental health patients' length of stay and optimising strategies to address the issue. Professor McNeil gave evidence that a particular focus of the project has been on patients with schizophrenia who are the highest cohort of mental health patients and have a more heterogeneous presentation,[444] meaning that addressing this cohort will see the most impact quickly.

f. I have already explained that SA Health are pursuing the initiative of taking a blood sample from patients on the ramp.

g. SA Health has committed to introducing consultant-led Rapid Assessment and Treatment models of care at metropolitan hospitals but has encountered recruitment issues[445] and a nursing-led model has been introduced in the interim at major metropolitan hospitals.

h. As I mentioned at [117], the Statewide Interfacility Transfer System has been mandated for most patient transfers. Dr Brooks gave evidence about the prior system of patients simply arriving at the destination hospital with a yellow envelope containing documents from the sending hospital.[446] These patients would inevitably wait outside the Department because they did not need emergency-level care. The introduction of SIFT has seen a dramatic reduction in the use of resources by managing patients this way,[447] with doctors on wards receiving notice of a patient's circumstances and accepting them for direct admission, bypassing the Emergency Department altogether.[448]

i. A transit lounge was introduced at the Lyell McEwin Hospital, and the Flinders Medical Centre are consulting on an expansion of their transit lounge to a 24-hour service.[449]

j. The operation of SWIFT, which I have detailed at [119], from Thursday to Sunday at the Lyell McEwin Hospital has seen a significant increase in weekend discharges.[450]

k. The 'Geriatric Emergency Department In-reach' project has embedded specialist geriatric expertise within the Department to provide a single point of contact, rapid assessment, senior decision making and care coordination for patients older

[442] Exhibit C47 at [139]
[443] T2504.6, T2506.29, T2508.2, T2509.12, T2510.7, T2511.36
[444] T2330.26, T1843.20
[445] Exhibit C47 at [159]
[446] T2518.22, T2519.16
[447] Exhibit C47 at [167]-[168]
[448] Exhibit C47 at [169], noting that not every patient is suitable for direct admission (see Exhibit C47 at [172]).
[449] Exhibit C47 at [191]
[450] Exhibit C47 at [226]

than 65 years of age.[451] This ensures that the patient receives the specific care they require earlier with the goal of reducing length of stay by 25%.

l. The Medical Assessment and Planning Unit was established adjacent to the Lyell McEwin Hospital Emergency Department.[452] It operates 24 hours a day and deals with patients who are expected to be discharged within 24 hours with a view to identifying appropriate out-of-hospital services that will be suitable for these patients. This is complemented with an Acute Surgical Unit that deals with patients presenting for emergency surgery that is expected to generate a length of stay less than 72 hours.[453]

m. Hospitals have been trialling new front-loading models of care in the hope of expediting patient progress.[454] This has been hindered by recruitment issues.[455]

188 Overall coordination of system resources is being introduced:

a. SA Health has turned some of its focus onto the better use of data. The rollout of a single statewide electronic medical record, Sunrise, has enabled live analysis of patient-level data.[456] SA Health established the State Health Coordination Centre (SHCC) which has brought about system-level oversight and navigation.[457] This work is no doubt assisted by the direct involvement of talented and driven clinicians like Dr Brooks who is posted at the SHCC in a multi-disciplinary team.[458] One particular project discussed in evidence was the construction of a digital model of The Queen Elizabeth Hospital so that real-time flow patterns can be viewed remotely in ways not possible without the digital model.[459] Professor McNeil's background and interest in technology has given the Commission for Excellence and Innovation in Health a particular advantage. One particular project he is pursuing is the development of a 'risk calculator' which takes real-time data to allow clinicians to make patient decisions which factor in overall system demand.[460]

b. The SHCC works with the Network Operations Centres of each Local Health Network to improve patient flow and to identify where system-level cooperation is required to facilitate patient care.[461] Paramedics receive guidance from Hospital Network Coordinators about the state of hospitals which they can use to select the most appropriate place to take their patient.[462] A mechanism of 'ramp control' is now used to ensure that no individual hospital is overrun with demand at times when others are less pressured, and this is a less absolute position than going on divert.[463] Dr Wright said there has been improvement with these initiatives.[464]

---

[451] Exhibit C47 at [227]
[452] Exhibit C47 at [233]
[453] Exhibit C47 at [240]-[241]
[454] T114.31, T1361.36, T1378.9, T1521.36, T1652.5, T1969.29
[455] T1841.21
[456] Exhibit C47 at [121]
[457] Exhibit C47 at [122]
[458] Exhibit C66 at [5]; Exhibit C47 at [126]
[459] T2563.15
[460] T2296.22
[461] Exhibit C47 at [130]
[462] T226.13
[463] T2443.11
[464] T1678.37

c. The ambulance service undertook an efficiency project which reviewed the work of the Patient Transport Service. The service was extended to assist 24 hours a day, which has seen an increase in on-time arrival from 25% to 80%[465] and a reduction in the workload pressure placed on fully qualified paramedics during busy times.

d. A 'Discharge Ready Long Length of Stay' project is identifying issues with, and implementing a range of process and efficiency improvements specifically for, patients who spend long periods in acute hospital beds.[466]

e. More effective coordination of mental health resources is being implemented with a view to improving the efficiency and flow of patients.[467]

189 Physical improvements are being made:

a. SA Health has made enormous investments in capital projects and redevelopments.[468] Eight additional beds were opened alongside the Modbury Hospital Emergency Department. A new Emergency Department was opened at Murray Bridge, larger than before. An additional 24 beds were added to the Flinders Medical Centre Emergency Department as well as six flex spaces, although this was subsequently reduced under the Monaghan Review[469] recommendations. The Emergency Department at Mount Barker was expanded by 12 beds. The Lyell McEwin Hospital Emergency Department was redeveloped with an additional 23 beds and a new Mental Health Short Stay Unit to accompany it. A new Emergency Department at Gawler was opened, larger than before. The Flinders Medical Centre and Royal Adelaide Hospital Emergency Departments have been remodelled. A new Emergency Department at The Queen Elizabeth Hospital was opened, larger than before. An aim appears to have been set in line with Australian Medical Association and Australasian College for Emergency Medicine advice to operate hospitals at 85% capacity which would allow them to better deal with peaks and troughs in patient presentations.[470]

b. SA Health intends to open a new Emergency Department in Victor Harbor, larger than before, and a new Women's and Children's Hospital which will incorporate a larger Emergency Department.[471] Hundreds of new ward beds are being opened between 2024 and 2028.[472] Specifically, SA Health intends to open 113 new geriatric beds across three hospitals, 142 mental health beds across five facilities, and a significant number of new hospital beds at Mount Barker and the Flinders Medical Centre.

c. Additional beds in hospitals, outside of the Emergency Department, have already been opened over consecutive years.[473]

---

[465] Exhibit C47 at [188]
[466] Exhibit C47 at [197]-[198]
[467] T1842.28
[468] Exhibit C47 at [141]-[143.1]
[469] Exhibit C47f
[470] Exhibit C47 Annexure RAL9a at 2
[471] Exhibit C47 at [143.2]-[143.3]
[472] Exhibit C47 at [175]
[473] Exhibit C47 at [174]

190 IT issues are also being addressed.[474] A practical example of a simple but expensive initiative is the 'tap on, tap off' system which reduces log-in delays for clinicians.

191 Policies are being used to minimise ramping:

a. SA Health has entered contractual arrangements for the use of private hospital facilities during periods of peak demand, facilitating the clearance of blockages at short notice.[475]

b. A formal 'Fit to Sit' policy was introduced after Dr Lawrence commenced as Chief Executive of SA Health and realised that there was no formal policy on this topic.[476] This standardises and guides decision-making around whether a patient arriving by ambulance can safely wait in the waiting room.[477] Where it is achieved, the ambulance is released back into the community ready to deal with demand.

c. A policy on managing the discharge of patients was introduced which streamlines the discharge process.[478]

192 Given all of this evidence, I find that SA Health's response to ramping is extremely comprehensive and well thought through. Yet, ramping remains an everyday occurrence. According to data published by SA Health, 3479 hours were spent on the ramp across the network in January 2025, an average of more than 112 hours each day. At the Royal Adelaide Hospital, the figure was 1178 hours. This represents an average of 38 hours a day which might, for example, be made up of about five ambulances for seven hours each or 11 ambulances for 3½ hours each. The Flinders Medical Centre recorded 902 hours, an average of 29 hours per day.

193 Dr Lawrence said that it does not matter how quickly new beds come online, the capacity is being eroded by growth in patient numbers.[479] This is yet another reason why eradication cannot be the only approach. To be clear, I find that SA Health's comprehensive attack on the root causes of ramping is an excellent use of public funds, but root causes cannot be the only[480] approach pursued when the issues are so deep.

The Q-Zone, Lyell McEwin Hospital

194 As I briefly mentioned, the Lyell McEwin Hospital Emergency Department was recently renovated, with a re-thinking of the best way of administering emergency medicine. Scoping of innovations in other hospitals was conducted.[481] At a basic level, Nurse Unit Manager Amy Jacobs, who was involved in the design process, said that there was a design intention of breaking staff conceptions about patient flow and so the new zones within the Department were ingeniously named after the cardiac rhythm complex; P, Q, R, S, T.[482]

---

474 Exhibit C47 at [147]
475 Exhibit C47 at [176]-[179]; T1662.11
476 T1920.15
477 Exhibit C41 at [30]; Exhibit C47 at [155]-[157]
478 Exhibit C47 at [192]
479 T1928.29
480 Recognising that 'only' is an inapt description for such a broad range of initiatives.
481 Affidavit C47g at [4]
482 Exhibit C59 Annexure ALJ1 at 1233.2

195 When constructed, the Q-Zone contained two de-escalation rooms, which were given the consumer-focused name 'quiet rooms'.[483] There were four cubicles which were initially used for front-loaded care. There were three cubicles that were always intended to be used for ambulance arrivals.[484] In February 2024, hospital management 'wiped the slate clean' and converted the entire Q-Zone into an area for ambulance arrivals with 24-hour/7-day nursing staff.[485] The staff comprise two dedicated ambulance offload assist nurses and one ambulance triage nurse.[486] When there are no ambulance patients to triage, the triage nurse assists in the care of the patients in the Q-Zone.[487] Assuming transfer of care is achieved for all ten spaces, this represents about the normal ratio for nurses to patients,[488] however some patients may remain in the care of two paramedics. The Department's Flow Navigator was also relocated to the area and now has a view over the ramp, the Q-Zone and the waiting room.[489]

196 Patients arriving by ambulance are brought to this area by paramedics and will wait in their care on a hospital bed until such time as a transfer of care can be achieved. That period of time will, obviously enough, vary. There is a 30-minute target.[490] Once a handover of care is achieved, the patients are put into the care of nurses who staff the area and the paramedics are released. The Q-Zone, structured in this way, has taken the name 'Rapid Offload Zone'.

197 Dr Anand pointed out that the Q-Zone bays were used as conventional treatment spaces during renovation works and so there is equipment there from those times, making it of an improved standard to usual waiting areas.[491] Ms Jacobs held the view that the area would not be as successful without cardiac monitoring, as many patients arriving by ambulance who are not Fit to Sit will require monitoring and, without the equipment, they would need to remain in the ambulance to use monitoring equipment there.[492] Ms Jacobs pointed out that sometimes patients who arrive by their own transport are not well enough to wait in the waiting room. These spaces are sometimes used to accommodate them while they wait.[493] Dr Anand pointed out that when access block reaches high levels, the Q-Zone also becomes blocked. Dr Lawrence pointed out that when staffing issues arise, the Q-Zone is less effective.[494] In my view, the occasional filling up of the space does not constitute a valid reason to dismiss the adoption of such an initiative. It does, however, make it very important to ensure that the space is used for flow and does not become merely a new wing of the Department.

198 Dr Anand spoke of difficult decisions needing to be made in times of high demand ('when the numbers blow out'), which involve an assessment of the appropriateness of assigning

---

483 Exhibit C59 Annexure ALJ1 at 1233.15
484 Exhibit C59 Annexure ALJ1 at 1235.16
485 Exhibit C59 Annexure ALJ1 at 1236.11
486 Exhibit C59 Annexure ALJ1 at 1236.17
487 Exhibit C59 Annexure ALJ1 at 1234.6
488 T979.38
489 Exhibit C59 Annexure ALJ1 at 1239.32
490 Exhibit C47g at [36]
491 Exhibit C58 at [7]
492 Exhibit C59 Annexure ALJ1 at 1238.33
493 Exhibit C59 Annexure ALJ1 at 1236.27
494 Exhibit C47g at [36]

only one triage nurse to 40 patients in the waiting room, but three nurses to the 10 patients in the Q-Zone who could remain in the care of two paramedics if required.[495]

199 I visited the Q-Zone at the Lyell McEwin Hospital in May 2024 and heard much evidence regarding it. At the time of the view, data published by SA Health recorded that there were 61 patients who had commenced treatment against a capacity of 59, with eight waiting to be seen and three expected arrivals.[496] There were three ambulances on the ramp.[497] The overall environment was far from hectic. At the conclusion of the view one hour and 20 minutes later, there were no ambulances on the ramp.[498] SA Health's trend data shows that there has been a significant and sustained improvement in offload times since the refashioning of the space.[499] It may be that this particular initiative is the most meritorious one amongst all of SA Health's recent work.

