**FINDINGS** of Coroner McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the death of:

# Codie Mansell-Moore

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# Record of Investigation into Death (With Inquest)

*Coroners Act* 1995
*Coroners Rules* 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Codie Anthony Mansell-Moore with an inquest held at Hobart in Tasmania, make the following findings.

**Hearing dates**

17, 18, 19 and 24 January 2023, and closing submissions received by 26 May 2023

**Appearances**

Counsel assisting the Coroner: V Dawkins

Counsel for the family: A Hensley

Counsel for the Commissioner of Police: M Miller and N Pearce-Rasmussen

**Introduction**

1. This inquest concerned the death of Codie Anthony Mansell-Moore, aged 17 years. Codie passed away at his home in Lutana on the morning of 10 December 2018, after having multiple seizures witnessed by his girlfriend, Emily Broderick, between approximately 6.00am and 6.51am. At 6.51am Codie stopped breathing and went into cardiac arrest.[1] The evidence allows me to find that Codie died of natural causes, being epileptic seizure complicating idiopathic epilepsy.[2]

2. An ambulance was called at 6.09am whilst Codie was experiencing seizures. Eleven minutes later, an ambulance, with a crew of two paramedics, "staged" at a point around the corner from Codie's house. However, the ambulance crew did not enter the house due to an "alert" in the system that they should not enter without police assistance. The presence of an alert signified risk to the safety of the paramedics. Delays in police availability meant that the paramedics were staged around the corner from the address until 6.57am waiting for the arrival of police. During this time, Codie

[1] C5 – Post Mortem Report of Forensic Pathologist, Dr Donald Ritchey, and evidence at inquest. Evidence at Inquest of Emily Broderick, Adam Marmion, Lisa Trevaskis and Zoe Richardson.
[2] C5 – Post-mortem Report of Forensic Pathologist, Dr Donald Ritchey, and evidence at inquest.

continued to experience successive seizures before entering into cardiac arrest at about 6.51am. At 6.57am the paramedics and a police officer (who had just arrived at the scene) entered the property to attend to Codie. Tragically, he was found to be in asystole and deceased.

3. The investigation and inquest focused upon the factors, processes and communications involving Ambulance Tasmania personnel and officers of Tasmania Police during the period of 50 minutes from the time of the initial emergency call until the time of entry and attendance upon Codie. The inquest focused upon whether, with regard to these factors, Codie's death could have or should have been prevented.

**Scope of inquest**

4. The *Coroners Act* 1995 ("the *Act*") requires a coroner to find, if possible, the identity of the deceased, how the deceased died, the cause of death, and where and when the person died. This process requires a coroner to make factual findings about the death without finding legal liability or apportioning moral blame for the death. A coroner does not charge people with criminal offences, or punish or award compensation to anyone, as such functions are for other courts. A coroner conducting an inquest holds an inquiry into a death with the benefit of oral testimony and documentary evidence to make the required findings.

5. The obligation to find *how death occurred* refers not only to the manner of death but the circumstances surrounding the occurrence of the death. It is a matter for the coroner to determine and investigate those matters that should properly be considered to be relevant, or potentially relevant, to the circumstances surrounding the death. Notions of common sense and ordinary principles of causation must be applied to consider any significant causal role of such matters in the death.[3]

6. Importantly, the role of the coroner is also critical in identifying matters contributing to or connected with any individual death with a view to making comments and recommendations for the prevention of further deaths. Pursuant to the powers under the *Act*, a coroner may make comments and recommendations about matters which

[3] I *Re The State Coroner; ex parte Minister for Health* (2009) 38 WAR 553 per Buss JA at [42]; *Atkinson v Morrow* [2005] QCA 353. *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.

have sufficient nexus to a death, even though the matter the subject of the comment or the recommendation cannot be necessarily found to be a matter which would, if it had been present, have averted death.[4]

7. In my function of determining the circumstances of Codie's death and factors contributing to it, the following matters were specifically considered at inquest:

   i. The actions and decision-making of the attending Ambulance Tasmania paramedics and the consequences of any delay by those paramedics in entering the premises.

   ii. The communication between the attending paramedics and the Ambulance Tasmania Communications Centre.

   iii. The communication between Tasmania Police and Ambulance Tasmania Communications Centre in relation to Codie's seizures, cardiac arrest and death.

   iv. Communication within Tasmania Police regarding availability to attend the premises to assist entry by the paramedics.

   v. Consideration of any guidelines, policies, procedures or systems of Tasmania Police and Ambulance Tasmania as they may be connected to the circumstances surrounding death.

   vi. The availability of and access to anti-seizure medication by the residents of Codie's household and their training in its administration; and communication by Ambulance Tasmania  with the family regarding this issue.

**Evidence in the investigation**

8. The documentary evidence tendered in this inquest comprised exhibits C1 to C49. The exhibit list is annexed to this finding.

9. A timeline of relevant communications between members of Codie's household, Ambulance Tasmania and Tasmania Police was produced by investigators and was

[4] Section 28 (2) and (3); , *Doomadgee & Anor v Deputy State Coroner Clements & Ors* [2005] QSC 357

used as an aid in the inquest. The timeline sets out the important communications between the emergency call to Ambulance Tasmania at 6.09am and Codie's death at about 6.57am. The timeline is annexed to this finding.

10. At inquest, oral evidence was received from:

- Douglas Mansell, grandfather of Codie;
- Ronald Moore, father of Codie;
- Emily Broderick, girlfriend of Codie;
- Constable Ray Guy, attending police officer;
- Sergeant Timothy Etheridge, attending police officer;
- Constable Jason Curtain, Tasmania Police radio dispatch operator;
- Sergeant David Hoggett (retired), Tasmania Police radio dispatch shift supervisor;
- Nicholas Poprawski, Ambulance Tasmania dispatcher;
- Zoe Richardson, attending paramedic;
- Lisa Trevaskis, attending paramedic;
- Adam Marmion, subsequently attending intensive care paramedic;
- Dr Tom Clemens, paediatrician who treated Codie in 2017 and 2018;
- Craig Gardner, toxicologist with Forensic Science Service Tasmania;
- Dr Donald Ritchey, forensic pathologist;
- Dr Anthony Bell, medical advisor to the Coronial Division;
- Mathew Crawford, Operations Support Radio Dispatch Services;
- Inspector (now Commander) Peter Harriss, then Acting Commander Operations Support; and
- Jordan Emery, Director Operations Ambulance Tasmania, now Chief Executive Ambulance Tasmania.

**Acronyms**

In this finding:

*AT* refers to Ambulance Tasmania;

*RDS* refers to Radio Dispatch Services, a division of Tasmania Police;

*SOC* refers to State Operations Centre of Ambulance Tasmania (communications centre);

*ESCAD* refers to Emergency Services Computer Aided Dispatch system; and

*RHH* refers to Royal Hobart Hospital.

**Background**

11. Codie was born on 8 May 2001 to Melissa Mansell and Ronald Moore. He died at 17 years of age on 10 December 2018. Codie resided at 13 Ash Street in Lutana with several family members - these being his mother, Douglas and Susan Mansell (maternal grandparents and primary caregivers), Shane and Bradley Mansell (his uncles) and his girlfriend, Emily. Codie's father, Mr Moore, also lived at 13 Ash Street from time to time but did not live there permanently. Codie was Aboriginal and actively engaged with the Tasmanian Aboriginal community.

12. Codie and Emily met at school. In her affidavit, Emily said that they were together for about three years from 2015 to 2018.[5] Their son, Noah, was born in September 2019. It appears that Codie had passed away by the time Emily discovered that she was pregnant.[6]

13. In his evidence at inquest, Codie's grandfather, Douglas Mansell, described Codie as being a passionate musician and talented guitar player. He spoke fondly of times spent singing and making music together.

14. Throughout his childhood, Codie was generally healthy. He was diagnosed with idiopathic generalized epilepsy in October 2016. This diagnosis means that the cause of the seizures is not able to be identified (but may be genetic) and each seizure affects all areas of the brain.

15. Codie was initially treated by consultant pediatrician Dr Doug Heller, before his care was later transferred to Dr Tom Clemens, who he first saw in August 2018.

16. At the time of death, Codie was prescribed levetiracetam 500mg tablets to be taken twice daily. He was also prescribed midazolam which was to be administered by trickling it slowly inside Codie's cheek in the event of him experiencing a prolonged seizure of more than five minutes.[7]

[5] C36 – Affidavit of Emily Broderick.
[6] The evidence is unclear on the timing of the discovery of the pregnancy.
[7] C37c – Letter from Dr Heller to Hopper; C7.1 - Aboriginal Health Service Records.

**Significant events before death**

17. In September 2016, Codie experienced his first seizure.

18. Despite being prescribed medication to manage his seizures, Codie continued to have seizures requiring visits to the RHH emergency department. In 2016, he was treated for seizures in October 2016 and November 2016. On this latter date, and MRI scan of his brain revealed no abnormality.

19. In 2017, Codie attended the RHH for seizures twice in January 2017, and in November 2017 and December 2017.

20. On 27 January 2018 Codie attended the RHH following a seizure.

21. On 10 June 2018, Codie was admitted to the RHH with a prolonged seizure and fever. He was admitted to the intensive care unit and placed under general anesthetic. In his oral evidence, Dr Clemens stated that Codie had an unusual and rare reaction to his medication, sodium valproate, which caused him to go into liver failure. After this admission, Codie's medication was changed from sodium valproate to levetiracetam (brand name Keppra). Codie was formally diagnosed with idiopathic generalised epilepsy in October 2018.

22. On 20 July 2018, AT was called to 13 Ash Street to assist Mr Moore, Codie's father. The attending paramedics on that date were Mikaila Dewberry, Zoe Richardson and Andrew Johnson. Mr Moore presented as intoxicated and unresponsive inside the house and was taken to the ambulance.

23. Mr Moore was given a sternal rub[8] when strapped in the ambulance, which he responded to and commenced removing the straps. He was able to alight from the ambulance and then walked towards Mr Johnson, and then the other paramedics. Ms Richardson described Mr Moore's approach as *"threatening"* and said that he was waving his arms around and displaying verbal aggression. He then walked up the street, returned to 13 Ash Street with the cannula in his arm and was angry. Police were called in response to Mr Moore's behaviour and officers attended the address.[9]

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[8] Application of pressure to the sternum to determine consciousness level.
[9] Evidence of Emily Broderick and Ronnie Moore.

