Lights and Sirens: How Coronial Inquests Can Highlight Challenges in Paramedic Regulation

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Paramedics provide emergency and community health services to diagnose, treat, transport and provide advice to patients. However, current regulatory structures do not adequately protect the public from the potential for paramedics to cause harm to their patients. Paramedic employers regulate the paramedic industry rather than the National Registration and Accreditation Scheme used for other equivalent registered health practitioners in Australia. A number of coronial inquests have considered the conduct of paramedics and highlighted the challenges of the current paramedic regulation in protecting the public from risk.

INTRODUCTION

From the day of its invention the ambulance has attracted a magnetic curiosity from humans around the world. This vehicle racing to the scene of accidents and illness demands attention. When you hear one coming, you turn. When you watch it pass you wonder, if only for a moment, where it might be going, who is inside and what horrific mishap the patient has suffered. After fifteen years spent in the back of ambulances I’ve come to realise that medics and paramedics are endlessly fascinating to the public.1

Paramedics, in their provision of emergency medical diagnosis, treatment and transport, have a significant public profile. The public has a very high level of trust in paramedics; they were voted the most trusted profession in 2014 and every year between 2004 and 2012.2 As such, there has been a recent push for harsher punishments for assaults on paramedics, with many Australian jurisdictions introducing tougher criminal sentences for such assaults.3 There has also been community outrage when offenders have been released with inadequate punishment.4 The community, therefore, has an interest in the outcome of regulatory discussions concerning paramedic governance as it somewhat takes ownership of the discipline already.

In the Parliamentary Select Committee of Inquiry Report into Ambulance Services in 1991, Jim Elder stated:

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3 Criminal Code 1899 (Qld) s 340; Crimes (Sentencing Procedure) Act 1999 (NSW) s 21A(2)(a); Crimes Act 1958 (Vic) s 31(1)(b); Criminal Code (NT) s 155A; Criminal Code Act 1913 (WA) s 318(1)(b)(i).

the ambulance service exists to serve the needs of all the people of Queensland. In life and death situations, one has the right to expect the benefit of an efficient service with up-to-date, high tech equipment and the assistance of uniformly skilled officers.\(^5\) This position is no less relevant now.

The paramedicine industry is largely unregulated, with employers taking primary responsibility for paramedic governance. Despite some statutory intervention into paramedic regulation occurring on an individual State and Territory level, the sufficiency of current paramedic regulation, and its ability to protect the public, is called into question. The evolving nature of emergency pre-hospital care suggests current regulation is failing to keep up with the discipline’s progression – causing wide-ranging issues for the public, as well as the paramedics themselves. The proportion of paramedics employed in a private capacity also demonstrates how the limited statutory regulation and employer governance does not cover all paramedics working in the industry. The lack of national uniformity causes a variety of challenges with the potential to adversely affect patient care. This study uses coronial inquests as a source to provide examples of risks to the health and safety of the public if paramedics do not perform to appropriate professional standards. The regulation of paramedics in the same manner as other registered Australian health practitioners is proposed as a suitable alternative to address the challenges in current paramedic regulation.

**THE ROLE OF AUSTRALIAN PARAMEDICS**

According to a South Australian legislative definition, a paramedic is a “health practitioner who provides pre-hospital emergency care services or community-based alternative models of care as a result of a request for emergency medical assistance”.\(^6\) The difficulty with prescribing a definition for “paramedic” is the challenge in describing the content of a rapidly changing discipline. For this reason, there is no widely accepted definition of paramedic practice. However, the United Kingdom’s House of Lords encompassed the important role of paramedics in their parliamentary debates:

Paramedics: they provide immediate care to the public and patients with acute clinical emergencies. They assess, treat and monitor patients in a systematic way according to … clinical protocols adapted to the requirements of local communities. The treatments provided include invasive procedures such as intravenous cannulation, intubation and the insertion of chest drains and the administration of a specified range of emergency medications, including analgesics. Paramedics typically will be the first health professionals on hand in an emergency.\(^7\)

Essentially, paramedics are urgent response and community support practitioners with advanced skills, knowledge, training and education in emergency health care.

**REGULATION AND PARAMEDIC REGULATORY ISSUES**

Regulation is a measure seeking to influence the behaviour of individuals and groups.\(^8\) Influencing behaviour, using specific standards, can produce “mechanisms of standard setting, information gathering and behaviour modification”.\(^9\) Different models of regulation exist, which Freiberg likens to “tools” in a “tool-kit”.\(^10\) Professional regulation can involve a self-regulatory model, state-imposed regulation, or a hybrid approach on the spectrum between the two concepts. Self-regulation, a form of private regulation, involves the discipline itself governing conduct and procedures of members. Comparatively, state regulation, considered to be public regulation, imposes legislative requirements

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\(^6\) Health Practitioner Regulation National Law (South Australia) Act 2010 (SA) s 120A(2).