The fixation with ramping figures

200 Having now established the problem and having established the work being directed at the problem, there is a fundamental issue that needs to be addressed before continuing. There is a lot of focus in the health sector, in the media and in the community on the ebbs and flows of ramping figures; is it up this month or down? While that occurs in the public, I have formed the view that bringing ramping figures down should not be my sole focus. I need to have regard to the figures only to understand that significant ramping continues. However, I am tasked with exploring the cause and circumstances of the deaths of three South Australians who died after periods of ramping. If there was an easy solution and ramping could be fixed overnight, I would focus on that. However, it is clear that there is no simple solution. In fact, aside from the Q-Zone, every effort that has been made so far appears to have been swallowed by an ever-growing demand on the health system. As efficiencies and improvements are realised, ramping gets worse.

201 As a consequence, and by the terms of the Act, I must focus on what caused the deaths of these three South Australians and what improvements can be made to avoid the same thing happening again, within the way a modern health system functions, which includes delays to transfer of care. Effectively, I must focus on recommendations which will make the process of being ramped as safe as possible. It can be easily acknowledged from the evidence of many witnesses, not least Dr Lawrence's comprehensive evidence, that SA Health are attributing enormous levels of resources towards the ramping issue and trying to reduce it. As I have said, that is an approach that should be commended. It is worthwhile and important work and it will hopefully see dramatic improvements in ramping figures. However, the evidence from numerous witnesses was that all modern healthcare systems have ramping. It appears to be almost impossible to eliminate. It may appear self-evident and understandable; unless hospitals hire enough doctors and nurses to ensure that someone is always available and not actively treating a patient, it is simply not possible to admit every patient immediately upon arrival.

202 The starting proposition, one that the Victorian health system appears to have recently reached, has to be that ramping is going to happen. Having accepted that, attention can

[495] Exhibit C58 at [8]
[496] Exhibit C53 at 18-LMH6
[497] T1221.17
[498] Exhibit C53 at 14-LMH2
[499] Exhibit C59 Annexure ALJ1 at 1237.5

turn firstly towards reducing the levels as much as possible. As I have said, so much is being done to address the issue. Secondly, to implementing improvements to the safety and comfort of those who have to deal with the consequences of ramping; patients and paramedics. I consider that I should make focused recommendations in areas where safety improvements can be expected. These should not only encompass physical improvements, but also process improvements, as well as broader cultural or attitudinal improvements. Just as a very wide approach is needed to reduce ramping, a wide approach is also needed to improve the safety of ramping.

203 In order to commence the process of cultural change and change in the community's attitude to ramping, I make a recommendation directed to the Minister for Health and Wellbeing:

> *Rec 1 That the South Australian Government formally acknowledge that ramping is a reality that all modern healthcare systems encounter. While efforts to reduce the levels of ramping remain extremely important, efforts must also be made to make the process of ramping safer for those patients who will inevitably experience it.*

204 Dr Lawrence agreed that it is reasonable to act on ramping as a reality but also continue to maintain a focus on strategies to end it.[500] If that fundamental policy was adopted, the health system can stop pulling itself apart each month as ramping figures roll in. It can instead focus on doing health the best way it can. The State of South Australia indicated that more recently there has been some level of recognition of this reality.[501]

205 The AEA opposed this recommendation, calling it 'incredibly dangerous'. Respectfully, that approach ignores the effect of later recommendations and disregards my reasoning that an entirely new way of thinking needs to be adopted throughout all levels of health care. The State of South Australia opposed the recommendation on a number of bases. I have taken into account the opposition to this recommendation. I still consider that a public statement is the necessary first step to moving beyond a paradigm where so much effort and energy is wasted on discussing ramping figures instead of actually focusing on improvements to the ramping process. It would have the effect of readjusting clinicians' views about ramping and ensuring their 'buy-in' on improvements. It would quell public disquiet about the phenomenon of ramping. I consider that in all of the circumstances of this Inquest, this recommendation is not only appropriate but is critically important. I encourage the State of South Australia to give very careful consideration to adopting this recommendation as setting the health system on a new path.

Key recommendations to improve safety

206 As I have said, given the context of this Inquest, my primary focus must be on improving safety for those who will be ramped. A number of key areas were explored where meaningful improvements might be achieved. I will make recommendations which will mitigate the consequences of the compromised standard of care attributable to ambulance ramping.

---

[500] T1937.14
[501] Written submissions of the State of South Australia dated 28 March 2025 at [47.2], [54] and [61]

Offload directions

207 The Court heard evidence of 'break glass' Directions issued under the *Health Care Act 2008* which effectively set a timeframe ceiling which, upon a ramped patient reaching, would see their immediate offload ahead of any other patient, including more seriously ill waiting room patients or more seriously ill ramped patients who arrived subsequently, but are yet to reach the ceiling.[502]

208 The evidence of the clinicians was that these Directions are not achievable and can in fact be dangerous to more seriously unwell patients.[503] They represent an added pressure and another consideration in an already complex scenario. The Ambulance Transport Policy requires consideration of the value of having ambulances in the community amongst clinical urgency.[504] It is at that level that offload should be considered rather than abstract timeframes which do not take into account the actual clinical picture facing the Department.

209 While I accept on face value that directions to offload ambulance patients who reach a particular ceiling are well-intentioned, they carry dangers and are not appropriate. Clinicians must be left to make appropriate decisions about patient order on the basis of their professional medical assessments. I have accepted submissions from the State of South Australia that Dr Lawrence has revoked these Directions and therefore I make no recommendation on this topic.

The appropriateness of the Australasian Triage Scale

210 The Court heard evidence from many clinicians about the manner in which patients are taken into the Department. A significant component of the process is reliance on the Australasian Triage Scale.[505] The Court heard that this scale is used by all hospitals across Australia.[506] It was first developed in 1976 as a three-category scale.[507] It has received numerous scientific validations as a tool which reliably determines urgency of patient arrivals.[508] It requires an assessment of an incoming patient in less than five minutes[509] and sets out the minimum amount of information that must be ascertained.[510] In many respects, it is a process of applying gut feeling using experience and observation.[511] There are a number of 'red flags' which will raise a patient's urgency, in particular haemodynamic instability.[512]

211 The Court heard that triage nurses are very experienced and have worked towards taking on the triage role through a progression pathway over a number of years.[513] Ms Toohey said that triaging is an art, different from other nursing roles, that is refined with time and experience.[514] The triage nurses who gave evidence all appeared to be sufficiently

---

502 For example, Exhibit C43c; Exhibit C47 at [260]
503 T1608.25, T1740.20, T1967.11
504 The effect of Exhibit C47c, which is currently being formally written into a new version of the policy (see T2280.23)
505 ATS
506 Exhibit C47 at [245]
507 Exhibit C39a at 11
508 Exhibit C39a at 11
509 T685.20, T2016.9
510 T780.18
511 T347.18
512 Exhibit C39 at [11]
513 Exhibit C39 at [10]; T643.34, T680.2, T990.3, T1337.13
514 T1133.23

experienced and adequately trained for the task and, in the case of Ms Crowther, appropriately supervised towards the end of her training. It certainly could not be said that there was any training issue which compromised the care provided to Mrs Panella, Mr Skeffington and Mr Jessett, except that mandatory visualisation was not enforced, an issue I will address shortly.

212 The ATS now breaks patients down into five categories.[515] Category 1 are patients that require immediate care (immediate patients). Category 2 patients are those who can safely wait 10 minutes for care (emergency patients). Category 3 patients are those that can safely wait 30 minutes for care (urgent patients). Category 4 patients are those that can safely wait 60 minutes for care (semi-urgent patients) and Category 5 patients are those that can safely wait 120 minutes for care (non-urgent patients).

213 Paradoxically, even though these times are frequently exceeded, the evidence of the clinicians,[516] as well as the expert opinion of Professor Kelly, was that no adjustment should be made to the Category assigned to a patient by virtue of the actual delay that may be experienced.[517] The effect of this is that all patients remain in relative order to each other, even though the specific timeframes will not be met.

214 On many occasions clinicians spoke about the manner of dealing with Category 1 patients.[518] These patients include those in respiratory or cardiac arrest or with airway concerns. They are patients who will not survive without immediate intervention. Their arrival rightly overrides anything else happening in the Department. They are usually dealt with in the resuscitation area. I find that this is entirely appropriate.

215 The Court heard that Category 3, 4 and 5 patients, while ranked on paper, are simply seen in order of their arrival. One witness conceded that the task of assigning a triage Category to these patients is ultimately pointless.[519] Given that all three of the South Australians under consideration in this Inquest were assigned to Categories within this band, the appropriateness of this practice was explored during the Inquest. One might reasonably infer that the process is not suitable, as it does potentially result in scenarios where numerous patients of lower acuity (4 and 5) might be seen before a higher priority (3) who arrives after them.[520] However, as is usually the case in the health system, there are underlying complexities and nuances to be considered.[521]

216 The primary factor at play is the use of streaming. This breaks patients down into streams of patients that are dealt with in different areas of the Department, with different resources and different goals. The best example of this in operation was a patient of lower acuity that is able to be seen in the ambulatory stream by a nurse practitioner without the use of a fully equipped hospital bed. The patient is discharged without having had any involvement of a doctor or any use of a space that could have been occupied by a sicker patient. Seen in this light, the earlier treatment provided to the lower acuity patient has had no practical impact on the higher acuity patient who was likely in a different stream, competing for different resources. Further, if strict category-driven intake was practised,

[515] Exhibit C39a at 9 and 23; Exhibit C43 at [9]
[516] T1135.24
[517] T2119.28
[518] T256.38, T352.23, T502.34, T1156.32, T1586.32
[519] T1166.24
[520] T1965.28
[521] T2067.19

the actual effect in light of the level of demand in the Department would be that some Category 4 and 5 patients would simply never be seen,[522] an unacceptable outcome. Dr Lawrence's view was that streaming is an effective way of dealing with intake.[523] Professor Kelly agreed.[524] Mr Peck pointed out that streaming models are used across the country and internationally.[525] In light of that analysis, there was no improvement identified in the manner of application of the ATS, which appears to be achieving what it needs to achieve.

217 The Court heard that triage is guided by an Emergency Triage Education Kit, a new version of which was released in 2024 and which was contributed to by Ms Toohey.[526] The new Education Kit is clear, comprehensive and concise. It contains 132 test scenarios. It is, no doubt, an excellent resource for triage nurses who are supported into the role generally after years of experience in emergency medicine.

218 The Education Kit defers to local hospital policies in respect of 're-triaging' but implies that patients should be reviewed after the expiration of the target timeframe.[527] This was another issue explored during the Inquest. There is a formal 're-triage' requirement of 30 minutes in Queensland and a general expectation of checking on patients in Victoria.[528] The very clear import of the evidence was that triage nurses, as currently staffed, would be unlikely to be able to comply with a requirement to visit patients again after 10, 30 or 60 minutes to review their condition.[529] I consider that other recommendations that I will make will address the workload of triage nurses and no separate recommendation need be made about 're-triaging' at set intervals. I am also concerned about the possibility of adding to the workload of triage nurses prior to a review of their duties being conducted. This could put a great deal of additional pressure on these busy staff and would likely not be achievable. It could have the effect of making triage nurses more difficult to find in urgent circumstances, as occurred in Mrs Panella's case. I have determined not to make any recommendation about re-triaging, particularly given that I will recommend observations be taken at minimum intervals by paramedics who will be empowered to escalate concerns. However, I note for the benefit of SA Health that this topic should be revisited once triage nurses are given more capacity and particularly where visiting ramped patients is not as difficult as it is outside the hospital.

219 In the end, triage categories are only part of a complex system of information that is used to determine patient order. In light of all of the evidence and in light of that analysis, I consider that I need not make any recommendations about the appropriateness of the use of the Australasian Triage Scale and its manner of implementation in South Australia.

Visualisation at triage

220 A key issue that was explored at Inquest was the lack of visualisation by triage nurses of ramped patients. Visualisation is a process of looking at and interacting with a patient

---

[522] T2067.6; Exhibit C41 at [12]
[523] T1966.1
[524] T2068.31
[525] T1374.38, T1410.12
[526] Exhibit C39a; T1051.17
[527] Exhibit C39a at 9 and 29
[528] Exhibit C49f; T2043.9, T2115.26
[529] T357.31, T765.31, T1150.28

while ascertaining their medical complaint.[530] The document now governing triaging, version 2 of the Australasian Triage Education Kit, mandates visualisation of patients during triage,[531] as did its predecessor. An accompanying document, 'Guidelines on the Implementation of the Australasian Triage Scale in Emergency Departments' explains that triage involves a combination of the presenting problem, the general appearance of the patient and any pertinent physiological observations.[532]

221 Professor Kelly explained that important information, meaningful nuances and subtle visual clues are easily lost in a triage where there is no visualisation. This can result in an under-appreciation of how unwell a patient is.[533] Dr Lawrence said that all patients should have a brief assessment by the triage nurse.[534]

222 Notwithstanding that the agreed-upon process requires patient visualisation, clinicians all agreed that visualisation is a critical part of triage.[535] The evidence of multiple witnesses established that visualisation was not standard practice at the time of the deaths of Mrs Panella, Mr Skeffington and Mr Jessett.[536] That it had become a totally accepted practice not to visualise a patient was evidenced by the introduction of an acronym expansion,[537] in effect a set of standard triage text which recorded that triage had been compromised due to busyness.