24. As a result of the attendance by paramedics on 20 July 2018, a safety alert in respect of the address 13 Ash Street was placed on AT systems for future attendances. That safety alert meant that ambulance crews were to have police officers present before entering the address.

25. A printout of the safety alert was tendered in evidence. It described the type of alert as *"Danger"* relating to the patient *"Ronnie Moore"*. The alert contained the following description: "*Police attendance required. Pt know [sic] to be violent/aggressive. 'Appeared unconscious for crew prior to aggresive [sic] state"*.[10]

26. This alert was requested by email from Mikaila Dewberry, in which she briefly described the incident on 20 July 2018. Ms Dewberry's email was included within the safety alert and provided a further description of Mr Moore, referring to him as a *"violent patient"*.[11]

27. Between 20 July 2018 and 10 December 2018, there were two separate attendances to 13 Ash Street by AT paramedics: one on 16 August 2018 for Ms Broderick (in relation to an anxiety state) and one on 3 September 2018 for Codie.

28. Ms Broderick described the attendance for Codie on 3 September 2018 as an occasion when he had a seizure in the back of her grandmother's car, which accords with the AT *VACIS* records.[12] On this occasion, Codie was transported by ambulance to the RHH for assessment.

29. Tasmania Police records confirm that police officers provided ambulance assistance at 13 Ash Street on both 16 August 2018 and 3 September 2018.

30. In the lead-up to 10 December 2018, Mr Moore moved to Devonport. Ms Broderick said that that Mr Moore had not been at Ash Street for at least three months before that date. Douglas Mansell gave evidence that in 2018 Mr Moore was living in Devonport and was an occasional visitor to the house.

31. Mr Moore himself gave evidence he had not seen Codie or been at 13 Ash Street for 4 to 6 weeks before Codie's death.

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[10] C44 – GCAD Patient alert.
[11] C44.
[12] C43 – ePCR 20.7.2018 to 10.12.2018;

**Circumstances surrounding death**

32. Between 7.30am and 8.00am on 9 December 2018, Codie consumed two 500mg tablets of levetiracetam as prescribed. Codie was required by his prescription to take four tablets per day, two in the morning and two at night. However, as he only had two tablets remaining at home, he made the decision not to consume his two night tablets but instead take them in the morning, following which he would attend the chemist and refill his prescription.[13]

33. During the evening of 9 December 2018, Codie smoked cannabis using a bong and went to bed with Emily at 13 Ash Street. They went to sleep at around 9.00pm.[14]

34. At approximately 5.00am on 10 December 2018, Codie awoke and told Emily that he was "*feeling really sweaty*".[15] At the time she thought he was just overheating and told him to put the fan on. They both then went back to sleep.

35. At just after 6.00am Emily awoke to Codie actively seizing. She described him in her affidavit as "*completely shaking, and he had froth coming out of his mouth*".[16] She cleared the blankets and pillows off the bed and went to wake Shane and Douglas Mansell. During this time, Emily called 000.

36. Emily's evidence accords with AT systems, recording that the 000 call was received at 6.09am. The case was initially given a Priority 3 rating at the time the call was taken. This required nonurgent ambulance attendance within 60 minutes.[17]

37. Initially, Emily put Codie into a side-lying position in accordance with her first aid training. In her affidavit, she stated that Codie had never discussed with her what she should do in the event he experienced a seizure. Emily observed that after Codie had been seizing for approximately 20 minutes, he stopped breathing.

38. In her affidavit, Emily described what happened after Codie had apparently stopped breathing:

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[13] ROD; C13 – Affidavit of Nikayla Roach.
[14] C13 – Affidavit of Nikayla Roach.
[15] C36 – affidavit of Emily Broderick.
[16] C36 – Affidavit Emily Broderick p 3.
[17] See C43 ePCR p.18.

*"When we saw this, Codie's other uncle Bradley helped me put Codie on the floor and I started doing CPR on him next to the bed. I probably did CPR for about four minutes, and then Doug took over and he did it for a little bit, but he kept stopping and starting cause(sic) he was crying and hysterical.*

*I quickly went and checked on Codie's Nan in her room because she was upset, and when I came back in the room, I got Dougie out of the way because he was continually stopping the CPR and I took over again. I would've done CPR for about 10 minutes or so before the Ambulance arrived.*

*When the Ambulance arrived, they came in and dragged Codie out from the bedroom to the lounge room and I would say they worked on him for maybe half an hour or so before they called it quits."*[18]

39. Emily provided a clear and credible account, in both in her affidavit and in her evidence at inquest, of Codie's seizures, of her efforts in attempting resuscitation, and the movements and assistance provided by the other family members.

40. Emily's efforts are also borne out by the 000 call which lasted for the duration of the incident, being 43 minutes and 53 seconds. In the call, the AT call-taker engaged in continuous instruction and communications with Emily and Douglas Mansell. This included instructions to communicate to the call-taker when Codie took breaths.

41. The time estimations given by Emily in evidence, particularly regarding when Codie stopped breathing, do not precisely accord with the known facts from the AT call information. However, the situation was understandably extremely distressing and her focus was solely upon resuscitating Codie.

42. As will be discussed further, the 000 call recording also revealed that Codie's family members gave the call-taker important information. This included that Codie was suffering further seizures; that Mr Moore was not present in the house; and, finally, that Codie had stopped breathing.

43. When the paramedics arrived in the house at 6.57am after police had become available to accompany them, they found Codie to be pulseless and in asystole.[19] Despite attempts at resuscitation until 7.30am, Codie was determined to be deceased.

[18] C 36 Affidavit Emily Broderick p3.
[19] The most serious form of cardiac arrest and usually irreversible.

**Autopsy**

44. On 11 December 2018 State Forensic Pathologist, Dr Donald Ritchey, conducted an autopsy. He concluded that the cause of death was an epileptic seizure complicating idiopathic epilepsy, with a probable significant contributing factor being his missed antiepileptic medication dose.

In Dr Ritchey's affidavit explaining his conclusions, he stated as follows:

> "*Death during epileptic seizure is unexpected but not uncommon. The mechanisms of death probably vary between individual cases. Seizure induced respiratory arrest followed by cardiac arrest is commonly cited and the witness account (sic) suggest that is likely in the present case. It is important that individuals with recurrent seizures be vigilant about their anti-seizure medication regimen.*" [20]

45. Toxicological testing of a sample of Codie's post-mortem blood revealed the presence of levetiracetam (his prescribed antiseizure medication) and THC (cannabis). Alcohol was not detected.[21]

46. Dr Ritchey gave evidence at inquest that the low levels of levetiracetam detected in Codie's blood tended to support the account that Codie missed his dose of this medication on the evening of 9 December 2018.

47. The inquest explored the question of whether Codie's use of cannabis contributed to his seizures. In this regard, questions were put to Dr Ritchey, Dr Clemens and Craig Gardner (forensic scientist). All three acknowledged that there is little research data available on whether THC, the principal psychoactive ingredient in cannabis, has the ability to assist in reducing epileptic seizures or, conversely, whether it could trigger or worsen seizures.

48. Dr Clemens said that he gave advice to Codie that he should try and reduce his use of cannabis; and that this advice was for his health and wellbeing generally, and also concern that it may make him more prone to seizures. He said cannabis certainly had the ability to interact with medications, which was one of the reasons for a blanket recommendation to avoid it if possible. [22]

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[20] C5 Affidavit of Dr Donald Ritchey p9.
[21] C6 – Toxicology Report
[22] Submissions of Commissioner of Police paragraph 11-13.

49. Despite the lack of clear evidence concerning the impact of THC upon seizures resulting from generalised idiopathic epilepsy, the advice to abstain from cannabis use provided to Codie by Dr Clemens was sound in the circumstances. However, the expert evidence does not enable me to make a positive finding that Codie's use of cannabis the evening before the seizures leading to his death played a role in triggering or prolonging his seizures the following morning.[23]

50. I accept the conclusions of Dr Ritchey as to Codie's cause of death and find that a significant contributing factor was Codie's missed dose of antiseizure medication on the evening of 9 December 2018.

51. Codie may well have been experiencing seizures for some unspecified time on 10 December 2018 before Emily awoke to find him seizing at 6.00am.

52. Dr Ritchey said in evidence that the frothy pulmonary oedema (the froth from Codie's mouth seen by Emily) tended to indicate that Codie may have already been seizing for a number of minutes whilst Emily was asleep. Dr Clemens also agreed that it was possible that Codie could have been having seizures prior to 6.00am. As will be discussed, complications and mortality increase as seizures continue unabated.

**Analysis of issues**

*The actions and decision making of attending paramedics and the consequences of any delay in entry to the premises.*

53. After the 000 call made by Emily Broderick to the AT call-taker at 6.09am, a crew from Glenorchy Station were assigned to the job at 6.13 am. The crew comprised paramedics Zoe Richardson and Lisa Trevaskis. At that point, the job was assigned to the crew as a Priority 2, meaning urgent attendance within 30 minutes. As noted above, when the call was initially received 4 minutes previously, it was given a Priority 3 status, requiring paramedic attendance within 60 minutes.

54. If the crew had entered the premises and attended Codie within the 30 minute timeframe for a Priority 2 callout, that is by 6.33am, he would have still been breathing.

[23] See summary of evidence in Commissioner of Police submissions paragraphs 11 to 13. Counsel for family did not address the point in submissions, nor did Department of Health.

55. As can be seen from the attached timeline of the recordings, the crew arrived and staged around the corner from 13 Ash Street at 6.26am. At 6.51am the crew were informed that Codie was not breathing. The crew entered the address at 6.57am when police arrived.

56. Again, from the recordings, I am able to find that 27 minutes into the 000 call, information was provided by Emily that Mr Moore was not present in the house as he was in Devonport. This information was provided in response to a question from the call-taker about whether Mr Moore was present.

57. It was not a requirement of the call-taker to question the caller about whether the subject of a safety alert was present. The call-taker is governed by specific question and answer "scripts" when communicating with callers about particular medical issues. Dispatch codes are generated about the case when the answers to the questions are recorded.[24]

58. The call-taker in this case followed the required "script" and correct procedures. However, he also took the initiative to ask the caller for information concerning Mr Moore, whom he was aware was the source of the risk and subject of the alert.