\(^7\) United Kingdom, Parliamentary Debates, House of Lords, 10 June 1999, vol 601, col 1652 (Baroness Hayman).


\(^10\) Freiberg, n 8; A Freiberg, “Re-stocking the Regulatory Tool-Kit” in D Levi-Faur and A Benish (eds), Jerusalem Papers in Regulation and Governance (Hebrew University, 2010).
upon professional bodies and members of the profession, Black suggests self-regulation is often too limiting, while state-imposed regulation is inadequate.\(^\text{11}\) This can lead to the imposition of a regulatory framework which incorporates elements of both public and private regulation.

Regulation of health professionals promotes integrity and values, which ensures behaviour promoting “trust and confidence in the standing of the profession”. It also reduces risk, which leads to greater public protection.\(^\text{12}\) Because of the significant degree of trust required between a health professional and a patient, inappropriate behaviour contravening the patient’s best interests can cause significant adverse consequences.\(^\text{13}\)

Health professionals in Australia are regulated under a single national system of regulation requiring national boards to monitor registration of applicants seeking entry to the professions.\(^\text{14}\) In this way, it is co-regulatory because the health professions are involved in the governance of their own discipline with the state providing overarching regulatory requirements. There are 14 health professions included under the National Registration and Accreditation Scheme.\(^\text{15}\) A number of processes were used to determine which health professions qualified for inclusion under the National Scheme. When determining whether to introduce regulation of additional health professions under the *Health Practitioner Regulation National Law*, it was decided to only implement regulation if the majority of the jurisdictions supported the change. Additionally, evidence would be needed to determine whether the occupation’s practice presented a serious risk to public health and safety which could be minimised by implementation of additional regulation in the form of inclusion in the National Scheme.\(^\text{16}\) Paramedics were not, and have not since been, included as a profession governed through the national health registration framework, despite the potential for patient harm.

Instead, ambulance services are regulated through State and Territory legislation,\(^\text{17}\) with the exception of the Northern Territory and Western Australia – the Northern Territory and Western Australian governments do not have a public ambulance service and instead contract their emergency services to St John Ambulance, an incorporated not-for-profit organisation.\(^\text{18}\) Paramedics themselves are regulated entirely through their employment relationship, although some State and Territory legislation contains provisions relating to paramedics themselves. Statutory regulation of the paramedic industry involves provisions relating to protection of title, drug regulation, legislative codes of conduct and complaints management. Statutes relating to paramedicine apply on a State and Territory basis and are entirely jurisdictional. While a majority of paramedics are employed through the public ambulance services, there is an increasing number of paramedics entering private practice where the statutory regulation often does not apply. There is significant disparity in regulation between jurisdictions, particularly in relation to the minimum training and education for paramedics.

There are two important developments which call into question the traditional model of Australian paramedic regulation. First, Australian paramedics have developed from “stretcher-bearers”, “ambulance drivers” and “ambulance officers” to highly skilled and tertiary-trained emergency providers of pre-hospital health care. Second, the emergence of privately employed paramedics working for organisations external to the public service also challenges the traditional model of state-based regulation through the employment relationship.

\(^{11}\) Black, n 9, 34.

\(^{12}\) I Freckelton, “Regulating Health Practitioner Professionalism” (2005) 23(1) *Law in Context* 1, 2.

\(^{13}\) I Freckelton, “Regulating the Unregistered” (2008) 16 JLM 413, 414.

\(^{14}\) *Health Practitioner Regulation National Law Act 2009* (Qld) Sch 1.

\(^{15}\) Medical practitioners, chiropractors, dental practitioners (dentists, dental hygienists, dental prosthetists and dental therapists), nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists, psychologists, Aboriginal and Torres Strait Islander health workers, Chinese medical practitioners, medical radiation practitioners, and occupational therapists.

\(^{16}\) Council of Australian Governments, *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions* (26 March 2008) Attachment B, r 1.3.

\(^{17}\) *Ambulance Service Act 1991* (Qld); *Health Services Act 1997* (NSW); *Ambulance Services Act 1986* (Vic); *Emergencies Act 2004* (ACT); *Ambulance Service Act 1982* (Tas); *Health Care Act 2008* (SA).

Despite the significant progression of their discipline, regulatory measures governing paramedic practice have not evolved at the same rate as the discipline itself. Paramedicine has progressed from stretcher bearers like Private John Simpson (Kirkpatrick) of the Third Australian Field Ambulance, using his donkey to transport injured soldiers from the battlefield to the field hospital,\textsuperscript{19} to health practitioners requiring tertiary qualifications and criminal history checks for practice.\textsuperscript{20} As such, consideration of the current regulatory structures of paramedicine is warranted to determine whether regulation is adequate to protect the public.

