CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Scott Cayirylys
Hearing dates:	3 – 6 February 2020
Date of findings:	3 March 2020
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of a man while awaiting ambulance – ambulance dispatcher downgraded response code – ambulance not allocated until police arrived at scene – NSW Ambulance policies and procedures – recommendations.
File number:	2016/273233
Representation:	Counsel Assisting the inquest: S Beckett of Counsel i/b NSW Department of Communities and Justice. NSW Ambulance: H Chiu of Counsel i/b NSW Crown Solicitor's Office. NSW Commissioner of Police: C Melis of Counsel i/b NSW Police Force Office of General Counsel. NSW Ambulance officers: B Bradley of Counsel i/b McCabe Curwood Lawyers. NSW Police Force officers: P Madden of Counsel i/b Walter Madden Jenkins. The family members.

Findings:	**Identity** The person who died is Scott Cayirylys. **Date of death**: Scott Cayirylys died on 11 September 2016. **Place of death**: Scott Cayirylys died in an ambulance while being taken to Coffs Harbour Hospital. **Cause of death:** Scott Cayirylys died as a result of a cardiac arrest due to profound blood loss causing hypovolaemia. **Manner of death:** Scott Cayirylys died while waiting for an ambulance, after he had inflicted an incised wound to his left arm.

Recommendations pursuant to section 82

To the Commissioner, New South Wales Ambulance:

1. That NSWA consider investigating whether it is feasible and advisable to exclude manual downgrades of the response codes for emergency incidents received through ‘000’ or otherwise.

2. That NSWA consider meeting with NSW Police Force and NSW Fire and Rescue to examine the need to revise and update joint ICEMS protocols, particularly those concerning communication of prioritisation.

3. That NSWA consider undertaking a clinical review to determine whether there is a need to amend its treatment protocols, training and instructions so that paramedics continue the provision of fluid and adrenaline for the entire period of resuscitation in cases of hypovolaemia.

Section 81(1) of the *Coroners Act 2009 (NSW)* [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of Scott Cayirylys.

Introduction

1. Scott Cayirylys aged 45 years died on 11 September 2016 while being taken by ambulance to Coffs Harbour Hospital, on NSW's mid-north coast. In his apartment that morning he had used a knife to cut himself on his left arm. He rang his former partner asking her to get help. She immediately rang emergency services, but due to a series of errors an ambulance did not arrive for over an hour. Tragically it was too late to save Scott's life, and he suffered a fatal cardiac arrest due to blood loss.

2. The inquest into Scott's death focused upon the reasons why it took so long for emergency medical help to arrive. The inquest also considered whether the failure to respond in time to save Scott's life was the result of systemic problems which needed solutions.

Scott Cayirylys' life

3. Scott Cayirylys was born in Sydney on 13 September 1970 and later moved to NSW's mid north coast. As an adult he worked as a crane operator. He married Kim Patterson and they had a son Mitchell, who is now aged 21 years. Although Scott and Kim divorced they remained on good terms with each other, and Scott was close to his son Mitchell.

4. In 2014 Scott met Nicole Andrews, and the following year they commenced living together in Coffs Harbour with Nicole's two children. Mitchell stayed with them every second weekend. In May 2016 Nicole and Scott decided to live separately but to maintain their relationship. Scott moved into an apartment in West Argyll Street, Coffs Harbour.

5. At the close of the evidence Scott's former wife Kim read to the court a loving tribute to Scott which their son Mitchell had prepared. Mitchell wrote eloquently of how his father told him every day that he loved him. Mitchell felt the loss of his father deeply, and he struggled with his education for some time afterwards. It was heart-warming to hear that he had recently graduated from the NSW Police Force Academy, much to his mother's pride and without any doubt, Scott's as well. Scott's sudden death was a shock to those who loved him, and they grieve his loss.

The night before Scott's death

6. In the months prior to Scott's death he and Nicole Andrews continued to see each other and they discussed getting married. However there were arguments between them which worried Nicole and made her uncertain whether they had a future together.