223 Shortly before the commencement of the Inquest, the Flinders Medical Centre introduced a visualisation requirement, which is effectively a workaround of numerous issues, that involves unloading patients from ambulances and returning them to the ambulance after triage.[538] Safety concerns were raised about blocking the entry when a resuscitation-level patient arrives,[539] however the evidence of clinicians was that this was workable and an overall improvement.[540] The clear import of the evidence was that Category 1 patients who require immediate life-saving treatment are able to be brought through even with airlock-visualisation in place. The evidence was that another issue of the expectations of patients is managed by explanations of the process.[541]

224 Dr Romualdez said that there is no proposal for triage nurses at the Royal Adelaide Hospital to conduct visualisation of ramped patients,[542] although if that was recommended she would work with nursing staff to make it happen.[543] I consider that without external disruption, Royal Adelaide Hospital patients will continue to be prioritised on the basis of second-hand information from paramedics.

---

[530] T726.30, T1124.26, T2015.29
[531] Exhibit C39a
[532] Exhibit C32a at 4
[533] Exhibit C49a at 9; T2014.2, T2015.1; Exhibit C49e at 10
[534] Exhibit C47 at [249]
[535] T252.37, T361.13, T623.10, T656.23, T746.28, T903.17, T906.32, T925.10, T1064.26, T1095.15, T1332.21, T1339.32, T1344.113, T1373.30, T1648.20; Exhibit C39 at [34]
[536] T129.9, T220.9, T342.26, T457.38, T606.6, T621.6, T626.30, T634.2, T656.15, T656.30, T670.31, T687.17, T688.18, T737.36, T806.34, T953.19, T970.29, T1063.17, T1095.28, T1331.19, T1649.10; Exhibit C37 at [41]
[537] T252.15, T311.3, T312.21, T664.26; Exhibit C18 at 108
[538] T800.38, T809.32, T944.14, T1348.1, T1373.17, T1389.13; Exhibit C38 at [20]; Exhibit C39 at [36]; Exhibit C41 at [27]
[539] T904.11, T915.19, T971.38, T1097.14
[540] T925.25, T998.6, T1063.29, T1095.10
[541] T840.37
[542] T1527.36
[543] T1527.24

225 The lack of visualisation appears to have most clearly had an impact on Mr Skeffington's care, as paramedic Stacey White gave evidence that Mr Skeffington was in a lot more distress during his episodes of dry retching than his observations showed. He was never visualised at these times.[544]

226 In light of the evidence, I make the following recommendation to the Minister for Health and Wellbeing:

> *Rec 2* *A statewide policy should be introduced requiring visualisation of patients arriving for triage, regardless of their manner of arrival, in line with the Australasian Triage Scale Education Kit. Additional resourcing for triage nurses may be necessary to achieve the requirement in practice. The policy should allow for each hospital to decide the manner in which visualisation occurs. The policy should be kept up to date with best clinical practice.*

227 The State of South Australia asked me not to make this recommendation on the basis that policies and procedures are inflexible, prone to outdating, might be inconsistent with national standards and are sometimes not supported by clinicians. The State submitted that if standards were to change over time and visualisation is no longer recommended in the ATS, then the existence of my recommendation would not require SA Health to continue the practice. In my view, given that the ATS mandates visualisation it cannot be said that this recommendation might be inconsistent with national standards. I do not foresee that such a fundamental and basic requirement will be removed from the national standard. All of the clinicians and administrators who gave evidence on the topic spoke in support of the requirement for visualisation to have a reliable triage. Given that, I consider such a policy would likely have clinician engagement. Given the clear evidence that this critical process is not conducted, I consider that this recommendation is an appropriate one to make. Leaving this issue to operational clinicians has simply not worked sufficiently.

228 The AEA supported this recommendation but asked me to consider including a prohibition on visualisation in airlocks.[545] I have carefully considered that issue. When close attention is paid to the evidence, it is clear that it did not establish safety issues which are so apparent that they would preclude visualisation in the airlock as being a viable option and, in effect, override the enormous advantages to triage gained by having a direct visualisation. To be clear, I do not endorse visualisation inside airlocks as an ideal practice, but as I have already explained, these are difficult times for the health system and some compromises are inevitable.

229 The AEA also asked me to consider recommending that a separate nurse be specifically assigned to deal with ambulance arrivals only.[546] While that is attractive, in light of the evidence I consider that it is very unlikely for paramedics to wait for any excessive time for a triage nurse. Mandating specific roles might be considered appropriate by SA Health, but I cannot say that with certainty. In this area of individual roles, there is the possibility of restricting flexibility in an unhelpful way. In the end, I am not satisfied that it is appropriate to recommend that this be mandated.

---

[544] T424.32
[545] Ambulance Employees Association written submissions dated 18 March 2025 at [34]
[546] Ambulance Employees Association written submissions dated 18 March 2025 at [34]

230 I have not been presented with evidence about the productivity of triage nurses and so, while I am satisfied on the evidence that they are too busy, I am unable to conclude with the required degree of certainty that an increase in triage nurse staffing is what is required, particularly where I propose to recommend that the duties of those staff are reviewed.

Triage distractions and workload

231 Triage nurses are a vital interface between patients seeking treatment and Emergency Department clinicians, providing the initial point of contact and liaising with staff in the Department and on the wards to facilitate the flow of patients. Triage nurses need to manage patient prioritisation which constantly shifts with developments amongst all patients. It is a challenging role.[547]

232 The Court heard evidence from six triage nurses about the number of distractions experienced and their effect. Paramedic Kristen Carter said that continual interruptions can throw her thought while trying to get through a triage handover and was one of the biggest frustrations in her work.[548] The following distractions were identified:

a. Communications with shift coordinators and area coordinators about:
   i. beds becoming available
   ii. requests to bring patients through
b. Discussions with other triage nurses about patient order
c. Radio notifications
d. Confirming incoming patient identity and directing them
e. Paramedics interrupting with a more urgent case
f. Phone calls
g. General noise[549]

233 Triage nurses spoke about developing the skill of taking a complex medical handover in a chaotic environment,[550] but agreed that interruptions and distractions do not assist.[551] The high demands of the triage role were part of the reasoning behind visualisation ceasing to be routine.[552]

234 One potential improvement identified was the removal of the obligation of the triage nurse to listen to the radio. This was rejected by the triage nurses who gave evidence, as they considered the information coming through to be critical for their role and that it must be a clinician who listens to what is being said.[553] The movement of the radio at the Royal Adelaide Hospital to be between both triage nurses was noted to be an improvement, as it meant that the role of listening to incoming notifications could be shared.[554]

235 Nurse Educator for the Southern Adelaide Local Health Network, Ms Toohey, agreed that triaging involves some administrative tasks, such as notifying other teams.[555] She agreed

---

[547] T1089.29
[548] T216.26
[549] T217.4, T257.18, T305.5, T415.18, T717.2 T961.31 T1088.10, T1316.18, 1334.19, T1452.4
[550] T717.25, T1139.30
[551] T962.14
[552] T342.26
[553] T359.6, T1476.25, T985.22, T1141.1
[554] T319.21, T327.37, T763.5
[555] T1098.36

that the removal of some administrative tasks would improve their ability to carry out triaging.[556]

236 Triage nurses spoke about having backup to help them in times of peak demand using an informal process,[557] but there being a delay to additional staff being able to attend to assist,[558] and there being concerns about taking a staff member away from somewhere else during busy times.[559] Ms Toohey considered that informal backup processes were adequate.[560]

237 While backup processes were generally thought sufficient,[561] that must be viewed against the background of visualisation and periodic reassessment being impossible to achieve.[562] Ms Toohey gave evidence of not calling for backup when required because it would have the consequence of removing a resource from another area equally under pressure.[563] Ms Heywood said that she would not seek additional support just to conduct visualisation on the ramp.[564]

238 Of course, triage distractions and an unrelenting workload not only make the triage nurse's actual triage task more difficult, but they also have an impact on the triage nurse's ability to fully do their work. In particular, I again refer to the fact that visualisations have faded out of practice due to workload pressures.[565]

239 In light of the ample evidence about workload pressures and distracting tasks, I make the following recommendation to the Minister for Health and Wellbeing:

> *Rec 3 SA Health should review the staffing model and workload of triage nurses at metropolitan Emergency Departments with a view to identifying tasks which may be appropriately carried out by an administrative support person assigned during times of peak demand to assist triage nurses. This review should consider the costs and benefits of an increase in administrative staffing per shift versus an increase in triage staffing per shift. The review should take into account any applicable workplace agreements. The review should be consultative and consider the full impact of any proposed changes.*

240 The State of South Australia submitted that there was insufficient evidence of the planning of triage nurses' work in order to make this recommendation. I disagree. Much evidence was given about tasks which add to the workload of the multiple triage nurses who gave evidence. My recommendation is merely that their duties be reviewed. If the result of that review is that staffing is sufficient and the tasks being undertaken cannot be asked of any other staff, then the recommendation will be satisfied. I consider that this is an appropriate matter upon which I should make a recommendation in order to prevent

---

[556] T1142.8
[557] T246.37, T341.33, T978.16, T1129.35, T1130.14
[558] T983.2, T982.23
[559] T978.16
[560] T1130.14
[561] T1130.14
[562] T656.30, T728.17, T746.28
[563] T1133.7
[564] T342.26
[565] For example, T671.2, T728.19, T740.34

further deaths through an inability to manage all tasks required of a triage nurse performing a crucial duty at a crucial moment in the patient's journey.

Triage handovers

241 The Court heard much evidence about triage handovers and the content of the triage note. There was a heavy focus on this issue, as there were differences discovered between the notes of paramedics and the triage notes recorded, sometimes in significant respects.[566] The evidence explored the differing purposes between paramedic records and triage notes and established that the notes will always be different.

242 Evidence from SA Health established that a new digital Patient Clinical Record is being developed which will integrate with Sunrise, so that a patient's observations will be transferred and recorded in the hospital's records.[567] This was welcomed by clinicians.[568] Hopefully this will be able to be charted visually, so that abnormalities can be easily identified with colour banding which has proven a useful tool over many years. Both efficiency and accuracy gains are likely to be achieved through the use of digital integration. More information will be available to doctors upon picking up a patient's case. This will also remove delays in locating the correct patient record at the triage desk.[569] This work is underway and I consider that I need not make any recommendation about it.

243 Notwithstanding the proposed digital integration of ambulance records, paramedics will still be required to conduct oral handovers to triage nurses. This will involve visualisation and a discussion about the actual medical impression of the patient so that a proper triage score can be assigned.

244 Professor Kelly, who routinely reviews South Australian medical files for coronial investigations, gave evidence about structured handover processes. Mr Gallagher said that he was trained to use a structured format,[570] however Professor Kelly said that she rarely finds handovers recorded in a structured way, which she considers to be a 'missed opportunity'.[571] These facilitate the handing over of a complex set of information in a short space of time without missing important topics. Professor Kelly considered that it would be appropriate for handovers to be mandated in a structured format.[572]

245 The AEA submitted that a structured handover might inhibit flexibility in tailoring a handover. Respectfully, what is proposed is a structure around the very broad topics to be covered rather than specific content. For example, under the 'ISBAR' structure, the 'S' requires recording of what the situation is, the 'B' requires recording of what the background is. These leave ample scope for customised clinician observations. I cannot accept the submission that recording content under particular headings in a particular order is 'another layer of bureaucracy', nor that extensive training is required.

---

566 For example T53.37, T54.18, T105.26, T268.15, T1343.13
567 Exhibit C65 at [32]
568 T322.12, T917.27, T2503.4, T1849.11
569 T760.13
570 T897.25
571 T2027.27
572 T2029.38

246 I have not been presented with any evidence that SA Health's rollout of a digital patient clinical record is expected to record a handover in a uniform way. It might be thought by designers that a blank page would be appropriate for paramedics to write their notes in whatever format they wish, replicating current paperwork. If it does require a set structure, a policy requiring that will be easily met during the rollout. In any event, I am proposing to limit my recommendation on this topic only to oral handovers, as I consider that the area where there are more likely to be miscommunications.

247 The State of South Australia acknowledged that accurate-handover issues persist,[573] but submitted that no recommendation is necessary because there is evidence of structured handovers being in use and being required under national standards. The State seems to call for a rejection of the evidence of Professor Kelly on the basis that she does not reside in South Australia. While I agree that the evidence did not establish that a failure to use a structured handover specifically contributed to the handover issues comprehensively explored in the cases of Mrs Panella and Mr Jessett, a standardised approach having flexibility within it is, in my view, an appropriate matter upon which I should make a recommendation.

248 In light of the evidence, I recommend to the Minister for Health and Wellbeing:

Rec 4 A statewide policy should be introduced mandating the use of a structured oral handover between paramedics and triage nurses.