**CORONIAL CONSIDERATION OF PARAMEDICINE AND THE CHALLENGES**

The coronial inquests considered below have each raised issues directly relevant to paramedic practice that question the current model of Australian paramedic regulation and its ability to protect the public.

**Coronial Inquest into the Death of Ruby Yan Chen (Qld, 2014)**

The Rockhampton Coroner’s Court considered the cause of death of a four-year-old girl, Ruby Chen, following treatment by flight paramedics.\textsuperscript{21} In August 2012, the girl was transferred by helicopter between Blackwater Hospital and Rockhampton Base Hospital for further care in a routine aero-medical transfer. The aero-medical team, made up of Queensland Ambulance Service intensive-care paramedics,\textsuperscript{22} collected the girl from Blackwater Hospital and requested a nurse remove her intravenous (IV) saline bag, which was hydrating the girl at the time. One of the paramedics then “primed” the same IV bag and “re-spiked” it ready for reuse on the patient. This process allowed paramedics to reuse the IV bag on the patient.\textsuperscript{23}

During the flight, the girl’s condition deteriorated leading to seizure and cardiac arrest. The flight paramedic commenced cardiopulmonary resuscitation but the girl was unable to be resuscitated. She was declared deceased upon arrival at the Rockhampton Hospital. An autopsy found an air embolism in her heart and jugular vein, which the Coroner commented was very unusual.

Coroner O’Connell held the air embolism came from the reuse of the partially depleted IV bag, which could have been prevented by utilising a new saline bag, readily available in the paramedics’ supplies. During the inquest, paramedics gave evidence that reason for the reuse of the IV bag was so they could “remain in a full state of preparedness”; however, the Coroner held this was inappropriate and IV bags should be single use only. The Coroner preferred the registered nurse’s evidence over the critical care paramedic as it was deemed more reliable due to inaccuracies in the paramedic’s statements. The Coroner concluded the girl’s death was attributable wholly to the re-spiking of the IV bag.\textsuperscript{24} The Coroner did not comment on whether the paramedics’ actions constituted misconduct or were unprofessional, only that they were inappropriate. It is unknown whether the paramedics were subject to any disciplinary sanction including cautioning or retraining, or whether they were even considered for disciplinary action at all.

Freckelton and Flynn identify the importance of transparency in health practitioner disciplinary processes, and suggest the accessibility of data relating to the national boards’ decisions enhances the “transparency and accountability” of health complaints processes — the availability of data is a “constructive” outcome.\textsuperscript{25} When there are concerns about a paramedic’s conduct, and the level of risk posed to a patient, there are no measures in place for the public to determine the effectiveness of


\textsuperscript{21} *Inquest into the Death of Ruby Yan Chen* (Coroner’s Court of Rockhampton, Coroner O’Connell, 12 December 2014).

\textsuperscript{22} Now called critical care paramedics.

\textsuperscript{23} *Inquest into the Death of Ruby Yan Chen* (Coroner’s Court of Rockhampton, Coroner O’Connell, 12 December 2014) 13.

\textsuperscript{24} *Inquest into the Death of Ruby Yan Chen* (Coroner’s Court of Rockhampton, Coroner O’Connell, 12 December 2014) 16.

current regulation as the disciplinary and accountability processes lack transparency. Individual employers are responsible for imposing disciplinary action, which means there is disparity between employers as well as between jurisdictions.

**Coronial Inquest into the Death of Thomas Olive (Qld, 2014)**

The Maroochydore Coroner’s Court considered the 2010 death of a four-year-old boy, Thomas Olive, from severe rhabdomyolysis, which is a breakdown in the skeletal muscle.26 The boy was taken to Nambour Hospital on 30 June 2010 as his parents noticed sensitivity to light and lower back pain in their son. He was not admitted. On 25 August 2010, the boy’s parents called the Queensland Ambulance Service after they observed pain, lethargy, a rash and irregular heartbeat in their son. The advanced care paramedic (ACP), accompanied by a student paramedic, met an intensive-care paramedic (ICP)27 on the way to Nambour Hospital who performed an electrocardiogram.

The medical reports, the electronic Ambulance Report Forms (eARFs), completed by Queensland Ambulance Service paramedics suggest miscommunication or misunderstanding of the boy’s condition. The ACP’s eARF documented improvement in the boy’s condition on arrival at the hospital; however, the ICP’s eARF recorded him as being acutely unwell.28 Upon arrival at the hospital, the boy was moved to a resuscitation bay upon request of the ICP. He went into cardiac arrest and could not be resuscitated. His parents lodged a health complaint with the Health Quality Complaints Commission about the way paramedics and the hospital handled their son’s matter.