7. In the week before Scott's death Nicole told him she had decided it would be best to end their relationship. Both were saddened by this. A few days later, on the night of 10 September they met up at the Coast Hotel in Coffs Harbour where both drank alcohol. Later that night an altercation erupted between Scott and a female friend of Nicole's, during which Scott pushed the friend to the ground. Security guards intervened. Scott expected that Nicole's friend would make a statement to police and that he would be charged.

8. The following morning was Sunday 11 September. Nicole spoke to Scott on the phone and found him to be very despondent about his life, and worried about being charged with assault. She then received a series of texts from him asking her to ensure that his son Mitchell didn't '*find him'*. In reply she urged him not to do anything silly.

9. At 10.50am Scott rang Nicole, asking her to get help. Nicole was seriously alarmed to hear Scott's groaning and laboured breathing. He seemed unable to tell her what had happened. She told him she would get an ambulance, and immediately rang triple zero. The time was 10.52am.

The NSW Ambulance dispatch system

10. In order to understand what happened next, it is necessary to give a description of how the dispatch system for NSW Ambulance [NSWA] works.

11. One of the core responsibilities of NSWA is to provide emergency transport for patients. NSWA divides the State into sectors, each of which is managed by a regional Control Centre. Within each Control Centre is a Duty Control Centre Officer [the DCCO], who supervises the deployment of ambulance resources within the Control Centre's geographical area. The Coffs Harbour region is managed by the Northern Control Centre, located at Charlestown Newcastle. This Control Centre is also responsible for the Upper Hunter and the Northern Rivers regions.

12. When a call for an ambulance is made to triple zero it is triaged using a computerised system known as the Medical Priority Dispatch System [MPDS]. Using a sub-system called ProQA, a NSWA call taker (also known as a Communications Assistant) asks the caller a series of questions based on on-screen prompts. When sufficient information is obtained, the ProQA system allocates a response code based on the urgency of the situation. A response code '1' for example requires the most timely ambulance response using lights and sirens. The incident then enters the MPDS system to be managed by a dispatcher located at the relevant Control Centre.

13. The Dispatcher determines the type and level of resource that will be required. He or she then identifies where the necessary resources are located and their approximate travel time to the scene. Dispatchers and Communications Assistants are expected to enter information and updates about the incident in the Comments field of their Computer Aided Dispatch System.

14. As part of its emergency dispatching process, NSWA also uses a system called the InterCAD Electronic Messaging System [ICEMS]. This enables NSWA to exchange critical information electronically with partner emergency organisations, including NSW Police.

Nicole's call to triple zero

15. Nicole Andrews' first call to triple zero was made at 10.52am, immediately after Scott rang her to get help. Her call was received by NSWA Communications Assistant Katie Carroll, who was working at a centralised location on NSW's south coast. Ms Carroll followed the ProQA prompts, in answer to which Nicole told her the following:

- Scott could hardly speak, was making funny noises, wasn't making any sense but had said to '*get help'*
- she thought Scott had hurt himself and that it could be a suicide attempt
- the previous night Scott had assaulted a girl and a security officer
- Scott did not have a weapon.

16. When asked if Scott was violent Nicole replied '*he can be, he has a bit of a temper'*.

17. Based on this information, the ProQA program allocated the incident a 'priority 1C 25DO1V' response. As noted, '1C' meant there had to be the most timely ambulance response, with warning devices including lights and sirens activated. The '25' signified that the incident possibly involved psychiatric or abnormal behaviour or a suicide attempt. '01' indicated that the patient was not alert, while the purpose of the 'V' suffix was to alert responders to the possibility of violence at the scene and therefore the need for police attendance.

18. After calling for an ambulance Nicole drove straight to Scott's apartment, but she was unable to get in as she had no key. When she rang Scott's mobile phone he was unable to talk to her, and all she could hear were sounds as though he was groaning and struggling for breath. She told him to hold on and that police and ambulance were on their way.

NSWA's initial response

19. At Northern Control Centre Ms Pauline Campbell was the Dispatcher who received this incident. Noting the 'V' classification, at 10.57am she sent a message via the ICEMS system to NSW Police, requesting their attendance at Scott's address.

20. At this point the first of a series of problems occurred. There was an error in the transmission of this request to NSW Police, and the message did not arrive. An error message was immediately recorded. Unfortunately it was not noticed by Ms Campbell, as she was due for her scheduled 30 minute break

and was in the process of handing over her shift to a relieving Dispatcher, Ms Donna Lawther (now Donna Ryan).