Triage communication

249 The Court heard evidence that there is no standardised practice of paramedics being informed of the triage Category their patient is assigned at the conclusion of triage, although paramedics do sometimes ask triage nurses.[574] Many triage nurses do offer the information.[575] Ms White was not informed of Mr Skeffington's triage Category, but inferred it was low from her conversation with the triage nurse.[576] Ms Pankoke said that it would be useful to know how long a patient is likely to wait.[577] Ms Araki and Mr Peck said that the time a patient might wait is a difficult thing to predict because there are so many factors involved.[578] This is a fair observation. Sometimes, paramedics are instead advised how long the last patient on the ramp waited before being taken in.[579]

250 The State of South Australia made submissions about potential friction that communication of the triage Category assigned could create. Friction may be experienced, but there are likely to be benefits which outweigh the risk of such friction.

251 There are obvious benefits in paramedics having more information about the hospital status and their patient's individual assigned priority. It must be remembered that paramedics are highly trained and have a great deal of experience on the ramp. They will be able to form an impression of whether their wait is likely to be long or short. If they knew their patient was at a lower priority and they observed chaos when they were inside

---

573 Written submissions of the State of South Australia dated 28 March 2025 at [94]
574 T124.34, T218.30, T356.36, T638.8, T692.25; Exhibit C39 at [30]
575 T834.35; Exhibit C37 at [40]
576 Exhibit C27 at [47]
577 T636.14
578 T692.32, T1421.5
579 T1420.30

triaging, they would be able to temper their language with their patient about the expected timeframe. They would also be able to feed information back to the Operations Centre about their likely availability for further cases, facilitating better management of resources. Knowing the assigned priority would also allow for them to make their own assessment as to whether some important feature of the patient's case has been missed during triage. For example, it might have raised a query about whether Mrs Panella's hypoxia had been understood or whether Mr Jessett's multiple comorbidities were appreciated, or even whether they should be handed over if they initially had not been. In the absence of the result of triage, paramedics have no way of knowing whether there has been an obvious error. The provision of the Category would serve as a safety net for glaring errors. Whether triage nurses have good or bad news, this should be shared with the paramedics. I consider that a policy is required for consistency of approach amongst clinicians across the State. In that light, I make the following recommendation to the Minister for Health and Wellbeing:

Rec 5 *A statewide policy should be introduced with, or an existing policy amended to include a requirement for triage nurses to advise paramedics of the triage Category assigned to each patient who is not immediately brought into the Emergency Department.*

Blood tests for ramped patients

252 I have set out above the proposal for blood samples to be taken on the ramp. I consider that this is a very important safeguarding technique that will identify cases of impending disaster. Dr Lawrence gave evidence that SA Health had decided to pursue the initiative, but had encountered significant opposition to this proposal, and so I am inclined to intervene. I make the following recommendation to the Minister for Health and Wellbeing:

Rec 6 *That a trial be undertaken of blood samples being taken from patients waiting for emergency treatment in metropolitan hospitals following triage who are anticipated to wait on the ramp beyond their ATS target timeframe, with the usual processes applied for the review of results to detect and raise alarm about results which indicate that the patient is at imminent risk of death. A review should be scheduled at the end of the trial to determine whether there were any unexpected negative impacts, with consultation of those involved.*

Conditions on the ramp

253 The Court heard a great deal of evidence about the conditions facing patients, paramedics and hospital staff on the ramp. These conditions create an environment of risk to patient health in various ways.

The environment

254 In respect of patients, multiple witnesses spoke of the discomfort of the actual barouche used in ambulances when used for prolonged times.[580] Dr Romualdez spoke of a sense of inaction felt by patients waiting outside.[581] All witnesses who were asked agreed about

[580] T232.16, T478.7, T927.38
[581] T1555.20

the undesirability of exposure of sick patients to extreme weather,[582] which results in the need to use air conditioning inside ambulances. This results in fumes being delivered into the ramping area. A number of studies have been conducted in relation to fumes on the ramp with external scientists recommending mechanical ventilation fans be used to minimise risk.[583] The most recent independent study relied on anecdotal experience of the scientist to conclude that exposure to fumes on the ramp was an irritant that brought about discomfort and a headache.[584] It appears to be quite difficult to scientifically quantify the fumes issue, but there does appear to be a genuine issue.

Deteriorations

255 Issues in dealing with deteriorating patients on the ramp were raised. If a patient is within the Emergency Department and crashes, an alert system is in place to assemble a MET quickly.[585] There is no equivalent on the ramp. That puts patients deteriorating on the ramp at heightened risk given that they need to be offloaded and brought in before a doctor even sights them, much less a team being assembled. If a patient crashes, these are critical moments which could be the difference between life and death.

256 There are three aspects to patient deteriorations. The first is the training of paramedics to detect slow deteriorations and being able to escalate them. Given that the primary role of paramedics is to stabilise patients and transport them to hospital, they are not traditionally trained to monitor patients over extended periods and detect deteriorations. I do not suggest that they would not appropriately identify deteriorations and act on them, I merely point out that it is not their traditional role to watch for deteriorations over extended periods. There are no specific timeframes for paramedics to record observations of ramped patients,[586] although set timeframes exist in the Department.[587] If a paramedic does detect a deterioration, they still have no power in the situation and are at the mercy of the triage nurse who makes all relevant decisions. Professor Kelly pointed out that an absence of formal protocols was inconsistent with National Safety and Quality Health Service Standards.[588] It was acknowledged that some junior paramedics, or ambulance officers without paramedic qualifications, may not have the confidence required to interrupt a busy triage nurse to discuss changes to their patient who has been deemed low priority. Also, in the case of Mr Jessett, Ms Weston did not consider that Ms Wegener was actually escalating Mr Jessett's case, instead believed only that she was providing an update.[589] Ms Wegener said that she was reporting a new symptom[590] and that she was concerned about it in light of Mr Jessett's history.[591] These approaches can be rationalised, however that there can be ambiguity demonstrates the need for clear guidance.

257 In light of those issues, Professor Kelly proposed a 'track and trigger' process where a patient's observations are taken at set intervals[592] and agreed processes followed where

[582] T622.4, T657.11, T1106.1, T1553.26, T928.2, T973.23, T1106.1
[583] Exhibit C65d Annexure PL6 at 15, Annexure PL7 at 59 and Annexure PL8 at 96
[584] Exhibit C65d Annexure PL8 at 117
[585] T2219.11
[586] T831.12, T832.37
[587] T980.7
[588] Exhibit C49a at 10; Exhibit C49c
[589] T952.28
[590] T804.12
[591] T820.5
[592] T2251.26

certain results are seen. To this end, Professor Kelly provided a copy of a track and trigger chart used by nurses inside hospitals in New South Wales.[593] It can be seen that observations are set out with colour bands representing levels of concern. Where a certain number of observations are seen within a certain colour band, specific steps for escalation are set out. I observe that the ambulance service has colour banded observations on its paper-based Patient Clinical Record, however the key difference in Professor Kelly's proposal is that there are currently no steps for escalations set out and to the extent there are, they do not relate to or involve the hospital. A key component of Professor Kelly's proposal would be the agreement by the hospitals of those steps. This would empower the junior paramedic or ambulance officer with a requirement to raise certain combinations of observations, and thus ensure that no patient's deterioration is missed as a result of these issues.[594]

258 The second component is the physical ability to escalate a patient's case. There are no, or insufficient, emergency buttons in the ramping area.[595] The result is that paramedics are required to walk back into the hospital to speak to the triage nurse. This is time consuming. This had a devastating effect in Mr Skeffington's case where a paramedic was sent inside to speak to the triage nurse, leaving paramedic Stacey White alone with Mr Skeffington. His condition escalated dramatically in that time and Ms White had to provide emergency care alone. Fortunately, she was able to bang on the side of the ambulance in order to attract the attention of nearby paramedics who began to assist with unloading him. A connection to the triage desk by radio was explored, however this is not timely and is not a suitable solution.[596] I accept that in cases of known extreme emergency, paramedics are likely to bring a patient directly into the Department without trying to seek permission first. However, as occurred in the cases of Mrs Panella and Mr Skeffington, deteriorations can build under the surface and time was spent seeking approval for entry. It is also not ideal to have such a potentially concerning event be left to individual clinicians to make their own decision about the right thing to do without any formal guidance. The evidence established varying views about how to handle a deteriorating patient and, for example, when it would be appropriate to simply bring a deteriorating patient inside the Department without prior permission.[597] In short, leaving this issue to individual clinical judgement creates an unsatisfactory situation.

259 The third aspect of deteriorations on the ramp is the time involved in unloading a patient to bring them into the hospital. During the Inquest I viewed a demonstration of unloading at the ambulance Operations Centre.[598] This takes at least a couple of minutes. In cases of deterioration, these are crucial moments, particularly when mounted on top of delays experienced in seeking out a triage nurse's attention.

260 Dr Lawrence said that a protocol to govern paramedic escalations could be developed if necessary to give guidance and empowerment.[599] In its submissions, the State of South Australia acknowledged that work is required in this area and pointed out that a policy

---

[593] Exhibit C49d
[594] T2024.16, T2218.25
[595] T194.1
[596] T193.29, T438.29
[597] T193.29, T200.24, T202.36, T429.24, T438.29, T979.24, T1098.9, T1102.6, T1334.1, T1377.28, T1542.4, T2407.14
[598] Exhibit C57 Annexure NEB1 at 7
[599] T1977.33

for escalations is in place in one hospital.[600] The State pointed out that clinicians who gave evidence had an inherent sense of the right approach to deteriorations.[601] Given that that could vary, I consider that a policy should be made and I consider that the process of managing deteriorations should take a particular form, colour banding, which has been very successful for many years. In order to deal with the issue of patients who deteriorate on the ramp, I make the following recommendation to the Minister for Health and Wellbeing:

Rec 7 SA Health should introduce a statewide policy and/or protocol for dealing with patients who deteriorate in the care of paramedics while waiting for admission to an Emergency Department. This policy should recommend observations by paramedics at minimum regular intervals (subject to clinical judgement) and would ideally contain a colour-banded chart with specific actions required depending on the results. The protocol should set out who is responsible for dealing with the deterioration on the hospital's behalf and what should be done. The protocol should endorse escalation in any circumstance where there is clinical concern, whether it meets the criteria set or not.

261 Mr Lemmer gave evidence that such a protocol is under consideration.[602] From my observations of the demonstration, there appears little that can be done to reduce the time involved in safely unloading a patient from an ambulance on the ramp. Identifying the need to do so early is therefore of high importance.

262 The AEA supported this recommendation but opposed the aspect requiring regular intervals. In my view, without a requirement to specifically take observations at set times, there is a risk that an escalation protocol will not actually achieve the purpose of identifying deteriorations early. In my view, this is a key aspect of the recommendation and it is appropriate to incorporate it.

Facilities

263 Another issue which arose was the availability of toilet facilities on the ramp. There are none. The result is that patients who have been ramped who wish to use the toilet must be unloaded from the ambulance taken inside to use facilities and then brought back to the ambulance.[603] This is a manually intensive task[604] which ambulance officers may be required to do multiple times. It is unlikely to assist the patient's health where they have been deemed not Fit to Sit.

The ability to properly care for patients

264 Issues with the undesirability of patient monitoring inside the confined space of the ambulance were explored. I entered and viewed the space available inside an ambulance.[605] Clinicians spoke of needing 360-degree access to a patient to properly assess their condition. This is impossible inside an ambulance.[606] Dr Brooks spoke

---

[600] Written submissions of the State of South Australia dated 28 March 2025 at [100.1]
[601] Written submissions of the State of South Australia dated 28 March 2025 at [100.2]
[602] Exhibit C65 at [15]
[603] T1105.35, T2487.9
[604] T905.16
[605] See Exhibit C53 at 8-SAAS3
[606] For example, T2420.12

rhetorically of wanting ten pieces of information in order to treat a patient and needing to make decisions in the Emergency Department with only four of those pieces of information, by assessing risk. She agreed that if she had to assess patients inside an ambulance, she may only get one or two of those pieces of information. Professor Kelly spoke of the same difficulty.[607] An ambulance is a suboptimal space to manage a sick person in circumstances other than active transport.

265 Another aspect of this issue is the phenomenon of paramedics providing a level of care which exceeds their training and usual scope of practice, which the State of South Australia has accepted is a safety concern resulting from ramping.[608]

Visualisation

266 A related issue which arose was the difficulty in conducting adequate visualisation by triage nurses of patients inside ambulances during triage and subsequently.[609] Given that the triage nurse is the only clinician to observe an incoming patient and that they are weighing many factors into their prioritisation system, this visualisation is incredibly important. Witnesses spoke of being able to view patients from behind and to the side,[610] which gives limited information about their condition.

267 There were also issues raised about the difficulty in conducting ongoing observations due to the distance between the triage desk and ambulance, as there is insufficient time in the triage nurse role to visit patients inside ambulances along the ramp.[611] This specifically caused a problem in Mr Skeffington's case as visualisation occurred after a specific request, but at a time when Mr Skeffington had settled.[612] If distances were shorter, a visualisation might have been facilitated quicker, during his less settled state.