There were some issues with the boy’s treatment. Neither eARFs were provided to the hospital prior to his cardiac arrest; however, it was declared that this did not negatively affect his treatment outcome. In addition to the consideration of the hospital’s response to the boy, Deputy State Coroner Lock determined the Queensland Ambulance Service’s eARF system required review but that the paramedics’ responses to the standard triaging and handover processes at the hospital were adequate.

Despite coronial clearance of wrongdoing, the facts from these findings highlight problems with the medical reporting and treatment of the boy. The paramedics miscommunicated or misunderstood the patient’s condition, suggesting significant disparity in skills and knowledge or lack of adequate communication skills. A failure to keep medical records has been considered unsatisfactory professional conduct or professional misconduct in the past with other registered health practitioners. It is unknown whether there was an investigation into the suitability of the paramedics’ medical reporting.29

**Coronial Inquest into the Death of Gemma Thoms (WA, 2013)**

A Western Australian Coroner’s Court held an inquest into a death occurring at the Western Australian Big Day Out music festival in 2009.30 Seventeen-year-old Gemma Thoms attended the Big Day Out with a friend after her parents gave her tickets. Ms Thoms had purchased five tablets of ecstasy to share with the friend accompanying her to the festival. On the morning of the festival, Ms Thoms consumed one ecstasy tablet and then consumed a further two ecstasy tablets upon entry into the festival. Coroner Mulligan noted that consumption of three ecstasy tablets was a fatal quantity and survival required prompt hospital treatment including advanced life support.31

After her drug consumption, a security guard noticed Ms Thoms appeared to be ill and arranged for her to be taken to the first aid tent where a St John Ambulance Service volunteer first-aider attended to her. He was not a paramedic. Ms Thoms did not admit to taking ecstasy to the first-aider.

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26 Inquest into the Death of Thomas Andrew Olive (Coroner’s Court of Maroochydore, Coroner Lock, 5 August 2014).
27 Now called a critical care paramedic.
28 Inquest into the Death of Thomas Andrew Olive (Coroner’s Court of Maroochydore, Coroner Lock, 5 August 2014) 10.
30 Inquest into the Death of Gemma Geraldine Thoms (Coroner’s Court of Western Australia, Coroner Mulligan, 8 March 2013).
31 Inquest into the Death of Gemma Geraldine Thoms (Coroner’s Court of Western Australia, Coroner Mulligan, 8 March 2013) 11-12.
treated her but dishonestly acknowledged the consumption of a single “Dexie”, a prescription drug. After being examined, the first-aider determined her to be fit to return to the festival and advised her to stay hydrated. Ms Thoms was released back into the festival and a short time later she collapsed and festival patrons assisted her. An ambulance was called and paramedics transported Ms Thoms to hospital where she died of acute Methyleneoxydimethylamphetamine (MDMA) toxicity.

When discussing treatment the deceased received at the first-aid station, the Coroner stated:

without intending to diminish [the] … volunteer[, it is obvious that his degree of training and expertise was far removed from that of medical professionals, such as doctors, nurses and paramedics who have studied and trained for years before obtaining their qualifications.33

The first-aider did not take the deceased’s temperature despite training documentation indicating a need to record a patient’s temperature. A full set of observations were only recorded once despite training documentation suggesting twice is required. Further, medical practitioner evidence at the inquest also identified that a person with “greater medical expertise and experience” would have considered the deceased’s abnormal pulse, respiratory rate and consumption of a “Dexie” as indicative of a requirement for urgent treatment and transport to hospital.34 The Coroner found early intervention for an ecstasy overdose can increase the chance of a patient’s survival, although it may not have prevented the deceased’s death in these circumstances.

Following the inquest, the Coroner made a number of recommendations significant to the issues under consideration. Coroner Mulligan recommended large-scale events, such as the Big Day Out, should have a medical centre or paramedics stationed within the festival. It was also recommended that a definition of “paramedic” under Western Australian law be created so the “general public can have confidence in the abilities of those who are protecting their medical interests at large scale events”. Finally, it was recommended that a form of registration be implemented to ensure only qualified practitioners can use the title of paramedic.35

Protection of title, also called reservation of title, refers to the regulatory mechanism restricting the use of various professional titles to people who are qualified to use them.36 Title protection makes it unlawful for unqualified people to use a protected title and, as such, protection of title for professions is an important way to maintain minimum standards within a profession.37 Title protection is a means of ensuring community confidence in health practitioners as it promotes a minimum standard of skill and expertise which can be monitored.38