59. It is trite to say that, if Mr Moore was known not to be present, there would be no known risk to the crew. Putting aside the existence of the recorded alert, this fact would potentially allow the crew to safely enter the premises to treat Codie in absence of police assistance.

60. Ms Richardson and Ms Trevaskis provided affidavits and evidence at inquest. Their evidence was largely consistent as between themselves. In summary, they gave evidence as follows:

    a. They had commenced their Glenorchy night shift at 5.30pm the previous evening (9 December 2018) and were to finish at 7.30am (10 December 2018).

    b. They received the information on the pager that the callout was to 13 Ash Street and that it was a low priority, being Priority 3 with convulsions. Alerts do not appear on pagers.

[24] C47b Affidavit of Jordan Emery explains the system of set questions.

c. They got into the ambulance at the Glenorchy station with Ms Richardson driving. Ms Richardson and Ms Trevaskis were equal in their roles, although on each job there is a driving paramedic and an attending paramedic. The attending paramedic has seniority on the job.

d. Whilst setting out in the ambulance, Ms Richardson realised she had been to that address previously. The address on the screen in the vehicle displayed the alert and it prompted her memory of the incident. She then communicated the details of the incident of 20 July 2018 to Ms Trevaskis, indicating that she had feared for the safety of the crew and was distressed in recounting the incident.[25]

e. As part of their training, attending paramedics are directed to stage (at a safe distance from the address) and wait for police in the event of a safety alert. Safety alerts are relatively common, with Ms Richardson giving evidence that there may be one or two per shift.

f. They have not ever entered an address containing an alert before waiting for police assistance. The decision not to enter 13 Ash Street was based primarily on the existence of the alert but also upon Ms Ricardson's experience on 20 July 2018.

g. Routinely, all paramedics obey the requirements of an alert specifying police assistance; and the requirement to wait for police assistance remains unchanged despite the level of the medical emergency. The need to wait for police is part of the primary "DRABC"[26] – where D stands for Danger because their safety is paramount.

h. Ms Richardson, as per standard practice, contacted SOC (at 6.15am as per the timeline) which confirmed the presence of the alert in respect of Mr Moore. Sometimes alerts are placed on addresses and that person may no longer be there. The alert may be years old.

i. Both Ms Richardson and Ms Trevaskis said that possibly an alert could be overridden by information conveyed to them from the SOC or police. In

[25] I have set out the incident details earlier in this finding.
[26] Danger, Response, Airway, breathing , Circulation,

circumstances where attending paramedics received official confirmation that the subject of the alert was not present, they *may* make a decision to enter the premises without police, depending on its assessment of risk.

j. However, even if there was not an alert placed on the address, both Ms Trevaskis and Ms Richardson would not have entered without police assistance, given Ms Richardson's previous recent experience with Mr Moore when she felt her safety was threatened.

k. Ms Richardson was unable to recall if she was told Mr Moore was not present. However, Ms Trevaskis said that she received this information from SOC (occurring at 6.39am as per the timeline). She said that they discussed the matter and, as the fact had not been confirmed, they should not enter without police. Whilst it was a joint decision, Ms Richardson was particularly adamant that they would not enter.

l. Communications do not occur between the paramedics on a job and members of the patient's household.

m. They were surprised the police were taking a while to get there as they are usually quite prompt. Ms Trevaskis said that she could not recall waiting for police as long as she did on this occasion.

n. During the time they were staged and waiting for police around the corner from the address, they became aware that the priority status of the patient had changed (at 6.21am) due to the patient having another seizure.

o. As they waited, and Codie continued to experience further seizures with increasing risk to his life, Ms Trevaskis said that it was an horrific and difficult situation but they were unable to "tick off" on the danger level. Ms Richardson said that the cardiac arrest added an extra level of concern for the patient.

p. They left where they were staged when a police vehicle drove quite quickly past their staging position to the address. Another police vehicle came from a different direction.

61. The evidence of the crew regarding their decision-making must be viewed in light of evidence provided by other experienced AT personnel.

62. Nicholas Poprawski was the ambulance dispatcher at SOC involved in most of the communications with the crew and police on this day. He gave evidence that the decision whether to enter the address was with the attending paramedics. This is evidenced by his statement on the recordings *"that's their call not to go in"*[27] after advising Ms Trevaskis that he had received information that Mr Moore was not present at the address.

63. Adam Marmion, an experienced intensive care paramedic, was tasked to attend when the case became a cardiac arrest or Priority 0. He gave evidence that if there was a safety alert, he would not approach an address without police present and had never done so. He said that it was difficult to answer whether he would have gone in when the information came through that the person was not at the address. He stated he continually has difficulty with the accuracy of that information received through the call-taker from the caller.

64. In the contemporaneous call between Mr Marmion and the SOC when he was tasked at, Mr Marmion says '*fair game'* when he is told that Ms Richardson had been assaulted previously at that address, that the person is not there but that the crew would not go in. [28]

65. The evidence of Jordan Emery, Director Operations AT,[29] was that paramedics are expected to wait for police and that the crew in this case acted in accordance with appropriate procedure.

66. Further, the recordings contain a call between SOC Deployment Supervisor Amanda Hutchison and Operations Supervisor Tessa Campin confirming the cardiac arrest and noting 'some issues' arising. In the call, Ms Hutchison stated "*I completely support the crew in relation to not going in*".[30]

67. No issue arose regarding the reliability of the evidence of Ms Trevaskis. However, it was submitted by counsel for the Commissioner of Police that Ms Richardson's

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[27] C26-8.
[28] C26- 12.
[29] Now Chief Executive Officer AT
[30] See C47b; C26-14

accounts of the conduct of Mr Moore on 20 July 2018 exaggerated the aggression he displayed towards her and her colleagues on that date, particularly her statement to Mr Poprawski that he had "*come out swinging*". It was submitted that I should also hold concerns in relation to Ms Richardson's evidence that she did not recall being advised on 10 December 2018 that Ronald Moore no longer lived at 13 Ash Street, Lutana.

68. Ms Richardson was clearly and understandably distressed by the previous encounter with Mr Moore. He did not perpetrate a physical assault but his actions could have been perceived as threatening and particularly disturbing due to his state of intoxication. She may have somewhat exaggerated his actions to her colleague but only to emphasise her fear in the current situation.

69. I do consider it somewhat unusual that Ms Richardson did not recall the important fact of being told Mr Moore was apparently not present, a matter that was preventing the crew from entering the address when the patient required urgent assistance. However, in her state of mind regarding Mr Moore, it may well have been dismissed as meaningless or unreliable.

70. I do not consider that Ms Richardson's evidence was deliberately false or misleading in either aspect. In any event, her evidence in these respects is not critical to matters in issue. She clearly held genuine concern for her safety about entering 13 Ash Street without police being present. All of her colleagues, including senior and experienced paramedics and managers, gave evidence that supported her decision not to enter.

71. Thus, I find that the paramedics acted in accordance with proper procedure, bearing in mind the risk of danger, in not entering the address. The alert remained on the system. Ms Richardson had recently been involved in a frightening encounter with the subject of the alert and there was no confirmed or validated information conveyed to her or Ms Trevaskis that the alert was no longer current such that they were free to enter the address.

72. Information from the caller's household regarding the danger, to the extent it was considered, was entitled to be treated sceptically by the crew in light of the situation. Paramedic safety is critical and the protective system of alerts is an important part of ensuring safety.

73. Counsel assisting, Ms Dawkins submitted that after the crew were told that Mr Moore was not present and also that the patient had had his fifth seizure (at 6.39am) they

could have taken the opportunity to reassess the decision not to enter in light of Codie's deteriorating condition. However, Ms Dawkins accepted that this submission was made in hindsight and knowing that the information that Mr Moore was not present was, in fact, accurate.

74. For these reasons, I make no criticism of the decision-making of Ms Richardson or Ms Trevaskis.

75. I find, however, upon the expert evidence that Codie's mortality was likely significantly increased by the delay in the paramedics arriving.[31]

76. Dr Clemens indicated in evidence that the longer a person suffered a seizure, the more likely that complications would arise. He said that studies indicated 1-3% of people with prolonged seizures, more than 30 minutes, died.

77. It is clear from the evidence that the crew arrived and staged around the corner 24 minutes before Codie stopped breathing and went into cardiac arrest. It was after they were staged that Codie had his third, fourth and fifth seizure, according to the 000 call.

78. Dr Anthony Bell, coronial medical consultant, provided a report in which he outlined that patients such as Codie with generalised convulsive status epilepticus (GCSE) require rapid evaluation and treatment. He noted that GCSE is operationally defined as having equal to or longer than 5 minutes of continuous seizure activity, or more than one seizure without recovery in between seizures.

79. Dr Bell reported that recommended pharmacological management for such patients is initially treatment with a benzodiazepine - in Australia, midazolam (short cerebral half-life) or clonazepam. He reported that in the pre-hospital setting when there is no established intravenous access, intramuscular midazolam (10 mg) is the best option for treatment. However, he said that nasal or buccal midazolam (0.2 mg/kg, maximum 10 mg) is also a reasonable option.

80. It is to be noted that, on 3 September 2018, paramedics responded very promptly to Codie's generalised tonic-clonic seizure and administered midazolam. The seizure then resolved.[32]

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[31] C22 – Dr Bell Report and evidence of Dr Clemens.
[32] C7,p30.

81. It is not possible to determine exactly what would have happened if Codie had been treated and medicated by paramedics at a time before he entered into cardiac arrest. However, left untreated, the known consequences of his condition included cardiac arrhythmias, hypoventilation and hypoxia, fever and elevated white blood cell count. Aspiration pneumonitis, neurogenic pulmonary oedema and respiratory failure may also occur in status epilepticus. Dr Bell also reported that cardiac injury due to massive release of catecholamines may also contribute to morbidity.

82. I find, upon the unchallenged expert evidence, that there was a good chance that Codie's death would not have occurred if timely treatment by paramedics had been available.

*The communication between the attending ambulance officers and the Ambulance Tasmania Communications centre.*

83. The AT crew, as part of established procedure, relied solely on the SOC for oral communication regarding this job from the time they left the station. The crew did not receive information directly from members of the household at the patient's address nor directly from Tasmania Police.