268 I accept that there are also likely to be safety issues with nurses having to visit an area with vehicles moving around.[613]

269 The State of South Australia initially made submissions to the effect that none of these issues are actually safety issues and are instead issues of comfort,[614] however later seemed to accept that at least some of the issues were related to patient safety.[615] I disagree with the submission, to the extent that it was maintained, that there are only comfort issues arising from the practice of ramping patients inside ambulances. There are certainly comfort issues, but they are overshadowed by clear safety issues both on the ramp and also affecting the patient's healthcare journey. In light of the evidence about the impact of ramping on patient outcomes,[616] I do not consider there to be any meaningful distinction between the concepts of appropriate healthcare for patients and safety concerns. The risk of poor healthcare is a safety risk in and of itself, even without regard to physical risks which I have set out above.

---

[607] T2215.23
[608] Written submissions of the State of South Australia date 28 March 2025 at [55.1]
[609] T269.26, T456.16, T633.37, T647.30, T654.21, T811.38, T954.4, T970.17
[610] See Exhibit C53 at 10-SAAS5; Exhibit C25 at [21] and [24]; Exhibit C31 at [15]
[611] T671.2, T748.3
[612] T403.9, T472.30, T596.37, T623.19
[613] T1096.21
[614] For example, written submissions of the State of South Australia dated 28 March 2025 at [8] and [52]
[615] Written submissions of the State of South Australia dated 28 March 2025 at [55]
[616] For example, T2538.33

270 Notwithstanding these issues, I consider the evidence establishes that, as the health system is currently structured, waiting in the back of an ambulance is the 'least worst' option or the safest option available in the current circumstances. To be clear, I do not accept the characterisation that external ramping in the back of ambulances is a 'well-attuned' solution to the problem of overcrowding. However, I consider it does represent the best that can be done in the current prevailing conditions, which must quickly be addressed, first by shifting attitudes and then by implementing safety improvements for ramped patients.

Internal ramping

271 A potential solution to these safety issues created by ramping was explored; internal ramping. The evidence established that internal ramping was conducted at Modbury Hospital until recently.[617] Interstate, internal ramping is the normal practice in Queensland and Victoria. There are many attractive features to internal ramping; it mitigates issues with visualisation, deteriorations, toilets, weather and fumes. It provides a small anxiolytic benefit for the patient merely from being inside a facility rather than a truck.[618]

272 Some clinicians raised issues about the indignity involved in being exposed in a corridor while sick.[619] Some clinicians raised concerns about clogging corridors with barouches, monitoring equipment and oxygen tanks, etc.[620] Mr Lemmer raised a complexity about having to choose what equipment to bring to a non-treatment space.[621] Some clinicians raised concerns about infection control.[622]

273 Professor Kelly said that internal ramping in an appropriate space is preferrable to external ramping, if ramping is necessary.[623] Dr Romualdez[624] and Ms Toohey agreed.[625] Dr Lawrence expressed her personal preference for internal ramping, but acknowledged physical limitations which make the practise inappropriate in South Australia.[626] Professor McNeil agreed that there are benefits to internal ramping even if they do not achieve a transfer of care and release of an ambulance back to the community.[627] Dr Brooks agreed that patient visualisation would be easier internally even if the triage nurse could not directly see the ramped patients at all times.[628]

274 The ambulance service formally supports internal ramping (although not all of its clinicians do), on condition that there is a suitable dedicated space which is fully stocked with appropriate equipment for use by paramedics.[629]

275 However, overwhelmingly, the witnesses indicated that the number of patients ramped would not be able to be accommodated inside the layout of the metropolitan Emergency

---

[617] T2415.11, T2471.22
[618] T2217.24
[619] T207.30, T624.8, T2491.29, T1106.27
[620] T472.37
[621] T2420.28
[622] T624.5, T732.25
[623] T2215.2
[624] T1573.24
[625] T1107.8
[626] T1860.16, T1939.16, T1967.26
[627] T2289.3
[628] T2491.22
[629] Exhibit C65 at [22]-[23]

Departments.[630] I apprehended the nature and extent of these difficulties during the views, particularly at the Flinders Medical Centre. It is likely for that reason that the recommendation to adopt internal ramping made in the 2012 Monaghan Report was never implemented.[631] Interestingly, that recommendation was made in the report as a 'strictly interim measure' while efforts being made to reduce access block were brought into effect. That was 13 years ago. Professor McNeil was clear that physical constraints are already a significant issue affecting the ability to flow patients through the Department.[632] This should not be exacerbated.

276 I accept the clear advice of the clinicians who work in these spaces each day; that ramping patients internally would not be appropriate.

The consequence of the inability to ramp internally

277 Given that there are extremely significant issues with ramping patients inside transport vessels (ambulances) and that ramping patients internally is not possible, a third approach is required. This is an approach that the Court heard is being pursued at the new Footscray Hospital in Victoria and which already exists at the Sunshine Hospital in Victoria.[633] That is, the construction of a specific area that allows for patients who arrive by ambulance to wait in the care of paramedics or ambulance officers in conditions with increased safety for the patient and staff. Western Australia has also previously had examples of ambulance areas which are effectively wards used by paramedics to deal with patients waiting for admission.[634]

278 Professor Kelly pointed out the counter-productiveness of taking existing Department space and converting it to ramping space.[635] Professor McNeil said it could potentially be beneficial to do so, but it would have to be properly planned and considered.[636] These spaces should not be within the current Emergency Department footprints.

279 Professor McNeil encouraged the consideration of the roll-out of the Lyell McEwin Hospital's Q-Zone as part of each hospital's wider efforts.[637] This proposal is similar to the Q-Zone, except that there would be no transfer of care within the area and it would not take away any current treatment space. Dr Romualdez said that an area could be built on the ramp at the Royal Adelaide Hospital.[638]

280 If a purpose-built area was constructed in the direct vicinity of the Department, but not within its current footprint, the following safety improvements would be realised:

- Ambulances would not need to continuously run to maintain air conditioning, meaning that the exposure to fumes would be less likely to occur.

---

[630] T917.15, T973.28, T1106.27, T1860.16, T1939.16, T1967.26, T2318.7, T2398.15
[631] Exhibit C47f at 8; T2132.23
[632] T2290.23
[633] T2037.27, T2042.25
[634] Exhibit C65 at [24]
[635] T2244.29
[636] T2288.4
[637] T2323.17
[638] T1633.12

- There would be less loading and unloading of patients, placing less stress on the patient and the paramedic alike.
- Triage nurses would be able to safely visit the area and conduct a proper triage, incorporating interaction with the patient and a 360-degree view of the patient without blocking any emergency ingress.
- Paramedics would not be required to monitor and manage patients in a transport vessel and would instead have ongoing 360-degree access to the patient as needed.
- Paramedics would not need to carry any equipment, as the area would be set up with equipment familiar to paramedics that they have access to.
- Where incidents of acute deterioration occur, to a resuscitation level, the patient would experience less delays because unloading would not need to occur. In these episodes, drawing the attention of the hospital staff would be easy, as emergency buttons could be placed in the area to allow paramedics to make a MET call or call a Code Blue directly from the area.[639] Existing procedures for these kinds of emergencies would then take effect.
- Where deteriorations occur, but less than resuscitation-level, drawing the triage nurse's attention would be easier because of the adjacency to the Department. Where a paramedic leaves the area to speak to a triage nurse, the other paramedic is not alone inside a truck with the patient should an extreme event occur.
- The patient experience would be vastly improved. Instead of sitting inside the back of a truck on an ambulance barouche for hours, patients could be transferred to a hospital mattress and would be moved to a more comfortable area which is temperature controlled, less noisy and has basic amenities like drinking water and, ideally, toilet facilities. Professor McNeil spoke about the anxiolytic effect, where patients who arrive at hospital experience a reduction in symptoms on account of their relaxed state from being in an environment of care.[640] They would likely begin to experience that effect.

281 If a purpose-built area was constructed, many other possible initiatives also open up, such as:

Doubling patient load in times of system-crisis

- This refers to a practice that Professor Kelly gave evidence about that is being explored in other jurisdictions.[641] A paramedic crew (consisting of two paramedics) arriving at hospital with a patient has the ability to hand their patient over to a crew (consisting of two paramedics) who is already at the hospital waiting with a patient on the ramp. One crew of two paramedics thereafter takes over the care of two patients. The other crew are free to return to pending emergency cases in the community. This would only be done in appropriate clinical scenarios. This process is not possible with patients in the back of trucks as those trucks are precisely what is needed to be released and it is physically impossible to share care across trucks. While the handover of care from

---

[639] T1542.4
[640] T2317.27
[641] T2038.11

practitioner to practitioner is not best practice, it is far less risky than leaving patients in the community waiting for ambulances.

Alternative staffing models

- In future, if staffing difficulties can be addressed and nursing numbers bolstered, there could be nurses assigned only to the ramping area who take handover from paramedics. This has been trialled in Victoria.[642] This then releases the paramedics back to the community and the nurses thereafter provide the level of care that paramedics would have if they had waited. Dr Wright pointed out that nursing care is less resource intense than two paramedics per patient.[643] Again, this would not be possible with patients in the back of trucks, as the trucks are what need to be released. Of course, this has also been achieved at the Lyell McEwin Hospital which evidences that this goal will be within reach once new areas are in place. Nurse staffing could be introduced as easily in an external area as it could in an internal 'Q-Zone-type' area.

Safeguarding against catastrophe

- While the proposal for blood samples to be taken by paramedics is, unfortunately, controversial, if a patient was housed in a suitable purpose-built area, it would be likely that nursing staff could visit (without concern of moving vehicles and fumes) and take blood samples which would reduce the patient's overall length of stay, lead to a quicker definitive diagnosis after admission and potentially identify an impending catastrophe. Given that nursing staff employed by the hospital would be taking the blood sample and requesting the test, this would simply fit within the hospital's usual processes which include a call through to the Emergency Department where there is an abnormal result of concern. In routine cases the blood sample will simply be left to wait for the patient to commence being treated and cared for by the Department. Put this way, it becomes clear that there needs to be no person assigned to be responsible for reviewing the blood test result; unless pathology identifies an extreme concern, it simply waits for the doctor assigned to the patient once in the Department.

282 These possibilities could be explored once new ambulance waiting zones are constructed and operational.

283 The real concern raised with these kinds of proposals appeared to be that the area would quickly fill up and its positive effect would be lost. Dr Lawrence made it clear that zones such as this must only be used for undifferentiated patients, to avoid them merely being filled with admitted patients.[644] The answer to this concern is to ensure that the ambulance waiting zone remains an area for use by triage nurses and paramedics and nothing else. Physical separation, while maintaining adjacency to the Emergency Department, would assist with that goal. A policy that, aside from resuscitation-level events, doctors cannot commence treatment for any patients in the ramping area (with an exception for the blood test to rule out a hidden impending disaster) would be logical. This would mean that to progress patients, the hospital would still need to intake them into a conventional

---

[642] T2039.19
[643] T1667.36, T1692.14
[644] Exhibit C47 at [221]

treatment space. Under this arrangement, the new ramping area would improve safety levels on the ramp without altering the hospital's approach to ramped patients.

284 In many ways therefore, what is proposed is a maintenance of the status quo of the ramping process; ramped patients wait outside the Department in the care of the paramedics who brought them until the Department can accommodate them. However, it would occur in a far safer way. Professor Kelly described these areas as 'unfortunate', but better than care in corridors or ambulances, which is the practical alternative.[645]

285 In light of that analysis, I make the following recommendation to the Minister for Health and Wellbeing:

> *Rec 8* *An ambulance waiting area should be constructed adjacent to, but not within, the Emergency Department of each metropolitan hospital which has experienced significant periods of ramping (i.e.,` in excess of 300 hours) in the majority of months over three years. These areas should be fitted out with appropriate equipment and supplies familiar to paramedics, to allow for patients who are unable to be immediately admitted to the Emergency Department to wait in the care of paramedics, ambulance officers or nurses outside of the ambulance. These areas should be fitted with appropriate emergency buttons. Policies should prevent the use of this space by the hospital, other than for visualisation and other triage processes by triage nurses, intake blood samples and sudden resuscitation-level events.*

286 I have decided against naming particular hospitals as I hold the view that the recommendation should be linked specifically to whichever locations continue to experience sustained ramping, rather than targeting any named list. The area should only be introduced where ramping cannot be controlled to an infrequent level or for brief durations.

287 Given that I have expressed a clear view in favour of blood samples being taken from ramped patients, I consider that it is appropriate to specifically reference it in my recommendation so that it is clear to all that I consider it an appropriate use of these areas.

288 The AEA urged me to make a recommendation for the construction of ramping areas without making a recommendation that the policy framework around ramping be changed (i.e., without recommendation 1). In my view, without such a fundamental shift being made, there is a genuine risk that the clinicians and administrators working in the health system will continue to actively oppose initiatives like the construction of these areas. If that occurs, they would likely be constructed in less-than-ideal circumstances, potentially without their full effect being realised. In my view, it is only in combination with the policy shift in relation to ramping that the areas can be properly pursued. Therefore, I do not accept the AEA's submission that this recommendation can properly be made without the first.

289 The AEA asked me to refrain from mentioning paramedics. While I consider that these areas are suitable for staffing by nurses in future, for present purposes I consider it more appropriate that they be established with a view to maintaining the status quo of the

---

[645] T2091.10

provision of care until they are established and operational, allowing for future revision of staffing models when safe to do so.