21. The result was that the police's non-receipt message was not noticed at the NSWA Control Centre until 11.13am, 16 minutes later. Along with other serious mishaps the delay in receipt of the request for police attendance had significant consequences, as will be described.

The incident is downgraded

22. On 11 September the DOCO at Northern Control Centre was Ms Venessa Cockburn. She noted the Cayirylys incident on her screen and at 10.57am she decided to downgrade the response code from '1C' to '2A'. A 2A response code requires the attendance of an ambulance within 30 minutes, and does not authorise the ambulance to use lights and sirens. This decision had far-reaching consequences.

23. In her statements and her evidence to the inquest Ms Cockburn explained her decision. At the time she believed that due to the incident's 'V' classification, which required the attendance of police, no ambulance officers would be able to enter the scene until police had arrived and secured the area or at the very least, had notified their estimated time of arrival at the scene. In her first statement she explained:
'*If the incident remained a 1C … this would have meant that a Paramedic crew responded under lights and sirens to stand off waiting for police and we would not have had a paramedic crew to attend the other pending incidents in Coffs Harbour'*.

24. Ms Cockburn therefore changed the incident's response code to '2A' to ensure that an ambulance was not assigned until there was confirmation that a police car was on its way to the scene.

25. Ms Cockburn's understanding of what was required was shared by the two other NSWA Dispatchers involved in this incident, Ms Pauline Campbell and Ms Donna Lawther. Each gave evidence at the inquest that they understood there to be a practice that when an incident had been allocated a 'V' suffix, they ought not to allocate an ambulance resource until they were notified by police that they were on the scene. Ms Campbell went further, stating that at the time she believed she should not allocate an ambulance until police had arrived and had given her a report of the patient's condition.

26. From the outset it can be said that this understanding of dispatch procedures was wrong. Then as now, procedures for potentially violent and high risk situations are subject to NSWA *Dispatch Procedure 9.01*. This requires that dispatchers:

- relay to paramedics all relevant information about the potential for violence or high risk, so the paramedics can make an appropriate risk assessment
- pass on to paramedics any directions from the police to '*stand off'* until police have secured the scene.

27. In situations assigned a ‘V’ suffix therefore, NSWA paramedics are able to attend the scene and make their own safety evaluation. They may decide for safety reasons to await the arrival of police. Nowhere is it stated that dispatchers are not to assign an ambulance to a ‘V’ incident until police arrive at the scene or notify they are on the way. Nor is it stated that dispatchers should downgrade the response code of an incident while they wait for this to take place.

28. At the inquest Ms Cockburn, Ms Campbell and Ms Lawther acknowledged they had been mistaken in their understanding of what was required in dispatching to ‘V’ situations. Ms Cockburn in particular was visibly distressed as she told the court that she deeply regretted her error and its consequences. Ms Campbell too was very regretful that she had made flow-on decisions based on this error, which will be described below.

Events between 11.00am and 11.30am

29. Just after 11.00am Ms Campbell handed over her shift to Ms Lawther. Due to her erroneous understanding of ‘V’ incidents, Ms Campbell had not yet allocated an ambulance to the incident. In fact at 11.02am an ambulance crew was available to be dispatched to Scott’s address, but for the above reasons Ms Lawther directed it to an incident which had a ‘2B’ response code, meaning that it required an ambulance within 60 minutes.

30. During the next ten minutes a number of new incidents in the Coffs Harbour area required ambulances. By 11.07am Ms Lawther had dispatched all rostered Coffs Harbour crews and ambulances. As yet no one had noticed that NSW Police had not received the request to attend at Scott Cayirylys’ apartment.

31. When all rostered ambulances had been allocated, Ms Lawther tasked an ambulance stationed at Urunga to travel to Coffs Harbour for ‘*area cover*’. Urunga is approximately 20-25 minutes driving time from Coffs Harbour. Ms Lawther was applying NSWA’s Fluid Deployment Policy, whereby an ambulance resource from the closest available station can be deployed to an area when local resources have been exhausted.