Tasmania, South Australia and New South Wales all provide statutory protection of title provisions for paramedics. Tasmania prescribes potential imprisonment or fines for people who impersonate or present themselves as a paramedic without the required and minimum qualifications.39 Tasmanian legislation now defines a paramedic as “an officer of the Ambulance Service [or ambulance service in another jurisdiction] who holds a prescribed paramedic qualification or a qualification and experience … to a satisfactory level of understanding and competence”.40 This is a relatively new

32 Inquest into the Death of Gemma Geraldine Thoms (Coroner’s Court of Western Australia, Coroner Mulligan, 8 March 2013) 17.
33 Inquest into the Death of Gemma Geraldine Thoms (Coroner’s Court of Western Australia, Coroner Mulligan, 8 March 2013) 16.
34 Inquest into the Death of Gemma Geraldine Thoms (Coroner’s Court of Western Australia, Coroner Mulligan, 8 March 2013) 20-22.
35 Inquest into the Death of Gemma Geraldine Thoms (Coroner’s Court of Western Australia, Coroner Mulligan, 8 March 2013) 42-43.
39 Ambulance Service Act 1982 (Tas) ss 39A, 39B(5).
40 Ambulance Service Act 1982 (Tas) s 3AB, as amended by the Ambulance Service Amendment Act 2013 (Tas).
protection implemented by the Tasmanian Parliament for protection of community and patient safety. Regulation 3 of the Ambulance Service (Paramedic) Regulations 2014 (Tas) prescribes the paramedic qualification to be a Bachelor of Paramedic Science. However, the definition of paramedic also suggests a paramedic can be a person who meets any requirements, conditions or approvals prescribed relating to that class of persons. The Regulations, though, do not provide further clarification pertaining to the meaning of a prescribed person under s 3AB(c) of the Ambulance Service Act 1982 (Tas). It is possible this will allow the title to be expanded to paramedics outside the State Ambulance Service, such as employees of private organisations, the defence force, international visitors and/or similar parties.

Members of the Tasmanian Parliament formally recognised how emergency management and provision of ambulance services has evolved over the last 30 years. Specifically, there has been an increase in the provision of private ambulance services, which has resulted in paramedics being employed outside of public ambulance services more frequently than in the past. The absence of protection of title provisions has the potential to cause problems for community members who are unable to distinguish between suitably qualified paramedics and those with first-aid skills only. It is believed legislative protection of title for paramedics in Tasmania will reduce the confusion surrounding who can legitimately call themselves a paramedic by enforcing sanctions for contraventions to the legislative provisions.

Similarly to Tasmania, protection of title is a regulatory tool being used for South Australian ambulance regulation. South Australia definitively protects the title of “paramedic” from unauthorised use, making it unlawful for a person to knowingly or recklessly take or use the title “paramedic” or allow someone to falsely believe the person to be a paramedic, unless the person holds the appropriate qualifications expressed by Parliament; the maximum prescribed penalty is $30,000. A paramedic in South Australia is a “health practitioner who provides pre-hospital emergency care services or community-based alternative models of care as a result of a request for emergency medical assistance”. The Hon IK Hunter, a South Australian Minister of Parliament, suggested protection of the paramedic title should minimise risk to the public as paramedics are often involved in highly invasive care which has the potential to cause significant harm to members of the public.

Finally, New South Wales is the most recent jurisdiction to formally acknowledge the need for paramedic protection of title through a legislative amendment. Section 67ZDA(1) of the Health Services Act 1997 (NSW) states that “[a] person who is not a paramedic must not, in any way, hold himself or herself out to be a paramedic”, with a maximum penalty of $11,000. Paramedic is then further defined as a person who is: qualified, trained or has the expertise prescribed by regulations; authorised as a paramedic under another Australian jurisdiction; or an Ambulance New South Wales staff member, or other person, who has been authorised to hold the title of paramedic from the Health Secretary. Qualifications include: a Bachelor of Paramedicine; a university conferred Graduate Diploma of Paramedicine; or a Diploma of Paramedicine issued by a nationally recognised registered training organisation.