290 I have carefully considered the position of the State of South Australia in respect of this recommendation. I consider that the brief position statement by agencies in the United Kingdom is of little guidance in the South Australian context, particularly in light of the composition of our ambulance service relative to our hospitals. I also consider that the temporary facilities spoken of in that document are not akin to what I have recommended, given that it speaks of facilities in the nature of tents.

291 While I do not intend that the construction of new areas take resources away from other aspects of the ramping effort, or create unintended problems or limit creativity, I consider that these areas are necessary, not temporarily, but in the long term. I consider that there are real and significant safety issues with housing sick patients for extended periods in the back of ambulances which must be addressed in order to prevent deaths. It must be remembered that a lower level of care has greater ramifications than just those that accrue during the time spent outside.

292 In that light, SA Health will need to carefully consider where the resourcing for this recommendation will come from. If SA Health consider that implementing this recommendation would preclude other initiatives which are also specifically directed at preventing the deaths of patients waiting on the ramp, then they will need to assess and justify the most appropriate use of their resources. If SA Health considers that they wish to instead continue with efforts at reducing ramping instead of efforts specifically directed at making ramping safer, then I do not consider that an appropriate approach. For that reason, I consider this recommendation is necessary to prevent further deaths.

293 Given that I have reached the conclusion that this recommendation is necessary, it follows that I do not consider the recommendation proposed by the State of South Australia, for an alert mechanism to be introduced on the ramp, is necessary. That solution does not address all of the safety issues that exist on the ramp but may be a useful interim improvement. I can foresee issues with using lights and sirens to alert hospital staff to deteriorations, similar to those spoken of in evidence which make it impossible to use the radio, as well as triage staff not necessarily being at the triage desk at the precise moment needed. While the State of South Australia submitted that there is no possible space at the Royal Adelaide Hospital, I observed plentiful space in the current ramping area for better facilities than are available inside ambulances which currently occupy that physical space. This space is immediately adjacent to the Department entry. Proximity to the ‘centre of the ED’ is not something achieved by waiting inside ambulances, therefore I do not accept criticism of new areas as being worse on that basis.

Flinders Medical Centre

294 Another issue which was raised as a serious impediment was the physical structure and placement of the Flinders Medical Centre Emergency Department. The hospital was opened in 1976, nearly 50 years ago. The expected service life of a hospital is 20 to 25 years,[646] with a refresh required about every ten years.[647] The population surrounding

---

[646] T2371.31
[647] T2372.14

the hospital has changed, with various small towns now being part of the metropolis.[648] Dr Lawrence pointed out that the Flinders Medical Centre meets required standards and is accredited,[649] but acknowledged that it would be unlikely to meet the current standards if those were applicable.[650] Dr Wright lamented the choice to construct the Emergency Department on a higher floor,[651] which he said has frequently returned to cause problems. Dr Wright said that the cramped floor plan creates inefficiency and adds to the cognitive overload for clinicians.[652] He said that space redesigns have led to dysfunction and inefficiencies.[653] I observed the Department overcrowded during the view. It was markedly more chaotic than the other hospitals that were visited, also during times of high demand and overcrowding. It was hard to concentrate. Professor McNeil said that the Flinders Medical Centre Emergency Department is not an environment that encourages the pursuit of excellence because it puts significant constraints on how patient care can be provided.[654] Dr Wright frankly said that it has not been providing ideal care for a long time and is increasingly not even providing good care.[655]

295 The Southern Adelaide Local Health Network's two largest hospitals are the Flinders Medical Centre and its companion, the Noarlunga Hospital. The Flinders Medical Centre is one of the two Level 1 Trauma Centres for the entire State.[656] Its Emergency Department is required to be equipped to handle the arrival of the worst cases.

296 In respect of the limited number of isolation spaces which affected Mr Jessett's case, Dr Lawrence said that retrofitting negative pressure is extremely complex and difficult.[657] That would be particularly so in already cramped spaces. Patients like Mr Jessett who present with conditions requiring isolation will therefore continue to be disadvantaged.

297 In addition to the issues raised with the current facilities at the Flinders Medical Centre, many witnesses said that a newly constructed ambulance waiting area could simply not be achieved near the current Emergency Department.[658] In effect, there is no space for internal ramping and there is no ability to construct a safe waiting area, therefore patients must continue to sit inside trucks waiting for admission. That is an unacceptable position for a major metropolitan hospital. For that reason, I make the following recommendation to the Minister for Health and Wellbeing:

Rec 9 *A review should be conducted by SA Health into the adequacy of the building and facilities of the Flinders Medical Centre Emergency Department to manage its demand and its expected role within the health system. The review should identify whether there is any suitable alternative location for the construction of a new Emergency Department, including consideration of the feasibility of moving it to the floor immediately below and whether that would allow for improvement of facilities and future expansion.*

---

[648] T902.26
[649] T1980.36
[650] T1981.3
[651] T1726.3
[652] T1726.14
[653] T1655.11
[654] T2370.10
[655] T1680.37
[656] T1351.11
[657] T1962.38
[658] T1726.9

298 This review should, quite obviously, occur with consultation of those who work at, or deliver patients to, the Flinders Medical Centre. It will be a matter for SA Health to determine who ought to be involved and to what extent.

299 While new facilities are being constructed at the Flinders Medical Centre which might facilitate more flow, I specifically draw attention to, and make my recommendation about, a review of the adequacy of the Emergency Department's facilities.

300 The State of South Australia submitted that there is no evidential foundation for the making of this recommendation and that it is not connected to the death of Mr Jessett who waited outside the Department for one treatment space likely to become available, or two others that were not going to become available. I disagree with the position put by the State. What happened to Mr Jessett and the evidence of Dr Wright alone raised an evidential foundation for at least the consideration of whether the current location of the Emergency Department is acceptable and whether what it offers is sufficient for the population it serves. The State submitted that I cannot be satisfied that there is inadequacy. That is precisely why I have recommended a review, not actual construction of a new Emergency Department. The State said that such a review would occur as a matter of course without a recommendation. I consider that, in light of the issues traversed in this Inquest, this is an appropriate matter upon which I should make a recommendation. It is a matter of public health[659] which might reduce the likelihood of another patient like Mr Jessett waiting outside for a limited resource with an undetected condition.

Who has duty of care for ramped patients?

301 An issue which was explored during the Inquest was the understanding of clinicians and leadership about who is responsible for the care of patients on the ramp. I am not permitted[660] and do not wish to make any findings or suggestions as to liability in respect of the deaths of Mrs Panella, Mr Skeffington and Mr Jessett. I will discuss the issue of clinicians' understanding of responsibility without reference to the individual cases.

302 Some witnesses held the view that the hospital only took responsibility for patients once they were admitted.[661] Some witnesses suggested that there might be two shared legal responsibilities.[662] Some suggested that responsibility for patients is split, with each group (paramedics and hospital staff) being required to do their job to the best of their ability.[663] One witness suggested that there was a shared responsibility for triage Category 2 patients who are brought inside the hospital to wait with paramedics.[664]

303 Some witnesses, especially those in leadership positions, acknowledged that patients on the ramp are within the responsibility of the hospital.[665] Mr Lemmer drew a distinction between who is responsible for a patient and who must provide care for a patient.[666] Other

---

[659] See s 25(2)(b)(ii) of the *Coroners Act 2003*
[660] See s 25(3) of the *Coroners Act 2003*
[661] T313.26, T317.27, T330.27, T809.4, T900.33
[662] T619.1; Exhibit C65 at [10]
[663] T1518.32, T1541.6, T1101.22, T1333.28
[664] T974.34
[665] T1659.6
[666] T2410.25

witnesses raised concerns about the hospital having any role in respect to care for patients on the ramp as it 'blurs boundaries'.[667]

304 Dr Lawrence and Dr Romualdez said that they have encountered those with the opinion that the patients on the ramp are simply not the hospital's responsibility, although that is not a view that they share.[668]

305 In my view, the law in the United Kingdom is clear and compelling. There are no clear reasons why it would not be followed in Australia if tested; the hospital has responsibility for patients who present seeking assistance from the point at which the hospital becomes aware of them.[669]

306 In Professor McNeil and Dr Grigg's report, they highlighted the legal scenario which they suggested is, when the caselaw is read, very clear even though it has not been tested in this State.[670] They drew an analogy from the United Kingdom common law which appears apt.

307 No witness could identify any policy which sets out the actual position, and many agreed that the lack of policy or shared understanding creates confusion.[671]

308 Professor Kelly's opinion was that a policy would be helpful as it would create a shared understanding of something the law already says.[672] Professor Kelly provided a copy of a policy in Queensland which simply says 'Hospitals assume overall responsibility for patient care from the time of triage'.[673] Counsel Assisting raised the idea of introducing a policy in South Australia which sets out very clearly that the hospital is responsible for patients on the ramp. Dr Lawrence considered that such a policy could be developed.[674] Professor McNeil said that given there is uncertainty, clarity would be welcome.[675]

309 It was apparently clear to all that such a policy would be a much-needed improvement and should be pursued. It appears that there was an attempt at proactivity on this topic after Dr Lawrence's evidence.

Responsibility of the media relating to SA Health initiatives to address ramping

310 I fully recognise that the administration of public services and the expenditure of public funds should carry with it heavy obligations of transparency and accountability. That is a fundamental aspect of our democratic system of governance. I also recognise that the media play an important role in facilitating that transparency and accountability. However, there are risks associated with some of the media's attention that is, as one witness described, 'hysterical'.[676] As I hope is obvious, I do not intend to restrict media coverage of a patient or patients who have suffered personal hardship, pain, or even death

[667] T448.35
[668] T1569.6, T1979.11
[669] For example, see *Darnley v Croydon Health Services NHS Trust* (2018) 3 WLR 1153 at [16]
[670] Exhibit C44
[671] T619.1, T900.10, T1659.17, T1705.32; Exhibit C49g at 10
[672] T2092.3
[673] T2037.3, T2230.21; Exhibit C49f
[674] T1996.16
[675] T2327.31
[676] T2546.25

whilst ramped. My comments are specifically directed to wider policy issues and strategies that may be implemented by SA Health.

311 In January 2025, it was publicly revealed that SA Health had produced a policy for consultation which set out with clarity that the responsibility over ramped patients fell to the hospital. I consider that SA Health should have been commended for taking a simple pragmatic step to make an improvement which had been identified during this Inquest. Instead of that commendation, a narrative was established which was, in short, wrong. The full consequence of this flawed narrative is not known, but it must have engendered some anxiety and apprehension in many concerned members of the public.

312 This was something done with obvious good intent, which merely puts into policy a statement of the existing law. It generally was not portrayed as a positive and well-intentioned acceptance of reality on the vital topic of legal responsibility for the care of patients.

313 It is clear that the road to reducing and indeed trying to eliminate ramping is going to be a long one. It is going to be paved with initiatives which are novel, initiatives which fail and hopefully initiatives which each individually contribute in a small way to the overall goal. If SA Health are continually pitted against the public by the media, then the path to a better future will be incredibly difficult. I highlight again that the policy produced by SA Health, while meaningful in written form, actually changed nothing about the law. The independent expert evidence of Professor Kelly, an extremely experienced and respected emergency physician, was to the effect that this policy would be very appreciated. As said, Queensland Health already has the exact same written policy.

314 I am concerned that based on the response to this objectively-positive initiative which actually effects no change, as to what can be expected when a well-intentioned initiative does fail, which no doubt will happen.[677] SA Health must have the courage and latitude to try new things without the fear of unfair criticism. They must of course be open and held accountable, but only in a fair and accurate way.

315 The media have a significant role in reporting on ramping to inform the public of any developments. I consider it appropriate to briefly discuss this issue in these Findings to emphasise that fair and accurate reporting may be a positive factor in emboldening SA Health to try new properly planned and discussed initiatives, even when the risk of mistakes and failure is real. After all, we are human; we make mistakes. But mistakes and failure are how we learn. Honest acknowledgement of setbacks, paired with balanced reporting, will contribute to a culture where reflecting on errors will foster improvement rather than defensiveness. In that sense, clear and accurate media coverage can support evidence-based innovation and the capacity to adapt. I am confident all initiatives will have the safety of patients and staff as the paramount consideration during planning and discussion.

316 In order to put this issue to rest, on the urging of the State of South Australia and the AEA to assist to overcome challenges encountered in the introduction of such a basic concept

---

[677] T2322.4

into policy, I make the following recommendation to the Minister for Health and Wellbeing:

Rec 10 That a statewide policy be implemented that makes clear that the principal duty of care for a patient who has arrived at hospital lies with that hospital, even if the patient is not admitted to the hospital but is ramped in the care of paramedics.

Recommendations which will assist with the effort to reduce ramping

317 After hearing the evidence about the enormous effort to eradicate ramping, I consider that there are a number of recommendations that will be useful in guiding the effort.