32. Ambulance 4481 set off from Urunga at 11.13am, crewed with Intensive Care Paramedics Angus Anderson and Mark Fairbairn. Ms Lawther did not assign Ambulance 4481 to the Cayirylys incident or to any specific incident. The ambulance proceeded to Sawtell, approximately fifteen minutes’ drive from Coffs Harbour central, and awaited further directions.

33. At 11.13am Ms Lawther noticed the error message signifying that NSW Police had not received the request for attendance. She re-sent the request and received an immediate acknowledgement. She did not inform police that dispatch of an ambulance to the scene was awaiting their arrival there.

34. Between 11.01 and 11.06 Communications Assistant Katie Carroll rang Scott a number of times. In only one of Ms Carroll’s calls to Scott was he able to

say anything to her. Between moans he told her he was '*bleeding to death'* and that he had '*cut*' himself. He begged her to *'hurry up'.* Ms Carroll was unaware that Northern Control Centre had downgraded the incident's response code from '1C' to '2A', as Ms Cockburn had not made recorded this decision in the 'Comments' field.

NSWA response between 11.30am and 12pm

35. At Northern Control Centre Ms Campbell resumed her dispatching duties at 11.28am after her scheduled break. She noticed an ICEMS message from police at 11.13 acknowledging the incident. However she did not allocate an ambulance to Scott because she had not heard from police of their arrival at the scene. This confirmation arrived at 11.29 (see paragraph >> below which describes the police response). Still Ms Campbell did not allocate an ambulance, explaining to the court her belief at that time that a police report on the patient's condition was required. This report arrived at 11.38, with a police message as follows:
'*Urgent ambo to location self-inflicted wounds unsure whereabouts injuries are however there is a fair amount of blood – ambos asap please and ETA'.*

36. On seeing this message Ms Campbell assigned Urunga ambulance 4481 to Scott's address. The time was now 11.41. Ms Campbell did not instruct the ambulance crew to proceed to the address with lights and sirens on; nor did the crew take this action of their own accord. Intensive Care Paramedic Angus Anderson explained this was because the incident was coded '2A'. He and fellow paramedic Mark Fairbairn stated further that they could not recall if they had been aware of the police ICEMS message at 11.38, requesting an ambulance urgently. Mr Fairbairn said that had he been so aware, he would have contacted the Control Centre and requested permission to proceed with lights and sirens.

37. At the inquest Ms Campbell told the court of her regret that even on the basis of her erroneous understanding of 'V' incidents, she had not assigned an ambulance to Scott's address at two critical points: at 11.21 when NSW Police notified that they were on the way; and at 11.29 when they messaged that they had arrived at Scott's address. She was further regretful that at 11.38 she had not instructed Ambulance 4481 to proceed to the scene with lights and sirens on.

38. Regarding the above, Mr Fairbairn told the court that had they been assigned the Cayirylys incident at 11.13am and had proceeded from Urunga to Coffs Harbour with lights and sirens activated, they would probably have arrived within approximately twenty minutes. Assuming this to be correct, Ambulance 4481 would have arrived at about the same time as the police.

The police response

39. At 11.13 NSW Police received the second request from NSWA for attendance at the Cayirylys incident. Two police officers, Senior Constable Jarrod Cutler

and Constable Matthew Lees arrived at Scott's address sixteen minutes later, followed shortly afterwards by Sergeant Bradley Durham.

40. As the police officers did not have a key or access to an open window they broke down the front door to get inside. Upstairs they found Scott on his hands and knees, at the doorway of the main bedroom. He was conscious and breathing, and was holding a blood-stained pillow. There was a significant amount of blood in the bedroom and bathroom. The police officers saw a deep wound on Scott's left arm, but did not notice any active bleeding from the site. They placed him in the recovery position and tried to keep him calm; however he was thrashing his legs from side to side and trying to get up.

41. Constable Lees went downstairs to send the urgent message to NSWA that has been described above at paragraph ??. As more time passed the police officers became increasingly alarmed about Scott's condition. His physical movements began to slow down, he felt clammy to the touch and they were unable to find a pulse. At 11.54 Constable Lees sent NSWA another urgent ICEMS message:
'Things are going downhill with POI need ambos urgently'.