When proposing the amendment, Mrs Jillian Skinner, the Minister for Health, stated:

There is one gap in the regulation of paramedics. Currently any person can call themselves a paramedic in New South Wales regardless of their level of qualifications and training … By protecting the use of

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42 Tasmania, Parliamentary Debates, Legislative Council, 26 September 2013.
43 Health Practitioner Regulation National Law (South Australia) Act 2010 (SA) s 120A(1).
44 Health Practitioner Regulation National Law (South Australia) Act 2010 (SA) s 120A(2), as amended by the Health Practitioner Regulation National Law (South Australia) (Protection of Title – Paramedics) Amendment Act 2013 (SA).
45 South Australia, Parliamentary Debates, Legislative Council, 31 October 2013, 5537-5538 (IK Hunter).
46 Crimes (Sentencing Procedure) Act 1999 (NSW) s 17.
47 Health Services Act 1997 (NSW) s 67ZDA(2).
48 Health Services Regulation 2013 (NSW) s 19A. This provision commenced on 1 February 2016.
the title “paramedic”, members of the public can be sure that those who call themselves a paramedic have the necessary qualifications, training or experience.\textsuperscript{49}

No other Australian jurisdiction imposes sanctions for unlawful use of the paramedic title. Without protection of the paramedic title, there is potential risk to public safety as patients could be treated by people lacking minimum standards of appropriate training and qualifications. Theoretically, a person without qualifications or experience could represent themselves as a paramedic without any fear of reprisals; there would be no guarantee for the employer or patient that the person is suitably qualified. Requiring the paramedic title to be held by a class of people with specific education and training arguably ensures that the public can have confidence in the skills of the paramedic treating them.\textsuperscript{50} Because the State Ambulance Services are the primary providers, and employers, of ambulance services in most jurisdictions they can use employment powers to require appropriate standards of their employees. Although, as the public ambulance services’ monopoly over paramedic employment in the community diminishes, so too do the protections provided to the public under the employment conditions. With more paramedic employers, it becomes more difficult to regulate title protection without statutory governance. There is evidence that more paramedics are being employed in the public sector than ever before, which suggests protection of title provisions are required in all States and Territories of Australia.\textsuperscript{51} A national scheme of paramedic regulation could ensure uniformity of this regulatory tool.

\textbf{Coronial Inquest into the Death of Margaret Vipond (Vic, 2013)}

An 80-year-old patient, Margaret Vipond, died from a heart attack on 25 December 2010 after emergency medical assistance was sought from Ambulance Victoria.\textsuperscript{52} This case was considered in Victoria’s Coroner’s Court; however, the findings were not made publically available. As such, information could only be sought from online newspaper reports, which has limitations.\textsuperscript{53}

It is alleged the paramedic involved treated Ms Vipond with saline, instead of Fentanyl, as the painkiller had already been siphoned off for the paramedic’s personal use before the patient’s treatment. It is not known the extent of the paramedic’s liability in Ms Vipond’s death as this information was not published. It is also not known whether the incident affected the paramedic’s ongoing employment nor whether there were any conditions imposed on the paramedic’s continuing practise. The paramedic involved avoided a criminal conviction and was drug diverted instead. The significant adverse outcome of the paramedic’s actions, being the death of a patient following paramedic care, shows the paramedic’s conduct significantly fell short of the standard reasonably expected of an equivalent health practitioner.

Under the National Registration and Accreditation Scheme, an equivalent case could render a practitioner guilty of professional misconduct. For example, in one case, a registered nurse was found to have stolen pethidine, and then damaged the Drugs Register and forged a staff member’s signature to hide the theft. The nurse was removed from the Register of Nursing and Register of Midwifery and was prohibited from reapplying for registration for at least 18 months.\textsuperscript{54} This disciplinary measure seems to be the average time given for roll removal for drug theft, with other registered nurses in

\textsuperscript{49} New South Wales, \textit{Parliamentary Debates}, Legislative Assembly, 3 June 2015, 1393 (Jillian Skinner).

\textsuperscript{50} Elkin, n 37, 688.

\textsuperscript{51} Australian Health Ministers’ Advisory Council, \textit{Consultation Paper: Options for Regulation of Paramedics} (Health Workforce Principal Committee, July 2012) 11.


\textsuperscript{53} The author acknowledges the limitations relying upon media publications as a source of data. First, details of the case cannot be substantiated from any other source so the accuracy of the data can be questionable. Further, reporting of the details is often quite brief and does not always provide enough information to establish the potential risk to the public. Finally, the media authors are often unavailable or unable to provide further information to assist in clarification. Despite these issues, media reports can still provide an indication of potential risk to the public that current regulation fails to prevent.

\textsuperscript{54} Health Care Complaints Commission v Pierce [2010] NSWNMT 23.
similar cases being removed from the register for a period of one\textsuperscript{55} to three years\textsuperscript{56}. In these cases, the findings of the respective tribunals were made public, demonstrating transparency, and the disciplinary sanctions were comparable to each other, showing fairness to the health practitioners. This situation does not exist for paramedics.