'Silo thinking'

318 The Court heard much evidence about silo thinking. This was a concept discussed by Professor McNeil and Dr Griggs in their report.[678] It is, effectively, the disregard of issues in areas of the health system other than the area in which one directly works. It is an entirely separate concept than the assessment of relative risk. Professor McNeil and Dr Griggs raised the issue with the suggestion that the health system as a whole needs to work together to allow the system to address risk wherever it may be. For example, a doctor on a ward needs to have knowledge of the situation in the Emergency Department to know how much demand there is for spaces on that ward. Similarly, an Emergency Department doctor needs to have visibility of the cases waiting for ambulances in the community so they can prioritise releasing ambulances and making space for those incoming cases. An advanced level would see a doctor with patients on a ward having visibility of cases in the community waiting for ambulances on the weekend so that they can decide to visit the ward to discharge a patient who was on the borderline of discharge on Friday, thus generating a space for an Emergency Department patient to flow into, in turn generating a space for the community patient arriving by ambulance.

319 The counter-argument to an allegation of silo thinking is that clinicians are trained to treat the patient in front of them.[679] Dr Brooks said that it was unfair to put pressure on clinicians to think of people in the community waiting for ambulances other than in a general sense, given the job of treating the patient they actually have is hard enough without the added pressure. Dr Lawrence said that this is a particularly hard task to ask of junior clinicians who are still learning.[680] This is a fair concern. At the other end of the scale, Professor McNeil pointed out that if a clinician focusses too much on the patient in front of them and expends a lot of resources on the one patient, it has the capacity to deny others the care they need.[681] A balance must be struck.

320 Professor McNeil and Dr Griggs essentially described a desire for a more cohesive health system which is more flexible to changing areas of demand. This is an extremely ambitious, but worthwhile, goal. There are, of course, small changes that might make a meaningful reduction to silo thinking. For example, screens at strategic locations could be used to ensure that all areas of hospitals have visibility of the level of demand being experienced elsewhere. There was evidence that these screens do exist in

---

[678] Exhibit C44
[679] T1835.10, T1904.3, T2267.35, T2560.3
[680] T1905.24
[681] T2269.2

some metropolitan Emergency Departments, allowing them to see ambulance demand.[682] The more availability of this data across the system, the more clinical leaders will be gently reminded that they are part of a wider effort and that their actions in their area could make a meaningful difference. That is, the very existence of the screens reminds those who pass them that they should be mindful of the need to maintain flow, particularly in times of peak demand. This is likely to be more effective and engaging if using real-time data than a static poster. Professor McNeil said that visibility is the first step and the culture of considering what to do about it is the second.[683] Professor McNeil's 'risk calculator' project may in time assist with this second step.

321 In light of that, I make the following recommendations to the Minister for Health and Wellbeing:

Rec 11 Status board displays should be rolled out with a wider scope than they are currently used. SA Health should consider the cost versus benefit to determine the breadth of the rollout.

Rec 12 A statewide policy should be implemented to address the principles of admitting patients to wards over census. It should set out the agreed indicators that trigger a requirement for wards to negotiate to take additional patients.

322 I consider that an over census policy is an appropriate matter upon which to make a recommendation. I disagree with the submissions of the State of South Australia that a statewide policy would not be sufficiently attuned to local conditions. As with many SA Health statewide policies seen during this Inquest, the policy itself would be framed widely and allow for local implementation. I also disagree that it would not sufficiently effect cultural change, I consider that a formal policy would drive change.

323 I do not consider it appropriate to nominate particular individuals who should lead any particular work.

Weekend discharge glut

324 I have discussed above the issue of the weekend discharge glut. Dr Lawrence explained that there are many factors involved in discharge fluctuations.[684] She has requested Local Health Networks improve the timeliness of their discharges but acknowledged that further work needs to be done. She said that $5.4 million (indexed annually) had been assigned for seven-day hospital services.[685] She expressed that senior medical staff being available on the weekend is critical to the provision of optimum health care. She spoke of the significant task involved in changing industrial conditions.[686] In order to ensure that the increased resource allocation to auxiliary services is optimally used, I recommend to the Minister for Health and Wellbeing:

Rec 13 A review should be conducted into the best manner of achieving an increase in weekend and overnight discharges across the metropolitan area. This

---

682 T2145.23
683 T2361.1
684 Exhibit C47 at [190]
685 Exhibit C47 at [193]
686 Exhibit C47 at [196]

might or might not include negotiating for a mandate or incentivisation of rostering across seven days in the enterprise agreement covering consultants when it next expires. It might include incentivisation of weekend rostering by initiatives outside of the enterprise agreement. It should include consideration of the establishment of SWIFTs across all metropolitan areas.

The fragmented LHN structure

325 The South Australian public health system is divided into ten Local Health Networks,[687] each servicing a geographical population and administering hospitals within its area.[688]

326 Dr Lawrence gave evidence that the LHN structure was adopted as recommended by a national panel and that it is the structure that exists across the country. Of course, that structure is better than each hospital having its own board. However, evidence was given by Dr Lawrence that the entirety of the three metropolitan health networks in South Australia could fit within the single Western Sydney health network. Professor McNeil said that metropolitan Adelaide's three health networks together are slightly smaller than one he worked at in Queensland.[689]

327 The question must therefore be asked, have the benefits that were intended from moving to a divided metropolitan LHN structure been achieved? With respect, LHNs which contain one major and one minor hospital carry inefficiency and create difficulties for those that work in the system. Some of these issues were explored during the Inquest.

328 In modern times, nurse and doctors work across hospitals which span LHNs.[690] Dr Brooks spoke of an administrative burden taken up through moving across the system, even having separate employee identification.[691] Each time they move, they are required to learn new processes and protocols. The issue is of even greater significance for paramedics who can be expected to attend multiple hospitals in a single day. It is likely that this fragmentation of policy and procedure is partly responsible for the overwhelming evidence in this Inquest that some key policy is not well understood and, in many cases, does not meet reality.[692]

329 While it is acknowledged that each metropolitan hospital is physically different and offers different services, I have heard no evidence which justifies vastly contradictory policies and procedures, nor differing staffing models. In fact, Dr Brooks gave evidence that standardisation of practise has real merit.[693] Her belief of that is so strong that, while in charge at the Royal Adelaide Hospital Emergency Department, she established the 'ED Standardisation Group' made up of clinical leadership from across all metropolitan Departments with a view to standardising practices.[694] Professor McNeil agreed that reducing variation across the system in what it does and how it does it is really important.[695]

---

[687] LHNs
[688] T1811.25, T1910.1
[689] T2344.27, T2345.6
[690] T1913.9
[691] T2555.29
[692] For example, T687.8, T724.36, T737.11, T1100.17, T1424.5, T2559.9
[693] T2513.30
[694] T2513.32
[695] T2368.19

330 During the Inquest there was evidence of a disconnect between Departments with senior doctors questioning whether they would even take a patient who had initially presented to a different hospital, even when objectively there was a good case for quicker entry to their own hospital.[696] This was in the context of Mr Jessett's circumstances, a patient who was thought to be stable enough to wait for four hours, and hence would be stable enough to be driven the 14 kilometres between Flinders Medical Centre and the Royal Adelaide Hospital to compete for entry to one of 67 rooms, instead of competing for entry to a single appropriate room at the Flinders Medical Centre. Dr Lawrence accepted that the divided management structure might lead to a lack of collaboration between hospitals.[697]

331 A single metropolitan LHN would serve to unite all metropolitan hospitals with a single voice of leadership and a single policy framework which allows for individual hospital variations. That is, one large network that spans Adelaide. It cannot be said that it could not be achieved. It has in other states. Professor McNeil himself has merged five hospitals into one LHN in another jurisdiction.[698]

332 I consider that there are benefits to at least looking at the matter and considering carefully what issues are caused by fragmentation and what the consequences would be of amalgamating. I acknowledge that actually restructuring the metropolitan health system would be a substantial undertaking. That will obviously be a significant factor to be addressed in a review by those who work in the system. I acknowledge that a review into this topic is, of itself, likely to take some time. In light of that, I make the following recommendation to the Minister for Health and Wellbeing:

> *Rec 14 A review should be conducted into the LHN structure across metropolitan Adelaide to consider whether there are advantages to incorporating all metropolitan LHNs into a single structure with standardised procedures and a single chain of command and whether that would benefit the healthcare provided and those who provide it.*

Mental health catchment areas

333 Professor McNeil said that mental health patients are a major factor affecting patient flow.[699]

334 The Court heard evidence that the catchment areas for mental health patients do not align with general medical catchment areas.[700] Dr Lawrence said that the Royal Adelaide Hospital has the most populous catchment area for mental health. It also receives patients from other LHNs, including regional areas.[701] Dr Brooks explained that due to a policy that LHNs must treat all mental health arrivals at their facility until discharge, the Royal Adelaide Hospital has a disproportionate share of mental health patients without an appropriate allocation of resources.[702] This increases demand for a limited number of mental health treatment spaces and exacerbates access block and ramping.

---

[696] T1614.16, Dr Lawrence accepted a hypothetical case for quicker entry (T1925.19)
[697] T1923.9
[698] T2340.35
[699] T2330.16
[700] Exhibit C66 at [18]
[701] Exhibit C47 at [145]
[702] Exhibit C66 at [19]; T2528.8, T2531.30

335 The large number of mental health patients add to the chaotic environment of some of the Emergency Departments. All witnesses asked spoke of the undesirability of having mental health patients in a stimulating environment with a lot of movement and noise for days at a time. Dr Brooks pointed out that these patients also have an effect on other non-mental health patients around them.[703] She said that at the Royal Adelaide Hospital she feels at times like she is running an Emergency Department out of a psychiatric ward.[704] There appears to be a misalignment of mental health resources compared with expected demand.

336 I make the following recommendation to the Minister for Health and Wellbeing:

Rec 15 SA Health should consider the appropriateness of the mental health catchment areas and whether the mental health resourcing within those catchment areas is aligned to the expected demand for those areas. Particular consideration should be given to the Royal Adelaide Hospital which receives a disproportionately large number of mental health patients.

337 I do not consider that it is appropriate to recommend the construction of new mental health facilities. The Court did not explore the depths of mental health resourcing and facilities. Any specific recommendation about facilities would require a great deal more evidence on the topic.

Transit lounges

338 The Inquest explored the usefulness of transit lounges. Dr Romualdez explained that an aspect of exit block, and therefore access block, are patients who are ready to be discharged from wards, but are delayed and continue to occupy the treatment space.[705] Ms Toohey said this might be patients simply waiting for transport, such as a family member to pick them up.[706] She said that it has been a successful mechanism to free up some space, but that it is commonly full at the Flinders Medical Centre.[707] Dr Wright and Mr Peck said that a limiting factor was that it does not operate 24 hours a day at the Flinders Medical Centre.[708] As I said earlier, this is currently under consideration. Dr Lawrence raised a clinical issue with moving elderly patients in the middle of the night which might slightly temper the usefulness of 24-hour transit lounges.[709] She also explained that transit wards do not help with the issue of patients waiting for residential aged care or disability care placements, who are unfortunately not simply transiting in the short term.[710] Mr Lemmer said that transit wards can be useful in assisting with interfacility transfer patients arriving where the ward bed is not quite ready.[711]

---

[703] T2535.7
[704] T2535.26
[705] T1583.30
[706] T1057.32
[707] T1109.26, T1110.2
[708] T1710.21, T1386.20
[709] T1954.13
[710] T1954.34
[711] T2453.6, T2456.13

339 Given how useful this tool could be, I make the following recommendation to the Minister for Health and Wellbeing:

> *Rec 16 SA Health should explore the expected benefit to the introduction or expansion of 24-hour transit wards accommodating patients of various levels of mobility at the major metropolitan hospitals.*

340 The AEA urged me to recommend a mandate for transit wards. In my view, SA Health should be given the latitude of determining in light of an actual analysis of the patient flow data where transit wards are likely to be of most benefit and what their size should be.

The Statewide Interfacility Transfer System

341 I have described the SIFT above. I was urged to make a recommendation to mandate the SIFT. The evidence I heard during the Inquest was to the effect that following the statewide Code Yellow in 2024, at Dr Lawrence's direction, the SIFT has been largely mandated as a required consideration, although it has not reached complete coverage of all transfers.[712] I note the submissions of the State of South Australia about efforts being made to increase the use of the SIFT. Given what has been achieved, I consider that a blanket mandate is not warranted and SA Health must have the latitude to finalise the implementation of this work when it is clinically appropriate for all cohorts of patients.

Extended Care Paramedics

342 I heard evidence about the usefulness of Extended Care Paramedics, in particular in treating patients rather than transporting them to hospital. This of course reduces demand on hospital beds (i.e., access and exit block) and reduces overcrowding in the Emergency Departments. I was urged to make a recommendation that the number of Extended Care Paramedics be increased. The evidence of Mr Lemmer was that before an increase in the size of this program, work is required on increasing its efficiency. I do not consider it appropriate to recommend an increase where the agency itself considers that premature.

Issues which arose incidentally

343 A number of issues arose incidentally which highlighted the need for process improvements.

Adverse incident reviews

344 The Court heard that none of the clinicians directly involved in the care of Mrs Panella, Mr Skeffington and Mr Jessett were directly involved in the adverse incident reviews conducted in respect of their deaths.[713] They were not even formally involved to the extent required to ascertain the full factual circumstances and context within which these deaths occurred.