84. The attached timeline incorporates the time recordings of the individual conversations, six in number, occurring between 6:15am and 6.57am (when the crew entered the address). The first five calls[33] occurred between Mr Poprawski and Ms Trevaskis. The information exchanged in the calls, as per the timeline, included the reason for the alert, the requirement of the AT crew for police attendance, updates on police attendance, updates on Codie's further seizures, that Mr Moore was not present and that, finally, Codie had entered into cardiac arrest.

85. Mr Poprawski indicated that, as a dispatcher for AT working in the SOC, he would sometimes also take 000 calls. As dispatcher on this occasion, he made the request for police assistance and, as indicated above, had conversations with the staged crew. Mr Poprowksi noted the 000 call-taker near his workstation was keeping him informed of what was happening with the job.

86. Both Ms Trevaskis and Ms Richardson gave evidence that they were not initially informed there would be a delay with police arrival. They were informed by SOC at

[33] 6.15am, 6.16am, 6.21am, 6.26am and 6.39am.

6.16 am that police were on the way and they should stage around the corner. Next, at 6.26am, SOC told the crew that police had no one available currently at the same time as informing the crew that the patient was currently having his third seizure.

87. The call at 6.39am was the first communication of an actual time estimate for police arrival, with SOC advising the crew that police could not free anyone until 7.00am.

88. I agree with the submission of counsel assisting that the communication from SOC relayed key information to the crew in an accurate and timely manner. I also note that SOC could not have provided the crew with additional information regarding the timing of police arrival as, before the call at 6.36am, SOC had not been provided with information from police about the delay.

89. In any event, the evidence of Ms Richardson and Ms Trevaskis was clear that they would not enter without police, regardless of when police became available. I find that the important information concerning Codie's situation and the job generally was conveyed to the crew and no additional communication of available information between the crew and the SOC would have resulted in a different outcome.

*The communication between Tasmania Police (RDS) and Ambulance Tasmania Communications Centre (SOC)*

90. The recordings tendered at the inquest indicate that, during the time in question, 6 calls occurred between SOC and RDS. These are included within the attached timeline but I have separated them below as follows:

| Time of Call | Participants | Content of Call |
|---|---|---|
| 6:16:22am | Mr Poprawski to Constable Curtain | Initial AT request for police assistance due to Mr Moore previously being aggressive and had *'come out swinging'*. AT will station around the corner. |
| 6:23:02-22am | Mr Poprawski to Sergeant Hoggett | Follow-up and ETA request, advising it has become a "*lights and sirens* |

| | | |
|---|---|---|
| | | *emergency for us, the patient's fitting again*" |
| 6:26:34am | Sergeant Hoggett to Mr Poprawski | Police do not have anyone to attend.<br><br>Mr Poprawski advises that one of the crew is one of those who was almost assaulted. |
| 6:33:05am | Mr Poprawski to Constable Curtain | Sergeant Hoggett advises he cannot get anyone, may not be anyone available until 7.00am. No one in Glenorchy or Hobart. |
| 6:50:02am | Sergeant Hoggett to Lauren Brooksbank (AT) | Confirming police have two people arriving shortly, within 10 minutes and police will meet at Ashbolt and Ash Streets. |
| 6:53:55am | Grant Perry(AT)[34] to Constable Craig Fehlandt | "*It is a cardiac arrest now*". Crew around the corner. Discussion about how far police are away, Constable Guy around corner, Sergeant Etheridge approaching Cornelian Bay. Mr Perry advises "*We are doing pushy pumpies at the moment.*" |

91. Constable Curtain received the first request for police assistance from Mr Poprawski. Constable Curtain was advised that the job was low priority at that stage and police attendance was required to assist the ambulance. Constable Curtain said that he checked the police systems and saw that Ronald Moore was flagged for violence at that address. He informed his Sergeant (Sergeant Hoggett) about the job and subsequently Sergeant Hoggett assisted in the communications with SOC.

[34] Identified by affidavit C47b.

92. In general terms, the communication by SOC to RDS involved making the initial assistance request, advising that Mr Moore was the reason for the request and updating police upon the medical urgency.

93. The communication by RDS to SOC involved providing SOC with information regarding the availability of police and the estimated timing of their arrival at the address.

94. The inquest focused upon two areas of potential deficiency in the communication between SOC and RDS that may have affected the outcome for Codie.

95. Firstly, SOC did not inform RDS that there had been information received from members of the household that Mr Moore was not present at the address. This information was available to SOC by 6.36am, noting that attendance upon Codie had been advised to RDS 13 minutes previously as having become a *"lights and sirens emergency"* (Priority 1, requiring immediate response).

96. Constable Curtain gave evidence that at all material times he was under the impression that Mr Moore was at the address. Both he and Sergeant Hoggett indicated that information was not passed onto RDS. This is also supported by the content of the recorded calls.

97. Sergeant Hoggett gave evidence that if RDS had received this information it would have been taken into account in the risk assessment when activating police resources.

98. Counsel for the Commissioner of Police, Mr Miller, submitted that the failure of AT to advise RDS that he had received information that Ronald Moore was not present and no longer resided at 13 Ash Street was a significant omission.

99. It was further submitted that, if this information was known, Sergeant Hoggett would have permitted Constable Guy to attend the address alone. Sergeant Hoggett himself gave evidence that, in such circumstances, he may have permitted Constable Guy to attend alone. Such permission would likely have resulted in the AT crew attending Codie immediately before he went into cardiac arrest or within a very short time of him going into arrest.

100. Relevantly, Constable Guy had arrived at the corner of Ashbolt and Ash Street after having left Bellerive police station alone in his police vehicle at 6.41am. He had been

instructed by RDS that it was an "two-up member response" because of the police history of that address. He was advised to wait for another car.

101. It is unclear as to exactly when Constable Guy arrived in the vicinity of 13 Ash Street. However he said that he "propped at the corner" and waited for the police unit G32 which he was told was coming from headquarters in Hobart. It appears that Constable Guy waited for several minutes, which may have been critical to Codie's life in these circumstances.

102. It is by no means certain that Sergeant Hoggett would have assessed it as suitable for Constable Guy to enter the premises alone, thus departing from the two-member response policy in the face of this medical emergency.

103. Sergeant Hoggett also gave evidence that a multi-member response was required not only due to the information police had received about Mr Moore being involved in a prior incident with an AT paramedic but also because he had prior convictions for resisting police and an outstanding arrest warrant. The policy for a two-member response was also confirmed by Acting Commander Peter Harriss[35] in his affidavit evidence, which included criteria that *the offender may be present* and *had a record of, or propensity for, violence.*

104. It was submitted on behalf of AT that these factors were present and warranted a multi-member police response. Additionally, it was submitted that it is unlikely that police would have been able to undertake meaningful enquiries, taking into account the hour of the day and the time period involved, to verify the whereabouts of Mr Moore in a timely manner. It was only 13 minutes between SOC being advised by the call-taker that Mr Moore was not present at the scene and Codie going into cardiac arrest.

105. Counsel for Codie's family, Mr Hensley, highlighted the requirements of the Tasmania Police *Operational Response Policy* in place on 10 December 2018 requiring "dynamic risk management".[36] That Policy outlined a 4-step process for assessing and managing risk when responding to a broad range of situations. Those four steps are headlined as "Assess, Plan, Implement, Re-Assess".

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[35] Then Acting Commander Operations Support; C24.
[36] C25, p9.

106. Mr Hensley submitted that no attempt was made by Tasmania Police to ascertain whether its database information indicating that Mr Moore lived at Ash Street was still current. He submitted that failure to make independent inquiries as to Mr Moore's current location might amount to a missed opportunity to "Re-Assess", and thereby detect that no such risk was present. However, Mr Hensley did not submit that criticism of police risk assessment was warranted in light of the short period of time involved and the lack of understanding of the degree of medical emergency. This submission is reasonable in the circumstances.

107. I also agree with Counsel for the Commissioner of Police that there was no evidence as to as to what inquiries could usefully be conducted in the time available and, not having been provided with any information to the contrary, Tasmania Police had no reason to doubt the accuracy of its database information.

108. SOC should have communicated the information concerning the absence of Mr Moore to RDS. It was an omission not to do so. However, SOC might not be expected to know exactly how providing this information could potentially hasten the police response by assessing it as suitable for a one-member response.

109. In relation to this first issue, I cannot find that, based upon the information available to him, Sergeant Hoggett should have reassessed the risk to allow Constable Guy to enter the premises alone. On the basis of the known police holdings in respect of Mr Moore at that time, there was sufficient information to indicate that he was a genuine threat. On that basis, it was entirely reasonable to adhere to the two-member response policy, especially with a lack of appreciation of the urgency of the matter.

110. The second issue arising regarding the communications between SOC and RDS involved the urgency of the medical situation not being accurately expressed by SOC or understood by RDS. Sergeant Hoggett gave evidence that he considered there was a lack of communicated urgency. He gave evidence he was not aware of AT's priority designation generally and that medical details were not usually provided to police to communicate the urgency.

111. At inquest there was exploration of the meaning of '*this is a lights and sirens emergency*' and whether that communicated the urgency intended by Mr Poprawski. Quite surprisingly, Sergeant Hoggett did not understand this term to communicate urgency.

112. Further, there was information given by SOC to RDS about repeated fits by the patient, but to a police officer with no medical training, questions arose about whether this was effective in communicating urgency.

113. Commander Harriss assessed the communication from the recordings following Codie's death. He formed the view that change in urgency was only communicated (and appreciated by RDS) at 6.53am when the matter was stated to be a cardiac arrest. The relevance of the deficiencies in communication of urgency is discussed below.

114. *If* the urgency was appreciated and *if* there had been information to RDS that Mr Moore was not at the address, the two-member response policy *may* have been modified and Constable Guy *may* have been instructed to proceed one-up as quickly as possible. He may then have been able to enter the premises with caution to allow the paramedics an opportunity to provide Codie with the timely treatment that, in hindsight, was critical. If all of these matters had occurred, there would have been a good chance of treating Codie, who would have either still have been breathing or have just entered cardiac arrest. I consider this to be a feasible alternative scenario.

*Communication within Tasmania Police regarding availability to attend the premises*

115. This issue raises the question of whether RDS did all it could reasonably do to have police officers at the scene quickly.

