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Ambulance Ramping Review Report

January 2024

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This report is provided at the request of the Health Minister, The Hon Chris Picton, as outlined in correspondence to Dr Bill Griggs and Professor Keith McNeil, dated 12 December 2023 (see attachments), in response to claims made in the media by Dr David Pope, along with a subsequent request dated 5 January 2023 to include consideration of the circumstances surrounding a death in the community, purportedly related to delayed ambulance response times related to ambulance ramping.

Dr Pope, an emergency physician, and current President of South Australian Salaried Medical Officers Association (SASMOA), has repeatedly asserted that patients have died in the waiting rooms of South Australian Hospital emergency departments as a direct result of hospital administration instructing clinical staff to prioritise the care of less sick (lower clinical priority) patients in ambulances subject to ramping delays, over patients of a higher clinical priority in Emergency Department (ED) waiting rooms.

Such a claim clearly requires a very thorough and careful assessment of both the veracity of the claim itself, and of the underlying systemic issues leading to the making of the claim.

Subsequent to the claims made by Dr Pope, counter claims were made by the Ambulance Employees Association (AEA), citing a case demonstrating that the opposite was occurring, that is, waiting room patients are being given preference over ambulance patients, with community ambulance responses consequentially delayed, and that patient harm (and in the cited case, a patient death) had occurred as a result of this practice.

Thus, the scope of our initial task was broadened and as a consequence there has been a necessary delay in finalisation of this report.

Three specific areas of review are therefore covered:

1. Assessment of the evidence regarding statements from Dr David Pope made on 7 December 2023 (and subsequently repeated), to the effect that hospital administrators have directed clinicians to unload ambulance patients over someone who is a higher clinical priority in the waiting room – and that this has led to deaths of several patients in the waiting room.

Paralleling this, assessment of the evidence regarding the statements made by the AEA that patient harm, and at least one patient death, had resulted as a direct consequence of waiting room patients being prioritised over ambulance patients.

2. Adherence with relevant SA Health policies.
3. Best practice management of managing the clinical safety risks between the ambulance ramp and the ED waiting room, with ensuring coverage for community emergency cases.

Methods:

1. Consultation with Dr Pope and SASMOA Chief Industrial Officer, Ms Bernadette Mulholland
2. Consultation with AEA Industrial Officer Mr Josh Karpowicz
3. Consultations with Emergency Department consultants and hospital administration at Northern Adelaide Local Health Network (NALHN), Central Adelaide Local Health Network (CALHN) and Southern Adelaide Local Health Network (SALHN). There was also to a lesser extent consultation with SA Ambulance Service (SAAS) Administration and some paramedics.

Note: this report was stimulated by issues cited by Dr Pope which occurred predominantly at NALHN (Dr Pope's employer). Thus, although SALHN and CALHN were consulted in some detail the focus was primarily on NALHN.

4. Extensive review of data from all relevant SA Health data systems and applications, including those systems through which critical clinical incidents are reported to enable finding of individual cases for review.
5. Follow up consultation with Dr Pope and Ms Mulholland.

Relevant SA Health policies

The *Ambulance Transport Policy* - dated 28 July 2023, specifically section 3.1.
This says:

In instances where a hospital has been determined as the most appropriate destination, every effort must be made to support the release of ambulances for further tasking to reduce the risk to other patients in the community requiring emergency or urgent care by:

a) Moving patients from the ambulance to an appropriate place in the receiving hospital (which may include triage, assessment/treatment area or waiting room) as soon as possible.

b) Prioritising ambulance patients for placement, where clinically appropriate, if the patient has arrived via ambulance and is triaged (as per the Australasian Triage scale (ATS)) as an equal category to those patients already in the waiting room. For example, where two patients have been triaged as ATS category 4 (one arriving by ambulance and one walk-in) the ambulance patient will be considered for placement first to allow the attending Paramedic or Ambulance Officers to be available for further tasking.

Legal Direction

Under section 33(4) of the *Health Care Act 2008*, a previous legal direction dated 25 November 2021 instructed that 75 per cent transfer of care from all ambulances to ED occur within 30 minutes of ambulance arrival, and no transfers longer than 60 minutes.

A legal direction such as this is both time and context limited and thus does not apply to the current scenario.

Findings

1. No evidence was found to support Dr Pope's contentions that patients had died (nor could we find any evidence of overt harm occurring to any patient) as a result of any instructions given by hospital administrators to offload ambulance patients as a priority over waiting room patients of known greater (or even of similar) clinical need. Furthermore, as shown in Figure 1 and Table 1, there is no evidence that patients conveyed to hospital by ambulance are given treatment priority over those in the ED waiting room.