**Coronial Inquest into the Death of Monica and Trent Speering (NSW, 2010)**

Coronial inquest findings from a case before the New South Wales Coroner’s Court in 2010 highlight a breakdown in employer policies and procedures, which, in the absence of mandatory notification requirements, led to the deaths of two people\textsuperscript{57}. In 1996, Mr Trent Speering commenced employment as a paramedic with the Ambulance Service of New South Wales. His colleagues filed complaints about him due to his poor temper and alleged bullying; Mr Speering’s response was to counterclaim that the complainants were in fact bullying him. Mr Speering also claimed he was suffering “stress anxiety” and lodged worker’s compensation claims, which were found not to be work related. As a result of aggressive and offensive behaviour to colleagues, Mr Speering was stood down on full pay pending an investigation and was eventually given a “show cause” letter to address potential dismissal. The Ambulance Service requested the Police Service suspend Mr Speering’s gun licence but there was “insufficient evidence to justify licence suspension”\textsuperscript{58}.

On the day Mr Speering received notification that he was due to meet with supervisors to learn the outcome of his “show cause” matter, he posted numerous letters to colleagues and the media disclosing an intention to kill himself and his mother, Ms Monica Speering. Upon receipt of the letter, a newspaper employee contacted police. Police attended Mr Speering’s home and, finding the home unoccupied, attended Ms Speering’s house. They found Mr and Ms Speering dead, both with a gunshot wound to the head. A suicide note and the gun were also found with Mr Speering. Mr Speering was held to have been responsible for both deaths.

A number of matters arose during the inquest. Mr Speering was psychiatrically assessed during his request for worker’s compensation and had been diagnosed with a severe paranoid personality disorder and depression, neither of which were likely reported to his employer. Colleagues had also filed concerns with their employer relating to Mr Speering’s fitness to practise but no action was taken to address those concerns. Coroner Jerram also indicated Mr Speering would have accepted treatment had it been made a condition of his ongoing employment.

While the Coroner did not suggest the Ambulance Service directly caused the deaths, she did suggest their policies and procedures for dealing with health and disciplinary matters were inadequate. When disciplinary matters overlap with misconduct and criminal matters, the employer needs to be able to sensitively address those issues. When there are concerns for the mental health of paramedics, the Ambulance Service needs to document, and act upon, those concerns with concurrent reference to the disciplinary and health matters\textsuperscript{59}. However, the Coroner did state: “[Paramedics] are highly trained, dedicated, skilled people and I take my hat off to them.”\textsuperscript{60}

Had a similar situation arisen with a registered health practitioner under the National Registration and Accreditation Scheme, there would have been an obligation for colleagues to report the paramedic’s conduct to their national board. Health practitioners are required to report notifiable conduct, which includes: practising their profession intoxicated by alcohol or drugs; engaging in...
sexual misconduct while practising; placing the public at risk because of an impairment; or placing the public at risk because of a departure from accepted professional standards.\(^{61}\) Failure to report is considered a disciplinary matter, although not a criminal one.\(^{62}\)

Further, employers also have an obligation to report notifiable conduct to the relevant national board.\(^{63}\) In the case of Mr Speering, the employer reporting his conduct to a national board would have had the effect of absolving them of the responsibility of deciding how to address the issues. As the national boards, under the National Scheme, can recommend conditions for ongoing practice, the deceased paramedic may have been able to receive treatment and then continue to practice without harming patients, himself or his mother. In this way, paramedic regulation failed here.

**Coronial Inquest into the Death of Nola Walker (Qld, 2007)**

A 2007 Queensland coronial inquest considered the death of 68-year-old Nola Walker who refused ambulance treatment and transport.\(^{64}\) Ms Walker was involved in a motor vehicle crash when she failed to give way in accordance with a traffic sign. She had been drinking heavily the night before. Those on scene reported the patient appeared uninjured, although the Queensland Ambulance Service was called. Three paramedics attended and conducted health assessments on Ms Walker. They indicated their preference to transport the patient to hospital but she refused. The paramedics were satisfied the patient had capacity to make a valid refusal of treatment.

Upon arrival of Queensland Police Service officers, the paramedics communicated that the patient was “fine” and was not being transported to hospital.\(^{65}\) The police performed a roadside breath test, which revealed a blood alcohol concentration of 0.198%. She was taken to the police station for further testing where she appeared to be falling in and out of sleep. Police believed her to be very intoxicated. They left Ms Walker to complete paperwork and upon return, could not find her pulse. The police called for an ambulance and upon arrival, despite attempts at resuscitation, Ms Walker was declared deceased.