116. Constable Curtain stated that on the system at the time he could identify whether police units were on a job and then would call them to confirm their status. When he received the initial call in respect of Codie, he recorded the job on the system and looked at what Glenorchy units were available. He then looked at other areas, Hobart in particular. At that time of morning, he said, there was not a lot of units available. Constable Curtain said that he was actively looking for available units and Sergeant Hoggett and Constable Fehlandt were also making checks to see if anyone was available.

117. Sergeant Timothy Etheridge, in charge of the Glenorchy Station at the time, gave evidence that all of his units were at Headquarters (Hobart) dealing with offenders. This accords with a contemporaneous call record that Glenorchy units had '*crooks everywhere'*.

118. Sergeant Hoggett gave evidence that he was made aware of the job and made numerous phone calls hoping to get in contact with someone who had started work early. He also indicated that Glenorchy was first approached, and then Hobart. These calls formed part of the evidentiary exhibits at inquest.

119. Ultimately, Sergeant Etheridge and Constable Guy were tasked to attend

120. Constable Guy was located after a call to Bellerive asking if anyone from RPOS[37] was available. He was 30 minutes early for his shift. He prepared to go, "kitting up" with the required gear, and headed straight to Ash Street.

121. Constable Guy arrived in the vicinity of the corner of Ashbolt Street and Ash Street and waited for approximately 5 minutes. Constable Guy expressed to Sergeant Hoggett a willingness to attend 'one-up', that is to enter the premises alone. [38] Sergeant Hoggett advised him that he could not go in and that it was a two-up job. Constable Guy gave evidence he had to follow a Sergeant's instruction.

122. Hobart Headquarters were contacted to seek availability of another unit. Sergeant Etheridge, present there at the time, indicated that he could attend.[39] He was advised that another officer from the eastern shore had been also tasked to attend.

123. Whilst Constable Guy was waiting outside, and Sergeant Etheridge was on the way to the address, they were informed it was a cardiac arrest. In light of this information, both officers separately decided to progress to the address.

124. Sergeant Etheridge gave evidence that as Sergeant in charge of Glenorchy, he could override the two-up policy with an 'dynamic risk assessment' and attend the address one-up. This resulted in him driving directly to the address.

125. Matthew Crawford, RDS Operations Support provided a helpful report reviewing the police availability at the time. He also gave evidence at inquest. In his report, he analysed the information logged into the ESCAD software to review the exhaustion of resources.[40]

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[37] Road and Public Order Services, Tasmania Police
[38] C23-12.
[39] C23-13.
[40] C34 Affidavit and Report of Matthew Crawford.

126. Mr Crawford outlined from his review that the four Glenorchy units and four Hobart units were all engaged on jobs. His review of Bridgewater Station night shift and Bellerive Station night shift indicated that there appeared to be some units available. [41]

127. Commander Peter Harriss noted in his affidavit and evidence that the RDS enquiries at the time were focused on Hobart and Glenorchy. He indicated that a general broadcast to source additional units on all channels may have provided a better and faster response. He indicated that a good opportunity for a general broadcast was when the situation became more critical; that is, at 6.33am when RDS told SOC that there was not anyone available.

128. Counsel for the family also submitted that an "all channels" call was appropriate and should have been made as soon as RDS was aware that there was a delay in locating police officers who were available to attend.

129. The evidence is not capable of establishing whether an "all channels" call would have resulted in locating police officers to attend at an earlier time. Constable Curtain gave evidence that he believed a communication over radio to a single channel would have targeted everyone who was at work at that time, given they would be on that channel or scanning the channels.

130. Similarly, Sergeant Hoggett did not consider that a general broadcast would have achieved a different result as he had contacted only those stations available that time of morning. He thought that, upon the information received, he did everything possible to have police attend the address. The evidence establishes that ongoing attempts were made to locate available officers, and that those attempts were in line with policy at the time. It is apparent that units from Glenorchy and Hobart were exhausted, with no one available for this job.

131. The information conveyed to Sergeant Hoggett by AT did not cause him to think that there was a medical emergency or consider a wider broadcast for police units. However, it might be thought that a *"lights and sirens emergency",* even without further explanation, might have been understood by an RDS officer as a situation requiring urgent police attendance.

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[41] N32, N33 from 6.40a.m., E32, E33, T39.

132. There is some force in the submission made by counsel for the Commissioner of Police that Mr Crawford's analysis of apparently available units was subject to unknown variables and may not support a definite conclusion that units from Bellerive or Bridgewater were in fact available to attend Codie's address.

133. However, I formed the clear view upon the evidence that if the urgency of the job had been impressed upon Sergeant Hoggett and RDS at 6.23am, a wider level of enquiry would certainly have been made and that urgency communicated to police stations and units. This is likely to have resulted in a quicker response, including prioritising the attendance at 13 Ash Street over other jobs. As it stood, by the time it became clear to Sergeant Hoggett that Codie required urgent medical care, Sergeant Etheridge was en-route to 13 Ash Street.

134. Counsel for the Commissioner of Police submitted that it would be inappropriate to establish a policy to routinely make an "all channels" call as soon as it is identified there will be possible delays in police attending to support AT crews. This is because the urgency of ambulance jobs varies; and that the attendance of units from other districts has resourcing and, at times, budgetary issues. I accept this submission. The unfortunate delay in attending 13 Ash Street was an uncommon occurrence and I do not consider I received sufficient evidence to make any recommendation in this regard.

135. As outlined above, the other factor delaying coordination of police assistance by RDS was its lack of knowledge that Mr Moore was likely not present at the address. I have discussed this issue above and observed that not having this knowledge was a lost opportunity to enable police to change the strategy to a one-up attendance, with Constable Guy, or any other single officer available, proceeding straight to the house without waiting. Commander Harriss noted that the information that Mr Moore was not present was not passed on to RDS. He said that if it had been, the risk assessment and member response may have changed considerably. I accept that this is the case.

*Consideration of any guidelines, policies, procedures or systems of Tasmania Police and/or Ambulance Tasmania as they may be connected to the circumstances surrounding death.*

*(a) Tasmania Police*

136. The *Operational Response Policy* is the relevant policy for discussion. Also tendered on the inquest is evidence of further policies developed since Codie's death. Commander

Harriss included in his affidavit some principles for response that were developed in March 2021.[42]

137. Deputy Commissioner Jonathan Higgins also provided an affidavit on 18 January 2023. This indicated that there is high demand for police to assist AT. He indicated that a meeting was convened on 9 January 2023 between senior representatives of both agencies. He noted the outcomes of that meeting included a resolution to review the Letter of Understanding between the organisations to include a triage process applicable to RDS relating to the priority of ambulance assistance jobs. At the meeting, Tasmania Police also committed to examining the use of terminology in this area as well as helping AT with updating its intelligence holdings.

138. I received in evidence the updated Letter of Understanding of 9 February 2024 which deals with processes for both organisations where police are required to be present with AT personnel at callouts. The updated Letter of Understanding includes the following processes;

- RDS requiring a Sergeant to triage and validate all requests from AT to ensure contemporary intelligence, including history and warnings.
- New arrangements to distinguish between requests for police assistance to AT for high-risk incidents, and those that are considered lower risk or nonurgent. There is also a requirement to jointly use consistent ESCAD priorities (Priority 1 to Priority 4) to triage the Priority of Dispatch required – for example Priority 1 requires immediate police attendance where time is critical and AT personnel are in imminent danger. Similarly, AT codes and descriptions of Incident Dispatch Priority is to be understood by TasPol.
- Procedures for the use of common language, direct communications between AT and TasPol to clarify and assess risk and response in respect of callouts and requirements of both agencies to advise of changes in respect of the incident, rendezvous point for staging purposes and estimated times of arrival. Supervisors of both communication centres are to maintain control and oversight of a coordinated response until the respective agency resources arrive at the scene.

[42] C35 Principles for Response.

- Reconciliation of incidents involving requests from AT for police assistance are now undertaken at least monthly between the Inspector in charge of RDS and the Director of Communications for AT.
- Tasmania Police is still working closely to assist AT to "data cleanse" its intelligent holdings to ensure records relating to addresses and individuals who may pose a threat to the safety of attending AT personnel remain accurate and contemporary.
- I accept the submission of Tasmania Police that, by the above methods, significant improvements have been made to provide an enhanced and improved response to incidents. It is also encouraging that these significant improvements are the result of increased collaboration at cooperation between the two agencies which is ongoing.

139. The processes contained within the Letter of Understanding are agreed to be incorporated into the training and operating manuals of the respective organisations. The matters dealt with in the Letter of Understanding address the significant issues concerning communication arising from this case.

*(b) Ambulance Tasmania*

140. Mr Emery gave evidence that, at the time of Codie's death, there were no written AT guidelines or policies in relation to responding to callouts with alerts. As previously noted, Mr Emery said that the practice at the time was that AT crews did not proceed until police were on scene. He gave evidence that the paramedics in this case therefore operated consistently with appropriate AT practice and expectations at all stages of the callout. I have accepted that this is the case.

141. Mr Emery said that for an alert to be added to a premises, a supervisor or paramedic would notify the duty manager of the SOC to provide details of the incident and also submit an SLRS requesting an alert. He indicated that the submission would be taken on its face value and the alert would be applied to the premises. The process of placing the alert would not involve any further analysis by a manager or other staff member of what happened and whether the alert was necessary. Whilst it is not suggested that alerts were placed against premises that were not considered warranted, this system suffered from a lack of further analysis and detail.

142. Mr Emery indicated that another deficiency of the alert system was that an alert remained in place until it was reviewed and removed. As there was no policy in place regulating or governing alerts, the alerts could remain for an extended period of time and become obsolete.

143. Quite obviously, obsolete alerts have significant resourcing consequences for Tasmania Police in workload and supplying attending units. They also add a level of complication and concern for attending AT crews, and potentially delay treatment for patients at the address.

144. Counsel for the family submitted that there were critical deficiencies in the design of the alert system, a submission I accept. These deficiencies include:

- A lack of clarity as to when an alert should be placed on an address;
- No meaningful oversight by supervisors or a central body to determine whether an alert should be placed on an address;
- No procedure to review the need for an alert or to remove an alert from an address;
- No communication with the residents of an address to let them know that an alert existed; and
- Only having one level of response to cover all types of negative interactions with patients or others at an address.