42. They received a response at 11.56 that Ambulance 4481 was two minutes away. According to Sergeant Durham, Scott went into cardiac arrest at about the same time the ambulance arrived.

The response of Ambulance 4481

43. Ambulance 4481 arrived at Scott's address at 11.59. Paramedics Anderson and Fairbairn found Scott lying at the top of the apartment's stairs. He had no pulse, his pupils were fixed and dilated, he had agonal breathing (that is, was gasping for breath) and was very pale. Mr Freebairn observed that he did not appear to have obvious bleeding from any wounds.

44. The paramedics commenced resuscitation but quickly found the space too restricted to treat Scott effectively. Mr Fairbairn decided he should be taken to hospital immediately. While Mr Anderson went downstairs to get a carry sheet, Scott went into cardiac arrest. The police officers assisted the paramedics to move Scott downstairs and into the ambulance, where CPR efforts continued.

45. A second ambulance then arrived to assist. Inside the ambulance Scott was ventilated with a bag mask, then intubated. The paramedics obtained intravenous access through Scott's right arm and commenced fluid therapy. Over the period 12.10pm to 12.19pm they administered three doses of adrenaline to try to recommence Scott's heart, and two boluses of fluid solution. The purpose of the fluid was to assist circulation of what blood remained in Scott's body. These efforts were to no avail: Scott's heart continued to show no electrical activity.

46. On the basis that this had been the case after twenty minutes of treatment, ambulance officers made the decision to cease treatment at 12.26pm.

47. Back at Scott's apartment, police officers found a note Scott had written for his son Mitchell. It had been placed on top of a jewelry box, and read: '*Mitch I love you, this is all I have in the world'.* Inside the box was a diamond ring and a gold link chain.

The post mortem report

48. A post mortem examination was conducted by forensic pathologist Dr Allan Cala. Dr Cala found the cause of death to be an incised wound to the left arm. He noted the wound was deep and had incised the median cubital vein. This can result in marked blood loss. Alcohol and other drugs were not detected in Mr Cayirylys' blood.

Evidence of Associate Professor Holdgate

49. The principal issue examined at the inquest was the adequacy of the emergency medical response to Scott's situation. The court was assisted with evidence from Associate Professor Anna Holdgate, Senior Staff Specialist in the Emergency Departments of Liverpool and Sutherland Hospitals. She provided two reports and gave evidence at the inquest.

50. Having reviewed the medical records and photographs, Dr Holdgate described Scott's injury as a deep wound to his anterior elbow. She explained the physiological changes that occur when blood drains from such a wound. A healthy adult will usually tolerate 15% loss of blood with little consequence. With blood loss up to 30% the patient typically becomes anxious, with elevated breathing and a raised pulse rate. As blood loss increases the patient's blood pressure decreases and he or she starts to lose consciousness. Peripheral pulses cannot be felt. With loss beyond 50% there is inadequate oxygen delivery to the brain and other vital organs, and the heart stops beating.

51. In Dr Holdgate's opinion, in the early stages Scott's blood loss could have been easily managed with simple first aid measures. Application of local pressure and elevation of his arm would have rapidly stopped the bleeding. Without these measures, as bleeding progressed he would require treatment to restore circulating blood volume. This would involve infusing liquids via an intravenous cannula until he could be got to hospital to receive a transfusion of blood products. Delay in taking these steps at the scene significantly increased his risk as haemorrhagic shock became irreversible.

52. In her first report Dr Holdgate had been critical of police for not immediately applying pressure to Scott's arm to slow the bleeding. She retracted this criticism after hearing evidence that by the time of their arrival there was no active bleeding from the wound.

53. Dr Holdgate was asked to provide her opinion as to the likelihood of Scott surviving if an ambulance had reached him at an earlier stage. She noted that Scott had most likely sustained his wound at or shortly before 10.50am. Based on his body weight she estimated it would take between 70 and 140 minutes for his entire blood volume to drain through his arm wound. In her opinion, when the police officers arrived just before 11.30am Scott's blood loss was approximately 40%, based on their evidence that he was conscious, confused, breathing rapidly and still had a palpable pulse in his neck. Appropriate medical treatment at this stage would have meant he would '*more than likely have survived'*. By this she meant the administration of intravenous fluids to bolster circulation of his remaining blood, until he could receive a transfusion of blood products at hospital. It is accepted that police officers are not equipped or qualified to administer IV fluids. This would have been the task of ambulance paramedics.