The State Coroner, Michael Barnes, found Ms Walker had internal bleeding and injuries as a result of the traffic crash, which ultimately caused her death. Medical experts considered that the intoxication as well as the medication the patient was taking could have masked the pain she felt from her injuries during the crash. However, the Court found their response to Ms Walker was adequate and they had no authority to compel her to undertake transport. The Court did recommend, though, that an exchange of information should have taken place between the police and paramedics. If the paramedics had warned police to observe her closely, and call for ambulance assistance if she became drowsy, she may have had access to the early medical treatment needed to save her life. The paramedics’ failure to provide advice is significant here. While Coroner Barnes concluded that the paramedics could not have compelled Ms Walker to attend hospital for further treatment without her consent, it was conceded that had paramedics realised their patient was so severely intoxicated they may have undertaken “more thorough investigations and a more critical assessment of Ms Walker’s capacity.”\(^{66}\)

**Coronial Inquest into the Death of Marshall Yantarrnga (NT, 2005)**

The final coronial inquest discussed here took place in the Coroner’s Court in Darwin where the circumstances surrounding the death of the Marshall Yantarrnga were considered.\(^{67}\) In this matter, an ambulance crew from St John Ambulance Service, the primary ambulance service and paramedic employer in the Northern Territory, was dispatched to Mr Yantarrnga following complaints of chest...
pain and fever. The ambulance crew was made up of a qualified paramedic, a student “ambulance officer” and a St John volunteer who was also an enrolled nurse. The crew examined Mr Yantarrnga but were unable to substantiate the cause of his pain which he identified was occurring in his chest and rib area. The patient had a midline thoracic scar which should have informed the paramedic of the patient’s history of heart disease.

The Coroner’s Court faced some confusion about Mr Yantarrnga’s wishes regarding transport. The ambulance crew suggested Mr Yantarrnga refused treatment and transport; however, Coroner Cavanagh concluded Mr Yantarrnga’s communication was “at best, an acquiescence by the deceased not to be transported”. The ambulance crew did not transport Mr Yantarrnga but also did not comply with the “Ambulance Not Required” policy necessitating patients sign a refusal of transport. After leaving the scene, the ambulance crew were called back and Mr Yantarrnga was found dead at the scene.

The Coroner found Mr Yantarrnga should have been transported to hospital for assessment. Following the death, but prior to the inquest, the St John Ambulance Service amended their “Ambulance Not Required” policy and disseminated it to staff. They had also implemented an auditing process for refusal cases as well as instituting cultural awareness training for all trainee paramedics. The Coroner acknowledged the policy changes.

The Coroner also made the following significant remarks concerning paramedic roles and responsibilities:

[A]mbulance officers must accept that they are not diagnostic physicians. That is not their role. Their role is to stabilise patients and transport them to hospital for assessment. I am not prepared to find that by failing to transport the deceased the ambulance officers in any way contributed to the death of the deceased, particularly given his medical history, however their failure to transport him certainly denied him access to timely emergency medical assessment … they are not and should not be the decision making gateway to [sic] access to emergency assessment.

The ambulance crew’s failure to transport highlights a breakdown in training and education with their organisation’s policies and procedures and demonstrates an adverse outcome for a patient. However, a paramedic’s role has significantly broadened since 2005, with paramedics being required to assess, diagnose and treat acute conditions of patients, which is beyond a stabilisation and transport role. As such, this is an example of how paramedics’ roles have progressed over a 10-year period and these findings of the Coroner from 2005 do not have the same level of relevance now as they did then. It is also an example of paramedics potentially performing an inadequate patient assessment or gaining an incomplete patient history which could have lead them to a different diagnosis. As such, their conduct arguably fell short of the standard reasonably expected of a paramedic, leading to an adverse patient outcome.

**CONCLUSION**

The current regulatory system for Australian paramedics is problematic because it lacks national uniformity. All aspects of paramedic regulation is governed on an individual State and Territory level, which means significant disparity exists in the industry. Further, as employers are responsible for industry regulation, the rising numbers of privately employed paramedics suggest this is no longer the most effective method for paramedic governance. Without a national system of registration, paramedics pose a serious risk to the public as the current disciplinary system lacks transparency. As the industry has evolved, paramedics’ skills and knowledge has expanded, which has led to the performance of more invasive treatments than ever before. There is evidence that paramedics have caused problems in the community that current regulation has either failed to prevent or failed to adequately address. The coronial inquest findings presented, while not exhaustive, provide evidence of potential for patient harm.

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However, it is also difficult to anticipate the full extent of potential misconduct due to the jurisdictional disparity and lack of transparency in the complaints and disciplinary process. Many of these issues could have been addressed using the national model of health practitioner regulation currently being utilised for other registered health practitioners. The National Registration and Accreditation Scheme has a uniform disciplinary response which ensures practitioners are treated fairly and the public has confidence in the standards of professional conduct. The coronial inquests provided above demonstrate the risk paramedics pose to the public and suggest it may be time for a co-regulatory framework to govern this discipline.