145. A critical question at inquest was whether the deficiencies in the alert system, as opposed to any failure or wrongdoing by any of the individual police officers or members of AT, was the main reason for the failure to provide Codie with timely medical care.

146. In this particular case, regardless of the alert, the AT crew would have assessed the callout as requiring police attendance- as they were entitled to do. This was due to the fact that Ms Richardson happened to have attended six months previously and experienced Mr Moore's behaviour.

147. Mr Emery gave evidence that he considered that the event on 20 July 2018 was within (perhaps at the threshold) of the range of conduct to which he would expect to attract an alert. He indicated that he considered the placement of the alert was justified.

148. I accept the evidence of Mr Emery in this regard. The alert was appropriate. AT paramedics are not equipped to defend themselves or trained to deal with perceived threatening or aggressive behaviour. In performing their role of treating patients, often using life-saving measures, they should not be expected to place themselves at risk.

149. It is most concerning and disappointing that AT crews, in performing their role, are regularly subjected to a range of unacceptable behaviour from persons at the scene. For this reason, I have no hesitation in accepting that a system of alerts on addresses remains necessary.

150. At the time of the inquest, Mr Emery gave evidence about a policy in development in relation to the alert system. The policy was tendered in evidence, still very much in draft form, and included methods for creating a safety alert, establishing levels of safety alerts and providing for a safety alert review process.

*151.* Just prior to handing down this finding, I requested evidence from AT regarding the progress of the policy and received correspondence and a further refined policy entitled *Management of Ambulance Tasmania Emergency Services Computer Aided Dispatch Alerts Procedure("the Procedure").*[43]

152. I received evidence from AT's legal advisor that AT anticipates that the *Procedure* will be implemented on 16 September 2024. The *Procedure* has been significantly refined since the first draft tendered in evidence and it appears that the delay has been associated with the complexity of the alert system and the need to redevelop it in consultation with several organisations, including Tasmania Police. I was advised, however, that the *Procedure* was formally endorsed by the relevant AT leadership committee on 22 July 2024.

153. Further final steps are required before the *Procedure* becomes operational, anticipated to occur on 16 September 2024. The *Procedure* outlines the process for requesting an alert, the process for creating an alert, the process for maintaining, reviewing and updating existing alerts, and governance structures in place for managing alerts.

154. The *Procedure* is comprehensive and deals not only with safety alerts but with medical alerts and access alerts.[44] It sets out prescriptive steps and identifies the personnel

[43] C49.
[44] C 49, Procedure p3. Note that access alerts relate to matters such as providing AT crews with information or instructions about how to enter a particular location.

responsible for managing and reviewing alerts and recording them on the ESCAD system.

155. The *Procedure* provides for three types of safety alerts in accordance with severity of the threat - *Awareness Only*,[45] *Proceed with Caution*[46], and *Stage*.[47] It also provides for reviewing a safety alert every 3 to 6 months depending upon the level of the alert. It provides for the ability to place an interim alert on a location or address for a maximum of 7 days where an alert is deemed to be required immediately.

156. Therefore, the *Procedure* addresses issues that were highlighted by the circumstances of the attendance of the AT crew at Codie's address on 10 December 2018.

157. If the *Procedure* was applied to the circumstances of this case, the alert relating to Mr Moore on 20 July 2018, would have been reviewed by AT on 20 October 2018 (three months) or 20 January 2019 (six months). It would seem likely, at least on a three-month review, that the alert would have remained current because police may not have been able to confirm that Mr Moore had permanently moved to Devonport. In fact, the evidence indicates that Mr Moore was still at the address intermittently until shortly before Codie's death.

158. If it had been reviewed after six months (following Codie's death), AT may have removed it if it was satisfied that Mr Moore had permanently left the address by that time. Whether, in fact, Mr Moore no longer visited that address by that stage is unknown and not required to be determined in this investigation.

159. Importantly, since 2019, AT and Tasmania Police are able to share with each other all the information recorded by each organisation on ESCAD. It seems that there had been an overly long delay in AT moving from its former communications system to ESCAD. With AT not using ESCAD at the time and relying on oral communication with police, it was less clear to police that the medical situation was escalating. Further, less information was available to enable accurate risk assessments.

160. Mr Crawford gave evidence that once an individual job in ESCAD is elected to be 'shared', Tasmania Police is able to see all the information recorded by AT from that

[45] No requirement for police assistance.
[46] Police requested to attend but crew may decide to proceed if police are en-route.
[47] AT crew are not to attend without police.

point. Similarly, evolving information from police is available to AT. Constable Curtain also stated that ambulance and police vehicles are visible on the system.

161. In the RCA Report finalised in February 2019, it was recommended that AT adopt the ESCAD system. The other recommendations focused upon involved AT and Tasmania Police collaboratively establishing common policies, operating instructions and language in order to escalate an issue for crew safety or patient need. [48]

162. As set out above, significant work has been undertaken by both organisations to achieve these objectives.

*The availability of and access to anti-seizure medication by the residents of the household and their training in its administration*

163. Dr Clemens gave evidence at inquest about anti-seizure medication and the training given to Codie's family members in administering it. He testified that the anti-seizure medication prescribed to Codie was midazolam in clear ampoules, provided off-label to be inserted buccally (into the cheek). He noted that the plastic ampoules are designed to have the top twisted off and the clear liquid inside dripped into the patient's cheek. This was advised to be given for seizures lasting more than 5 minutes.

164. Dr Bell stated in his report that "*The clinical situation of a seizure lasting over 5 minutes was appropriate time to administered midazolam intraorally, as trained. The treatment was likely to be effective*."[49]

165. Dr Clemens said that training to family members was provided on how to administer this medication as well as general seizure first aid.

166. Dr Clemens also gave evidence that he could not find any good quality trials determiming that the giving of midazolam at home is safer than not giving it, but that it is extrapolated from the hospital data that it seems it is relatively safe in the hospital setting or by ambulance officers. He said that balancing the risk against the benefit, it may be beneficial if the patient is having prolonged seizures and has demonstrated a response to midazolam previously. Dr Clemens could not find any record of Codie being given buccal midazolam but he had successfully stopped his seizures previously with treatment involving the injection of midazolam.

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[48] C27.
[49] C22 – Dr Bell Report.

167. Dr Clemens gave evidence that there was a good chance that home administration of midazolam by family members may have helped Codie on 10 December 2018 but he did not know whether he would elevate it to *likely* to have helped.

168. With respect to the training of Codie's family members in administering midazolam, Dr Clemens indicated that from his review of the notes, training in the use of home midazolam occurred on the following dates:

    a. On 2 May 2017 by Dr Doug Heller with Douglas Mansell.[50]

    b. On 20 February 2018 by Dr McKinlay with Douglas and Susan Mansell.[51]

    c. On 7 March 2018 by Dr Clemens with Codie and John Wright (a nurse from the Karadi Aboriginal Services).[52]

    d. On 10 April 2018, prior to Codie going to Flinders Island, by Dr McKinlay with Codie and Douglas Mansell.[53]

    e. On 28 June 2018, when Codie was discharged from the Royal Hobart Hospital. The notes specify 'family members' but do not specify the identity of the family members.[54]

169. Dr Clemens indicated the notes did not indicate that Mr Moore or Emily had been trained in the administration of home midazolam. He indicated that Emily was not likely trained in its administration for two reasons; first, that he would not revisit the topic of home midazolam use on each appointment with Codie and second, that he would not usually provide this training to a non-family member, especially one under 18 years old.

170. Mr Mansell gave evidence that he recalls being told about home midazolam and how to give it to Codie, but a male nurse was supposed to come around to their house and show them. He also indicated that a nurse in hospital showed it to him and that it would be put into Codie's mouth if seizing. He later remembered going through it with Dr McKinlay, and the advice was that if Codie was in a seizure for longer than 5 minutes he should give it to him.

[50] See also C37c – Letter from Dr Heller.
[51] See also C37b – Letter from Dr McKinlay.
[52] C37b – Affidavit Dr Clemens.
[53] See also C37b – Letter from Dr McKinlay.
[54] C37b – Affidavit Dr Clemens.

171. Dr Clemens indicated that a home visit, for re-education by John Wright (a nurse), for this purpose is something that would likely happen.

172. Mr Mansell was asked whether he had this medication at his home, and had access to it on 10 December 2018. Initially he stated he did not have it and would not have had it on 10 December 2018. During evidence he revised this and stated the vials would have been kept in his ensuite, and that they collected the vials from the chemist with a prescription. He stated that the vials might have been in the house, but he couldn't give it to Codie because Codie was frothing at the mouth and he was more worried about him. He also commented he may have found a vial recently.

173. Emily could not recall being trained in the home midazolam. I accept that she did not have the training and was not aware of the midazolam in the house.

174. I find that Mr Douglas Mansell had been trained in the use of home midazolam and that he likely had some at home at the time. Whilst Codie was seizing, and whilst they were waiting for the ambulance on 10 December 2018, it would have been an appropriate time for Mr Mansell to administer it to Codie. If he had done so, Codie's seizures may have stopped and he may have survived. No one in the household, it seems, thought of administering midazolam during Codie's seizures.

175. However, in the circumstances Dr Clemens did not criticise Mr Mansell for not using the home midazolam. He commented that he had different expectations on family members as compared to health professionals, and viewed home midazolam as akin to training a family in CPR. He indicated he could imagine a situation where a family was unable to feel confident to administer the home midazolam, and he noted that the information he had from Ms McKinlay was that Mr Mansell engaged with the training but Susan Mansell did not wish to take on the training.

176. The evidence of Dr Clemens was such as to consider the ability of family members to have the ability and presence of mind to administer midazolam during a seizure as a "bonus", much like the ability to perform CPR, and no negative comment ought attach to a failure to do so.

177. Further it is clear that Mr Mansell was extremely distressed at the time. This is evidenced by the 000 call[55] and his evidence.

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[55] Tendered on the inquest as C26 1a and 1b

178. Further, at no time on the 000 call was Mr Mansell or Ms Broderick informed there would be a delay with the ambulance attending. It was reasonable for them to expect (as they did) that having called the ambulance, it would be there shortly as it had done in previous attendances.

179. There was exploration at the inquest about whether the AT call-taker might make enquiries of the caller about whether they have access to anti-epileptic medication.