Likewise, the case of a patient death cited by the AEA could not be definitively linked to the clinically inappropriate prioritisation of waiting room patients over ambulance patients, although over the past 12 months, data (see Figure 1 below) shows that there is a trend for non-ambulance arrivals at EDs to be seen more quickly than those conveyed by ambulance.

It would however be wholly inappropriate and incorrect at this time, to draw the definitive conclusion from this data, that such a trend is the result of a systematic/deliberate bias towards non-ambulance arrivals. There are many reasons why such a trend may be occurring, and a much more in-depth and granular analysis is required to reach a definitive conclusion as to what is occurring here, and why.

Dr Pope was unable to provide us with any specific cases or identifying details for any patients whose cases supported his contention, which meant we had to conduct a broad search to identify any such putative cases. We sought examples from other ED specialists, from senior ED and hospital clinical administration, as well as from the databases which record deaths and adverse clinical events. We also sought information from safety and quality monitoring officers and their systems.

We could find no evidence that ED staff had been directed to give lower priority patients in ambulances priority over higher triage category waiting room patients, and likewise, could find no definitive evidence of the counterfactual situation, that is, that there was a deliberate bias towards prioritising the care of waiting room patients over those in ambulances. As above, a follow up in-depth analysis is underway to examine the trend observed in the data and as displayed in figure 1.

2. It is not clear at this juncture when or whether the *Ambulance Transport Policy* is being followed, and if not, why not. There are many valid clinical reasons why a waiting room patient is prioritised for care

over an ambulance patient of the same triage category. This relates not only to the disposition of the patient (e.g. chair vs stretcher), but also the nature of the illness or injury which may be amenable to fast tracked diagnosis (e.g. x-ray for a fracture). As stated above, if anything, the trend in the data (figure 1) suggests that the policy as such is not being consistently followed. As previously stated however, no definitive conclusions should, or indeed can, be drawn without further analysis of said data. This analysis is complex and is underway.

As stated, the legal direction was time and context limited and is not relevant to the current circumstances. That said, it is noted from the data (figure 3) that for the calendar year 2023, approximately 48 per cent of ambulance transfers occurred within the desired 30-minute timeframe, 86 per cent within 60 minutes, and 98 per cent within 120 minutes.

Although not explicitly stated, there was an inference in some discussions that initiatives/actions were being “directed” in order to “fudge” the data, i.e., to make it look better. *We found absolutely no evidence that practices had been enacted, or that data was being manipulated, to present a more palatable view of the ambulance ramping situation.*

3. While we found no specific examples or cases that fitted Dr Pope’s contentions, we do acknowledge the genuine levels of stress and concern being experienced by clinicians, across both the hospitals and the ambulance service.

Much of this stress and concern is driven by the desire for all clinicians to do the best they can for their patients, in the context of feeling overwhelmed, with little perceived ability to positively influence the system, and indeed in many cases, with a lack of complete understanding of the broader goals of the system.

During this review, we identified a number of broader system and human issues which are worthy of further understanding. These specific issues address the third area of review and are considered under the headings of Silos; Legal responsibilities; Authority gradients; Tolerance of Ambiguity; Timing; and Structure. Understanding these issues will help provide the context in which, and how, decisions are made. Recommendations are offered with a view to improving the system to enable more effective decision making, and in doing so address the third of the original issues for review.

Silos:

It is clear there is every endeavour by clinicians to provide best practice clinical care for individual patients. However, workload, and paradoxically, attempts to manage risk in one area, may result in adverse outcomes in another part of the system. This is typical of the interdependency inherent in complex system dynamics and requires a different, non-linear, approach to problem solving. Under current modes of operation, clinical care applied in discreet silos means that the clinical priority and care

of individuals is considered only within the context of where that care is delivered (e.g. ambulance, emergency department, hospital ward etc) with decisions regarding risk and its management also considered within these silos. Appreciation of consequences of such decisions outside these silos at a “cross system” level, is therefore difficult and limited.

There is currently no sophisticated process in place to enable a more holistic view and assessment (calculation) of the relative risks that exist across the continuum of urgent and emergency care from the home to hospital discharge, and thus no consideration of where the highest risk exists across that continuum for any given patient at any given time. This is critically important to understand given the dynamic nature of healthcare delivery.

This individual siloed approach often means that efforts to decrease risk in one area (silo) may result in a disproportionately higher and sometimes unappreciated increase in risk in another part of the system.

At any point in time, any current assessment in this regard relies at best on the experience and intuition of individual clinicians. In addition, there is no single point of accountability or responsibility for taking such a system view of where individual patient risk is highest at any point in time, and thus how decisions in one silo might affect another silo and/or the risks within the patient care system as a whole.