54. When the ambulance crew arrived at 11.59am Scott had, in Dr Holdgate's opinion, only a small chance of survival. This chance became even smaller once he went into cardiac arrest which, as noted, probably occurred on their arrival or almost immediately afterwards. In addition to IV fluids he now needed adrenaline to try to restart his heart.

55. The ambulance paramedics took these measures, administering boluses of IV fluid and three doses of adrenaline. Scott did not respond to the treatment. At 12.19pm the paramedics ceased administering IV fluids and adrenaline, and stopped CPR at 12.26pm. They did so in reliance on NSWA *Cardiac Arrest Protocol C3*, which advises that the resuscitation effort may cease if the patient's heart remains in asystole after resuscitation has been in progress for 20 minutes or longer.

56. Dr Holdgate expressed the view that it would have preferable for the paramedics to have persisted with fluid therapy and adrenaline for a longer period, at least up until the point where they ceased CPR. She acknowledged however that by this time Scott's prospects of survival were extremely low, and she was not critical of the individual paramedics. In her view this was a minor deficiency in the care provided by ambulance officers who were working in very difficult circumstances. Furthermore:
'… the delay in Scott receiving attention when he first asked for help was by far the major contributor to his preventable death'.

57. Dr Holdgate's overall conclusion was that with timely medical treatment Scott's injury was '*eminently treatable'*. In her opinion, notwithstanding that by 11.30am he had lost a lot of blood he would '*more than likely have survived'* with medical treatment at that time.

58. I accept Dr Holdgate's evidence on this point. I find further that had NSWA followed its own procedures an ambulance crew would almost certainly have been on scene by the time the police arrived, and would have been ready to give the necessary emergency treatment. The conclusion I reach is that Scott's death was preventable.

The response of NSWA following Scott's death

59. Each day of the inquest was attended by senior managers of NSWA including Assistant Commissioner Anthony Gately, the Director of NSWA's Control Centres since July 2017. At the close of evidence Mr Chiu, Counsel for NSWA, expressed to Scott's family an apology on behalf of NSWA for the errors that had led to his tragic death.

60. Mr Gately gave evidence at the inquest. He told the court that following Scott's death NSWA had undertaken an internal review of what went wrong that day. Mr Gately confirmed that the actions of NSWA staff in downgrading the incident's response code and in deferring the dispatch of an ambulance were contrary to NSWA's policies, then and now. Ms Cockburn, Ms Campbell and Ms Lawther had received counselling and now fully understood this to be the case. I have mentioned that in court all three officers and in particular Ms Cockburn and Ms Campbell expressed their deep regret for the mistakes they had made and the tragic consequences.

61. Following the internal review Mr Gately issued an operational alert to NSWA staff reinforcing the obligation to comply with *Dispatch Procedure 9.01*.

62. Mr Gately had also reviewed a specialist report which those assisting the inquest had obtained from Ms Nichole Bastian, Operations Manager at South Australia Ambulance. Ms Bastian gave evidence at the inquest. In her report and evidence Ms Bastian noted that the downgrade of this incident had been in breach of NSWA dispatching policies. She described changes recently made at SA Ambulance, whereby the response code for an incident cannot be downgraded except by the State Duty Manager or an Emergency Operations Centre clinician.

63. Mr Gately told the court he was exploring the feasibility of introducing such a reform in NSW. One method would be to alter NSWA's computerised system such that a manual downgrade of an incident's response code could not occur, as had happened in this case. Instead, it could only be downgraded once another ProQA session regarding the patient's clinical condition had been undertaken. This would help ensure that an incident was not downgraded without consideration of the patient's condition.

64. Mr Gately was asked whether there was a 'culture' among NSWA dispatchers of downgrading the response code for potentially violent incidents, as Ms Cockburn had done. Mr Gately had undertaken a review of NSWA incidents in 2017 and 2018. The resulting statistics indicated that although there had been downgrades in those two years, they were relatively few in number. The court was advised that NSWA intends to continue monitoring this situation with ongoing audits.