180. Mr Emery gave evidence that there are no questions or axioms in the Protocol 12 Fitting/ Convulsions to instruct the caller to administer medication. He noted that the only two protocols out of over 30 that recommend medication is asthma and anaphylaxis. Mr Emery also provided a subsequent affidavit and attached Medical Priority Dispatch System Card set.[56] In the affidavit, he indicates this card set is identical to the electronic system and reflects the questions and algorithm within the computers system. The card set provided is Card 12 – Convulsions/Fitting. He indicates in his affidavit that the call taker is expected to work through the questions and answers and a dispatch code is generated.

181. Mr Emery gave evidence that he did not think that Ambulance Tasmania would extend beyond the parameters of the MPDS to give advice as to other medications to be given, as that would carry substantial risk as 000 call takers were not medically trained, beyond their training to take emergency calls.

182. I do not consider that, based upon the evidence of Mr Emery, it is appropriate to make comment or recommendation regarding changes to the existing protocols, which have been established over many years.

**Conclusion**

183. Codie died as a result of continuous untreated epileptic seizures occurring over the course of about 50 minutes on the morning of 10 December 2018. The seizures were treatable with midazolam administered buccally or intravenously. Additional life-saving treatment was readily available within the emergency department of the RHH, only minutes from Codie's home.

[56] See C47a and C47b.

184. In this very sad case, I have examined and commented upon the many matters presented by the evidence that are important parts of the circumstances surrounding his preventable death.

185. Unfortunately, Codie suffered a severe condition that required strict adherence to medication. Ideally, he should also have avoided cannabis use which may have exacerbated his epilepsy. His missed dose of medication contributed to the onset of his seizures before his death, with his recent cannabis use perhaps being a contributing factor.

186. If Codie or those responsible for him had ensured a continuous supply of medication, his seizures may have ceased or may have reduced in severity. I do not intend criticism of Codie or his family in making this comment but it highlights that particularly vigilant management and dedicated treatment of Codie's condition was necessary on an ongoing basis.

187. Further, treatment for Codie's seizures in the form of midazolam was almost certainly present in the home. If Mr Douglas Mansell had administered midazolam to Codie whilst he was seizing in accordance with the training given to him, this would have had a positive effect and may, at least, have allowed more time for successful treatment. The distressing circumstances and Mr Mansell's own level of capability meant that he did not turn his mind to this available life-saving measure.

188. If the paramedic crew had proceeded directly into Codie's house and treated him, they would have administered treatment to halt Codie's seizures, and would have transported him quickly to hospital for further treatment. In this scenario, Codie would not have died.

189. However, the paramedic crew did not enter Codie's address during his escalating seizures because of the risk that Mr Moore presented to their safety, reflected by a safety alert in the AT system. The placement of the alert upon the premises was fully justified.

190. In the circumstances of Mr Moore's previous behaviour, and given the presence of the alert, it was reasonable and in accordance with normal procedure for the paramedic crew not to enter without police assistance despite the known urgency of the situation for Codie.

191. It was also reasonable and in accordance with normal procedure that the crew remained staged away from the address despite information received from the family that Mr Moore was *not* present. This information was unable to be accepted as correct by the paramedics. Even if this information had been passed on to RDS, police would have been unable to verify its accuracy at that time such as to allow AT to remove the safety alert and give assurance to the crew that the danger was not present.

192. However, if the information that Mr Moore was not present had been passed on to RDS by SOC, there was a good chance that the risk assessment for the police operational response may have changed from the required two-officer attendance to a single officer attendance. Although SOC personnel might not have understood exactly how police might use this fact in responding, in hindsight, any relevant information relating to the very reason for seeking assistance should have been passed to police.

193. Unusually, police were unable to readily provide assistance to the AT crew for this callout, but efforts continued to be made by RDS through the usual channels.

194. Sergeant Hoggett of RDS did not appreciate the significance of the communication by SOC at 6.23am *"..just become a lights and sirens emergency for us, patients fitting again."* This, in my view, clearly signified an escalation in urgency by use of the words *lights and sirens.* A reassessment of police response in light of the new urgency of the situation should have occurred at that point.

195. Applying the *Operational Response Policy* a one-up response may well have been determined by RDS to be appropriate in light of the time-critical emergency together with the fact that there had been no suggestion from SOC that aggressive or problematic behaviour was actually occurring at the household.

196. An "all channels" broadcast for a one-up response, emphasising the nature of the medical emergency, is quite likely to have resulted in the attendance of a police unit to the address.

197. Two further matters connected to Codie's death should be mentioned in conclusion.

198. Firstly, the unwillingness of the paramedic crew to enter the address and the subsequent alert was because of Ronald Moore's previous behaviour. If he had not engendered fear in the attending paramedics six months previously by his behaviour, the paramedic crew on 10 December 2018 would have entered the address shortly after 6.16am and Codie would have lived.

199. This case demonstrates that aggressive or violent behaviour towards AT paramedics can be directly linked to poor outcomes for patients. It is completely unacceptable for those professionals tasked to help in medical emergencies to be subjected to such behaviour. It is also unacceptable that patients requiring urgent treatment may be prevented from receiving it due to no fault of their own.

200. Secondly, at the time of Codie's death, AT had not implemented the ESCAD system. Both Tasmania Police and the Tasmanian Fire Service had implemented ESCAD at that time, but there had been significant delays in AT doing so. If it had been in place, the shared information, (for example, relating to Mr Moore's alleged absence) may well have improved the response.

201. Finally, I acknowledge the work done by both AT and Tasmania Police since Codie's death to review and improve the system of alerts generally and, in particular, safety alerts where police assistance may be required.

**Formal Findings**

202. I find, pursuant to section 28(l) of the *Coroners Act*, that:

a) The identity of the deceased is Codie Anthony Mansell-Moore, date of birth 8 May 2001;

b) Codie had a cardiac arrest as the consequence of suffering multiple, untreated seizures in the circumstances set out in this finding;

c) The cause of death was epileptic seizures complicating idiopathic epilepsy; and

d) Codie died at or just before 7.00am on 10 December 2018 at 13 Ash Street, Lutana, in the state of Tasmania.

**Recommendations**

203. I make the following recommendations pursuant to section 28(2) of the *Coroners Act* 1995:

204. I **recommend** that Ambulance Tasmania immediately finalises and implements the *Management of Ambulance Tasmania ESCAD Alerts Procedure*; and, once implemented, reviews the operation of the *Procedure* on a regular basis and ensures that required amendments are made in a timely manner.

205. I **recommend** that Ambulance Tasmania and Tasmania Police together review the effectiveness of the joint arrangements regarding police assisting ambulance contained in the *Letter of Understanding - Response to High Risk Incidents* at regular intervals prior to its expiration.

**Dated:** 9 August 2024 at Hobart, Tasmania

**Olivia McTaggart**
**Coroner**

Annexure A

| No. | TYPE OF EXHIBIT | NAME OF WITNESS |
|---|---|---|
| C1 | REPORT OF DEATH | Constable Nikayla Roach |
| C2 | LIFE EXTINCT AFFIDAVIT | Dr Lori Coulson |
| C3 | POLICE AFFIDAVIT OF IDENTIFICATION | Constable Nikayla Roach |
| C4 | MORTUARY AMBULANCE AFFIDAVIT OF IDENTIFICATION | Anthony Cordwell |
| C5 | POST MORTEM AFFIDAVIT | Dr Donald Ritchey |
| C6 | TOXICOLOGY REPORT | Craig Gardner |
| C7 | MEDICAL REPORTS (USB & disc) | THS and Aboriginal Health Services Records |
| C8 | VACIS REPORT | Ambulance Tasmania (AT) |
| C9 | AFFIDAVIT (15.1.2020) | Douglas Mansell |
| C10 | AFFIDAVIT (15.01.2020) | Mark Watterson |
| C11a | AFFIDAVIT (13.3.2019) | Sergeant Tim Etheridge |
| C11b | AFFIDAVIT (7.11.2022) | Sergeant Tim Etheridge |
| C12 | AFFIDAVIT (14.10.2021) & NOTES | Constable Ray Guy |
| C13 | AFFIDAVIT (30.01.2019 | Constable Nikayla Roach |
| C14 | AFFIDAVIT (08.02.2020) | Constable Leighton Beer |
| C15 | AFFIDAVIT (17.01.2020) | Constable John North |
| C16 | AFFIDAVIT (14.01.2020) | Detective Constable Travis Smith |
| C17 | AFFIDAVIT (16.08.2021) | Zoe Richardson - Paramedic |
| C18a | AFFIDAVIT (unsigned) | Lisa Trevaskis - Paramedic |
| C18b | AFFIDAVIT (10.01.2023) | Lisa Trevaskis - Paramedic |
| C19 | AFFIDAVIT (22.06.2021) | Adam Marmion - Paramedic |
| C20 | AFFIDAVIT (04.08.2021) | Rebecca Wells - Paramedic |