345 The Court heard about factual issues with the reviews. The review of Mrs Panella's case recorded that she had an unconscious collapse which is in direct contrast to the evidence

---

[712] T1889.7

[713] T230.18, T381.5, T476.5, T634.36, T1624.21, T847.35, T884.18, T1019.8, T1031.6; Exhibit C26 at [53]; Exhibit C27 at [77], although a team leader on shift at the time of Mr Skeffington's attendance participated in an SLS process; Exhibit C17 at 14; and Ms Toohey participated in the Pit Stop Huddle in respect of Mr Jessett; Exhibit C39 at [38]

and the records.[714] It recorded an arrival time at hospital of 9:45pm which appears to be a misreading of the 'arrived scene' time on the Patient Clinical Record.[715] In the case of Mr Skeffington, it was suggested that he had been strapped to the ambulance stretcher and that this may have made it difficult to assist him when he began vomiting. The evidence from the paramedics involved suggests that this was unlikely to have been the case. In respect of Mr Jessett, assumptions were made about the validity of blood tests which were not supported by the evidence.[716] It recorded 98 patients in the Department at the time of his arrival, which was incorrect.[717]

346 Professor Kelly's opinion was that best practice would be for clinicians involved to have input into reviews as they have valuable information about the context and nuanced details of the care of a patient which you cannot get from records.[718] Further, it recognises them as experts and it minimises the risk of system improvements being identified which are not feasible, practical or have barriers to implementation.[719] Professor Kelly considered that these reviews must be conducted on a 'no-blame' basis as an exercise in working out what went wrong and what can be fixed. Professor McNeil agreed that clinicians should be involved where they are willing, at least to the extent of providing facts.[720] Professor Kelly accepted that clinicians should be given the right not to participate in adverse incident reviews if that is their wish.[721]

347 Dr Lawrence considered that the goals of an adverse incident review could be met with or without clinician involvement,[722] but raised no concern about the suggestion that clinician involvement be mandated,[723] with the option available for the clinician to decline.

348 Dr Romualdez expressed that reviews are conducted without those directly involved to ensure an independent approach.[724] Dr Brooks considered that it is important to 'close the loop' (i.e., provide information about the outcome of reviews) in a caring way, but expressed a preference for adverse incident reviews to be kept separate from debriefing processes which are important for clinicians. She said that the proper facts can be ascertained by having representatives of each workgroup participating in the review process after having liaised with the clinicians involved to ascertain their account.[725]

349 The State of South Australia made submissions about this being a philosophical issue, given there were diverse opinions about the role that clinicians should play in reviews. In my view, it is appropriate to have those philosophical discussions about the role of clinicians in discussion about process, procedure and identifying improvements, however

---

[714] Exhibit C24 at 1; Exhibit C15 at 1 and 6; Exhibit C16 at 16
[715] Exhibit C24 at 1; Exhibit C23b
[716] T2052.12
[717] T1168.11
[718] T2070.14
[719] T2070.31
[720] T2367.14
[721] T2071.34
[722] T1974.15
[723] T1975.4, T1997.11
[724] T1624.21
[725] T2524.26

it is not appropriate to have those discussions about clinicians being directly involved in providing a full and clear picture of all of the circumstances involved in an incident.

350 The difficulty with the approach preferred by Dr Romualdez and Dr Brooks is that there are factual issues which have been highlighted in the reviews in this matter and clinicians who have said they would have readily participated if asked.[726] The system as it stands is not working optimally. I make the following recommendation to the Minister for Health and Wellbeing:

Rec 17 SA Health should amend the Clinical Incident Management Policy to include a requirement that clinicians directly involved in providing care are offered the opportunity of providing information to the reviewers on a no-fault basis and including a process for those involved to be notified of the outcome if they wish.

Ambulance advice about demand

351 In the course of her review, Professor Kelly highlighted advice given to people who call triple zero and are unlikely to receive an ambulance response quickly.[727] Professor Kelly's opinion was that the language used is not accessible.[728] In particular, Professor Kelly said that saying 'we are experiencing high demand for emergency services' may not get the message across that an ambulance is not coming. Professor Kelly said that clearer language such as 'significant delay' would be preferrable and that it should give alternative examples such as transport with a 'friend or family member'. In order to address that, I recommend to the Minister for Health and Wellbeing:

Rec 18 The SA Ambulance Service should review the accessibility of its scripting in situations where there will be significant delay in the arrival of an ambulance to ensure that it makes the fact of delay clear and provides examples of alternative options.

352 This recommendation does not require the introduction of any new concepts. It merely seeks to refine the language used in circumstances where this topic is already raised.

Consultation

353 The AEA urged me to make a recommendation that any changes to the workings of the Emergency Departments occur only following consultation with the AEA and others. While it was established in evidence that some changes have occurred with minimal consultation, in my view the evidence failed to establish that the level of consultation was inappropriate. It must be remembered that Emergency Departments deliver a much wider gambit of services than its intake processes. While I consider consultation is important, I consider that it should be left to SA Health to determine when and to what extent agencies should be consulted about proposed modifications to facilities, policies and processes.

---

[726] T381.5, T847.35, T884.18, T109.8, T1031.6; Exhibit C26 at [54]
[727] Exhibit C49k
[728] T2246.17

Amalgamation of recommendations

354 I have made a number of recommendations for the introduction of new policies and procedures or protocols. I wish to make clear that these recommendations do not necessarily need to be viewed in isolation to each other. Where multiple recommended policies are suitable for inclusion in a single policy, that should be done. Where an existing policy is suitable to be amended or expanded, that should be done. I do not wish to be taken to suggest that new policies should be independent from the framework of policies that already exist in the health system.

Input from a nursing organisational perspective

355 Obviously enough, many of the recommendations that have been suggested directly relate to the work of nurses. Counsel Assisting made contact with the Nursing & Midwifery Federation of South Australia in order to encourage their participation, to any degree, in the Inquest. The Federation did not cooperate in any way.[729] It is unfortunate that they did not wish to have any input into an Inquest which was exploring their working conditions and that the Court has not had the benefit of their advice in respect of proposed recommendations. It would be most unfortunate if they were to seek to oppose any recommendations after they have been made. I note now with frustration and disappointment, to say the least, that the Federation has chosen to make public statements on important issues about ramping, both internal and external, and its effect on their members. I cannot now consider nor act on their reported issues revealed publicly on 16 and 17 July 2025.[730]

Counsel

356 I wish to thank counsel for their assistance in this complex Inquest. I want to mention Mr Evans, Counsel Assisting the Court, for his tireless efforts and enthusiasm in coordinating the vast material and presenting it with great skill, which also allowed the interested parties' counsel to focus on their respective submissions. His meticulous preparation and impartial approach ensured that all relevant information was thoroughly examined, facilitating a sound understanding of the issues at hand. Mr Evans' dedication has been instrumental to the Inquest, and his contributions are deeply appreciated.

Condolences

357 Having heard complex and technical evidence about the state of the South Australian health system it is important to remember the lives of those whose deaths were under investigation. The loss of a family member is difficult in any circumstance. Where it comes in tragic circumstances, that loss can be very deeply felt and long lasting. I express my sincere condolences to the families of Mrs Panella, Mr Skeffington and Mr Jessett on the loss of their loved ones. It is my hope that the health system adopts my recommendations and improves the manner in which people wait for entry to Emergency Departments during times of extreme demand. In this way, the loss may have meaning for the families in that something positive has developed from the death of their loved ones. Mrs Panella, Mr Skeffington and Mr Jessett were each important and productive

---

[729] Exhibit C51
[730] For example, article in The Advertiser, 17 July 2025, pages 10-11

South Australians. I hope that part of their legacy is that their deaths caused an improvement in care for all other South Australians.

358 I attach extracts from family statements to this Finding. These statements reinforce the valuable life they lived in their devotion to family and work.

Keywords: Ambulance Ramping; Delayed Transfer of Care; Triage; Emergency Departments

Annexure – Extracts of family statements

Mrs Panella

Anna arrived in Australia in 1958 with her mother and younger brother. She was 15 years old and didn't speak a word of English. Her father migrated six years earlier in 1952 where he worked with the Unley council to support the transition from Italy to Australia. During those years, he worked hard to save money and buy a home in the suburb of Parkside. Once he had established the family home, he sent for his family whom he had not seen for six years.

Anna's early employment began at San Remo Pasta—a well-renowned company that employed and supported many young migrants in the 1960s.

While travelling to work she met a fellow young migrant, Antonio (Tony) Panella at a bus stop in the city. They formed an instant friendship, talking at the bus stop every single day before work, until Tony sought after her father to ask for her hand in marriage. Anna was only 17 years old and her father felt she was too young for marriage. He told Tony to return in two years when she was older.

Tony continued to wait for Anna at the bus stop and the pair solidified their friendship. Once two years had passed, he returned to Anna's father to ask for her hand in marriage. And so, in 1962 Anna married Tony Panella and the couple lived all their life in Payneham. In 1963, they had their first and only child Lina.

At the age of 20 years, Anna gained employment at a private nursing hospital in St. Peters as a cleaner. The Matron in charge saw that Anna was a dedicated, compassionate and responsible worker and asked Anna whether she would be interested in a nursing career. Given that her English and, in particular, her writing of the English language was not up to par to meet the necessary requirements, she was unsure if this was a reasonable career path. The Matron, however, felt this wasn't a barrier and proceeded to assist her student in learning to speak and write English proficiently. Anna eventually acquired the relevant nursing qualifications to pursue her desired career for 42-years. During this time, she worked at two nursing hospitals providing care to geriatric patients and was being a welcome sight to fellow Italian migrants who often did not speak English.

Anna and her husband worked hard all their lives, both choosing to retire at 70 years respectively. They put their daughter through university, paid off their home and two investment properties despite working in relatively low-paying jobs. They believed that working hard was the key to building a good life for themselves and their family.

In July of 2007, Anna lost her husband unexpectedly in his sleep. They were married for 45 years. She faced many challenges after her husband's death and struggled to manage her grief. With her daughter living in Melbourne, she was left to live alone for the first time in her life. But she forged through with strength and resilience knowing that her nursing career and support of her family would provide her with the solace needed to move through this phase of her life.

In 2015, Anna became an Australian Citizen, which was one of the major highlights of her life. In that same year, she returned to Italy her country of birth for the first time since 1958 with her daughter and family. She had not seen her village in 50-years and even though much remained the same, Anna had already found her new home in Australia.

Anna was an avid church goer, and participator in the church community. She also enjoyed walking as a means of keeping fit, for general mobility, and for her mental health; it was her primary means of getting around as she did not drive. The only time walking became difficult was on days when her thrombosis played up.

Anna was respected and admired by her colleagues, friends and anyone who knew her. Her patients loved her, as did their families. Anna spent many a Christmas and Easter working away from her family and spend it working and brightening the day for many patients who didn't have families on these festive days.

She loved to cook, meet and talk to new people, care for others, attend her exercise classes, celebrate her faith and—above all else—she adored her family! Anna was a wonderful wife, mindful mother and generous grandmother, and these were the roles she lived for.

I thank you for the opportunity to be able to highlight fragments of my mother's life that made her the strong and caring women she was until her death. It saddens me that her life was taken in such an awful and distressing way. She provided medical care to so many individuals and trusted that she too would be provided with the same medical care. Unfortunately, the health system let her down in April of 2019 when she **ultimately** needed help the most.

Mr Skeffington

Firstly, I would like to thank and acknowledge all those directly involved with looking after my dad. To Stacey and Erin from SA Ambulance, we thank you from the bottom of our hearts, you guys are truly amazing, and we appreciate the love and care you provided to my dad. To the ED and ICU nurses, doctors and all staff at the RAH, you were phenomenal, and we are forever grateful. As a clinical nurse myself I can fully understand how busy and time poor you must feel at times in your position.

About my dad- mostly known as Brian but we still referred to him as Pa. Despite being 89 dad was relatively healthy, so to lose him suddenly to an acute catastrophic event was quite a shock. Dad emigrated from Ireland by himself at 18 years of age looking for a new life. He worked across Western Australia in the mining industry until a mining explosion saw him flown to Adelaide to treat his injuries. Here in Adelaide, he met Mum- married and remained here ever since. His entire working life then was at General Motors Holden where he started on the assembly line as a young man but worked his way up in the company. Dad and Mum both worked hard and sacrificed a lot to providing for my late brother and myself with the best private school education. Since retirement, nothing pleased dad more than his children, grandchildren and great grandchildren. He would take any opportunity to have his photo taken with them. He was proud of us all. He was very much looking forward to celebrating his 90th birthday with all of his family. Prior to his passing, dad was living independently, he was still driving, walked unaided, helped mum with her local charity work, and put the bins out weekly for those not able in their small retirement village. He loved doing his daily crosswords and reading anything to increase his knowledge. He wasn't how you would picture a typical 89-year-old. We felt had had many more years to share with Pa.

Sadly, his passing was attributed to ramping. Had he have been collected and admitted into hospital within an hour or two, his bowel obstruction would have been identified, a nasogastric tube inserted, and he would still be with us today.

To sitting in ICU and having to tell my dad that his lungs were too damaged from his aspiration and no further treatment options were available to save his life still upsets me to this day. Within an hour or so of his life support being turned off he slowly passed away with all of us feeling helpless. This in his case was the end effect of the ramping crisis.

We hope the findings and recommendations from this inquest can avoid any further preventable deaths and other families to not have to go through what we have endured.

Mr Jessett

Mr Jessett's family did not wish to provide a personal statement.