65. Mr Gately was also asked about a further area of NSWA protocol. This concerned the system used by NSWA to indicate to police the priority needed for their response. For some years a Joint Protocol between NSW Police Force and NSWA has been in force, providing three priority categories of

‘Urgent’, Intermediate’ and ‘Non-Urgent’. The court heard however that only the first and third of these priorities were made available to the NSWA dispatcher when requesting police assistance. Further, the Joint Protocol pre-dated the introduction of the ICEMS system, whereby responding police have access to additional information which can guide the priority of their response. Mr Gately agreed there could be value in considering whether the joint protocols needed revising, in particular those concerning communication of prioritisation.

Question of recommendations

66. I have found that Scott’s death was preventable, a finding that may well add to the distress of his loved ones even if they have long suspected this to be the case.

67. It was also evident that the much delayed response to Scott’s call for help was the result of errors on the part of NSWA staff. It is fair to say that NSWA has taken this tragic event seriously, and has sought ways to address those factors which contributed to the errors. The steps they have taken have been described above.

68. I have mentioned two areas where in my view there is scope for NSWA to consider further improvements. These are first, the possibility of alterations to NSWA’s computerised system to prevent manual downgrades of response codes, and secondly a review of its joint protocols concerning communication of response priorities. In submissions on behalf of NSWA, Counsel for NSWA responded that NSWA was willing to consider these proposals. They are the subject of recommendations 1 and 2 below.

69. In light of the evidence of Dr Holdgate, Counsel Assisting proposed a third recommendation. This is that NSWA undertake a clinical review of its policies and procedures to consider whether in cases of hypovolaemia, fluids and adrenaline should be continued for the entire period of resuscitation. In my view there would be value in such a review. I emphasise that the intention is not to lay open for criticism the paramedics’ efforts to save Scott’s life. At all times they complied with NSWA’s treatment protocols. The proposal is made in the interests of ensuring NSWA’s protocols in such cases accord with best clinical practice. I have made it the subject of the third recommendation.

70. I accept the submission made on behalf of NSWA in relation to a further proposal, that there is no need to expand upon the existing text of NSWA’s *Dispatch Procedure 9.01*.

Conclusion

71. I do not make any finding that Scott died as a direct result of an intention to end his own life. It is true that the evidence indicates he cut his arm that morning with the intention of harming himself. That he was experiencing thoughts of self harm and suicide is further supported by the poignant note he left for Mitchell. It seems however that he quickly realised he wanted to live, judging by his urgent call for help to Nicole. It is very sad to think that his life could have been saved and that he may have had many years ahead of him to see his son grow up.

72. On behalf of us all at the Coroner's Court, I offer Scott's family and friends my sincere sympathy for their loss of a father and friend.

73. I am very grateful for the excellent assistance provided in this inquest by Counsel Assisting and the Office of General Counsel, as well as that of those representing NSW Ambulance and police.

Findings required by section 81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I make the following findings.

Identity
The person who died is Scott Cayirylys.

Date of death:
Scott Cayirylys died on 11 September 2016.

Place of death:
Scott Cayirylys died in an ambulance while en route to Coffs Harbour Hospital.

Cause of death:
The cause of Scott Cayirylys' death was cardiac arrest due to profound blood loss causing hypovalaemia.

Manner of death:
Scott Cayirylys died while waiting for an ambulance, after he had inflicted an incised wound to his left arm.

Recommendations pursuant to section 82

To the Commissioner, New South Wales Ambulance:

1. That NSWA consider investigating whether it is feasible and advisable to exclude manual downgrades of the response codes for emergency incidents received through ‘000’ or otherwise.

2. That NSWA consider meeting with NSW Police Force and NSW Fire and Rescue to examine the need to revise and update joint ICEMS protocols, particularly those concerning communication of prioritisation.

3. That NSWA consider undertaking a clinical review to determine whether there is a need to amend its treatment protocols, training and instructions so that paramedics continue the provision of fluid and adrenaline for the entire period of resuscitation in cases of hypovolaemia.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner
Lidcombe

Date
3 March 2020