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|---|---|---|
| **C21** | **AFFIDAVIT & PHOTOGRAPHS (6.02.2020)** | **Constable Nicholas Monk** |
| **C22** | **MEDICAL REVIEW** | **Dr Anthony Bell** |
| **C23**<br>**1-28** | **DISC - Radio Dispatch Services (RDS)** | **Department of Police, Fire & Emergency Management (DPFEM)** |
| **C24** | **AFFIDAVIT – Police Review (17.07.2020)** | **Inspector Peter Harriss** |
| **C25** | **Operational Response Policy** | **Department of Police, Fire & Emergency Management** |
| **C26**<br>**1a-15** | **DISC– State Operations Centre (SOC)**<br>**Call Recordings** | **Ambulance Tasmania** |
| **C27** | **FINAL RCA REPORT** | **Ambulance Tasmania** |
| **C28** | **CONVICTION HISTORY** | **Ronald Albert Moore**<br>**Department of Police, Fire & Emergency Management** |
| **C29** | **AFFIDAVIT (29.9.2022)** | **Nicholas Poprawski – Dispatcher**<br>**Ambulance Tasmania** |
| **C30** | **AFFIDAVIT (15.11.2022)** | **Sergeant David Hoggett**<br>**Radio Dispatch Services** |
| **C31** | **AFFIDAVIT (15.11.2022)** | **Constable Jason Curtain** |
| **C32a** | **AFFIDAVIT (22.11.2022)** | **Jordan Emery**<br>**Ambulance Tasmania** |
| **C32b** | **AFFIDAVIT (7.12.2022)** | **Jordan Emery**<br>**Ambulance Tasmania** |
| **C33** | **MANAGEMENT OF AMBULANCE TASMANIA ESCAD ALERTS** | **Cassandra McKenzie**<br>**Ambulance Tasmania** |
| **C33b** | **DRAFT MANAGEMENT OF AMBULANCE TASMANIA ESCAD** | **Cassandra McKenzie**<br>**Ambulance Tasmania** |

| **C34** | **AFFIDAVIT AND REPORT (22.11.2022)** | **Matthew Crawford**<br>**Radio Dispatch Services** |
|---|---|---|
| **C34b** | **REPORT DISPATCHES TO 13 ASH STREET** | **Matthew Crawford**<br>**Radio Dispatch Services** |
| **C35** | **PRINCIPLES OF RESPONSE** | **Tasmania Police** |
| **C36** | **AFFIDAVIT (10.12.2022)** | **Emily Broderick** |
| **C37a** | **AFFIDAVIT (7.12.2022)** | **Dr Tom Clemens** |
| **C37b** | **LETTER FROM DR MCKINLAY (13.1.2023)** | **Dr Tom Clemens** |
| **C37c** | **LETTER DR HELLER (2.5.2017)** | **Dr Tom Clemens** |
| **C38** | **AFFIDAVIT (5.1.2023)** | **Ronald Moore** |
| **C39** | **PROPERTY RECEIPTS X2** | **Royal Hobart Hospital & Tasmania Police** |
| **C40** | **VACIS REPORT (RONNIE MOORE)** | **Ambulance Tasmania** |
| **C41a & b** | **MINUTE TO MINISTER AND EMAIL** | **Ambulance Tasmania** |
| **C42**<br>**a-g** | **AMBULANCE COMMUNICATIONS 10.12.18** | **Ambulance Tasmania** |
| **C43** | **VACIS REPORTS FOR 13 ASH STREET – 20.7.18 – 10.12.18** | **Ambulance Tasmania** |
| **C44** | **GCAD PATIENT ALERT** | **Ambulance Tasmania** |
| **C45a** | **COMPLEX CLIENT MANAGEMENT PROCEDURE** | **Ambulance Tasmania** |
| **C45b** | **SNIPS AND DESCRIPTION OF SRLS** | **Ambulance Tasmania** |
| **C45c** | **ENTERING RISKS IN GUARDIAN COMMAND** | **Ambulance Tasmania** |
| **C46** | **AFFIDAVIT 18.1.23** | **Jonathan Higgins - Deputy Commissioner**<br>**Tasmania Police** |

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| **C47a&b** | **MPDS CARDSET & AFFIDAVIT 7.2.23** | **Jordan Emery**<br>**Ambulance Tasmania** |
| **C48** | **Updated Letter of Understanding** | **Tasmania Police** |
| **C49** | **Draft Dispatch Alerts Procedure** | **Ambulance Tasmania** |

**Annexure B**

## INQUEST INTO THE DEATH OF CODIE MANSELL-MOORE

## TIMELINE

**GLOSSARY**

**AT - Ambulance Tasmania**

**SOC – State Operations Centre (Ambulance Tasmania)**

**RDS – Radio Dispatch Services (Tasmania Police)**

**Cat – Priority Category (increasing in urgency from Cat 3 to Cat 0)**

**AVL – Automated Vehicle Locator**

**RCA – Root Cause Analysis**

| Exhibit Number | Time of Call | Event | Caller | Receiver |
|---|---|---|---|---|
| C26 1a, 1b | 0609 | SOC receives call from Codie's family member who rings AT to report seizure<br><br>Designated Cat 3 (non-urgent) | Caller - Emily Broderick,<br><br>Douglas Mansell then takes over the call | SOC call taker - Daniel Mundy (Emergency Medical Dispatch Support Officer) |
| C27 RCA | 0613 | AT crew assigned – Designated Cat 2 | | |
| C27 RCA<br><br>C26 2a | 0615 | AT crew advise SOC they are aware of alert on address.<br><br>AT crew states will not attend without police as | AT crew – Zoe Richardson (Paramedic) | SOC – Nick Poprawski (Communications Team Leader) |

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| | | previously *Ronnie got up swinging at us* | | |
| C26 2<br>C23 1 | 0616 | SOC rings RDS to request assistance | SOC - Nick Poprawski | RDS – Constable (Cst) Jason Curtain |
| C26 3 | 0616 | SOC to AT via radio - police on way, stage around the corner | SOC - Nick Poprawski | AT crew – Lisa Trevaskis (Paramedic) |
| C26 1a,1b | 0621 | SOC on phone with family member additional seizures | SOC - Daniel Mundy | Emily Broderick or Douglas Mansell |
| C26 4 | 0621 | SOC to AT additional seizure – upgrade to urgent Cat 1. Will have you wait and get an ETA | SOC - Nick Poprawski | AT crew – Lisa Trevaskis |
| C26 4<br>C23 6 | 0623 | SOC calls RDS asking for ETA.<br>SOC advises *now lights and sirens emergency, another fit.* | SOC - Nick Poprawski | RDS – Sergeant (Sgt) Dave Hoggett |
| | 0626 | AT arrive at location | | |
| C26 5<br>C23 9 | 0626 | RDS contact SOC - no police units available | RDS – Sgt Dave Hoggett | SOC - Nick Poprawski |
| C26 6 | 06.26 | No police – Patient having 3rd fit | SOC - Nick Poprawski | AT crew – Lisa Trevaskis |
| C26 7<br>C23 11 | | No police units available | SOC - Nick Poprawski | RDS - Cst Jason Curtain |
| C23 10 | 0629 | RDS contacts police Constable S Allen, he advises Constable R Guy ready to start soon | RDS – Sgt Dave Hoggett | Cst Sam Allen |

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| C23 11 | 0633 | RDS contact SOC to advise unable to get anyone to attend | RDS – Cst Jason Curtain | SOC - Nick Poprawski |
| C23 12 | 0633 | Constable R Guy books on and agrees to head to the job but told to wait for another police. | Cst Ray Guy, call sign Tango 19 | RDS – Sgt Dave Hoggett |
| C23 13 | Time not know n | RDS speak to Golf 32 to send 1 officer to back up at address | RDS – Sgt Dave Hoggett | Sgt Tim Etheridge, call sign Golf 32 |
| C23 15 | Time not know n | SOC updated | RDS – Sgt Dave Hoggett | SOC - Lauren |
| C26 1a<br><br>(time on recordin g 27.03) | 0636 | SOC – family reports another seizure.<br><br>SOC asks if Ronnie Moore is there and family indicates he is not and provides details. | SOC - Daniel Mundy | Emily Broderick<br><br>Douglas Mansell |
| C26 8 | 0639 | SOC phones AT that alert person is not at the address. (*Not communicated to RDS)*<br><br>Advises patient in his 5th fit. Ronnie Moore not present, is in Devonport, outlined who is in the house. Police can't get anyone free until 7.<br><br>Ms Richardson will not go in regardless. Asked *if this guy suffers from* | SOC- Nick Poprawski | AT crew – Lisa Trevaskis |

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| | | *seizures and how genuine this is.* | | |
| C26 1a,1b | 0645 | SOC advised by family - breathing and on his side | SOC - Daniel Mundy | Emily Broderick or Douglas Mansell |
| C23 13 | 0646 | G32 Sgt Etheridge is at Hobart Police Station and offers to attend. Police advised of alert and note R Moore has warrant. | RDS – Sgt Dave Hoggett | Sgt Tim Etheridge Golf 32 |
| C26 9<br><br>C23 15 | 0650 | RDS contact SOC and advise police on way to meet AT | RDS – Sgt Dave Hoggett | SOC - Lauren Brooksbank |
| C26 1b | 0651 | SOC gives phone advice to family re CPR as patient not breathing | SOC - Daniel Mundy | Emily Broderick and Douglas Mansell |
| C23 18<br><br><br><br>C26 9a | 0653 | SOC contact RDS and advise cardiac arrest, how far away are police. We are now doing *pushy pumpies* (meaning the *family* is performing CPR) | SOC - Grant Perry (Communications Team Leader) | RDS – Craig Feihlandt (Radio Dispatch Operator) |
| C23 19 | 0654 | RDS convey to police AT crew on scene doing CPR it's a cardiac arrest (*this is incorrect*) | RDS – Cst Craig Fehlandt | Cst Ray Guy Tango 19 |
| C23 20a, 20b | | Golf 32 Sgt Etheridge speaks with RDS and receives instructions about getting to the incident | Sgt Tim Etheridge Golf 32 | RDS – Cyndy Garrett (Radio Dispatch Operator) |
| C26 10 | 0654 | AT crew phone SOC. Asks if Nick is there. Ms | AT crew – Lisa Trevaskis | SOC - Grant Perry and Lauren Brooksbank |

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| | | Trevaskis asks for update. Told Police is on the way to Ashbolt and Ash Sts. Ms Trevaskis request day crew. Ms Trevaskis is told now it is an arrest, they are to stay on it and further ambulance requested. | | (Emergency Medical Dispatcher) |
| | 0654 | SOC dispatches second AT crew | | |
| C26 11 | | SOC radio to Crew 44 to phone | | |
| C26 12 | | SOC phone call to Adam AT crew updating him re the incident. "Zoe was assaulted".<br><br>During the call first crew enters the house | SOC – Lauren Brooksbank | AT crew – Adam Marmion (Intensive Care Paramedic) |
| C23 23 | 0656 | AVL records Golf 32 Sgt Etheridge at scene. Emily Broderick performing CPR. AT not on scene | | |
| C27 RCA | 0657 | T19 Const Guy arrives at the scene.<br><br>AT arrives at the scene | | |
| C26 13 | | Call to crew on scene – cardiac arrest | SOC | AT crew on scene |
| C26 14 | | Unknown AT personnel – phone call<br><br>Discuss the alert, justification to not enter. | | |

| C26 15 | | SOC to Crew on scene – cardiac arrest – died at scene | SOC - Lauren Brooksbank | AT crew – Adam Marmion |
|---|---|---|---|---|