It is not uncommon for individuals to feel that the main/only cause of issues in their silo is what happens in other silos, which they feel unable to directly influence. This can lead to feelings of helplessness and thus to increased stress. These issues cannot be addressed without a multi-silo/whole of system approach.

This situation is by no means unique to SA Health, but it does present an opportunity to develop a more nuanced approach to risk management across the system to enable the optimal balance to be achieved in what is inherently a system where there are no ‘no risk’ scenarios. Agreeing an approach to this challenge will be a critical initiative to managing acute demand into the future. Highly sophisticated analysis of data, with predictive analytics will be required.

Legal responsibilities:

We found a level of confusion regarding who has legal responsibility for which patients, at which time, and in which location. There appears to be a not uncommonly held view, that patients who are on the ramp in an ambulance and who have not yet come in through the hospital door, are somehow not the ED/hospital’s responsibility. In some cases, there appears to be a clear but undocumented practice not to send clinicians out to the ramping area nor to allow patients to be brought into the triage desk unless there is a major deterioration. Rather, an assessment of triage category/urgency is made based on information from the ambulance crew. Furthermore, the ambulance crews providing information to the triage desk to inform this triage category determination range in skill sets and experience from Extended Care/Intensive Care Paramedic to Volunteer Ambulance Officer level.

By extension, a similar principle exists in terms of the risks to patients in the community, and who has legal, ethical and moral responsibility for ensuring their needs are best met within what is inherently a resource constrained system.

Our search for any case law in this area in Australian jurisdictions failed to turn up any clear examples. However, case law in the UK is clear on this point, and a relevant example is provided below - Danby vs Croydon Health Services NHS Trust (2018).

Danby vs Croydon Health Services NHS Trust (2018).

This case involved a man who suffered a blow to his head on 17 May 2010. He self-presented to hospital. He spoke to a clerk but not to any clinical person. He was advised by the clerk that there would be a very long wait. This information was found to be incorrect and significantly overstated the potential wait had he been correctly clinically assessed.

As a result of this advice, he left after 19 minutes waiting, only to be returned later by ambulance after a collapse at his mother's house. He subsequently suffered permanent brain damage in the form of a severe and very disabling left hemiplegia because of the effects of an expanding extra-dural intracranial haematoma. This was a time critical but potentially treatable problem from which it was felt he would likely have made a full recovery if he had not left the ED prematurely.

The Court's view (in both the original case and the appeal) was that legal responsibility begins when the hospital is aware a patient is there, even if they have not yet been clinically assessed. The hospital argued they had not clinically assessed him and therefore had less / no responsibility. The court took the view that it was the hospital's decision to require patients to first present to a non-clinical person and they were responsible for the consequences of this practice.

If applied to the South Australian context, the parallels from this case are clear. This precedent applies to all patients in the waiting room, and logically by extension, all patients who are on the ramp, as it is a hospital decision not to allow them inside for formal assessment and triage, regardless of any shared responsibility with the ambulance service.

We note that one Local Health Network reported they “are also going to implement a Rapid Assessment Model in the ED from 2024 which includes senior clinician in-reach to the waiting room. The trial has been completed with excellent results”.

We further understand there is ongoing discussion within the ED community regarding teams who can assess and reassess patients both on the ramp and in the waiting room. This is clearly important as patients' conditions may change over the time they are waiting.

Authority gradients:

Healthcare systems traditionally operate with a hierarchical and authority-based (command and control) structure. These structures are designed to optimise patient care, however hierarchical structures when over-utilised in a complex system, may negatively impact patient, professional, and organisational outcomes, and undermine system effectiveness. In particular, authority gradients, and/or perceived

differences in status, may result in misunderstandings/misinterpretations and communication breakdowns.

A senior person's "suggestion" may be perceived as an "order" by a person lower in the hierarchy regardless of the senior person's intent. In extreme cases, some people within a hierarchy may feel they have limited or no power to change or challenge things when in reality, they may be able (and be expected and operationally required) to do so.

One example we found of a communication difficulty in this respect involved a situation where a more senior Registered Nurse (RN) was communicating with a more junior RN regarding potential patient movements. What was intended as a discussion by the more senior person was perceived by the more junior staff member as an instruction.

Authority gradient risk requires active organisational management and appropriate processes to flatten power gradients to ensure people at all levels feel appropriately empowered to make effective decisions within the boundaries of their knowledge and experience. This is the essence of effective leadership which is critical in complex systems such as healthcare. This may partly explain some of the concerns shared with us by clinicians, which in many cases were not referencing specific cases but rather expressing a general perception/feeling which we might paraphrase as: "This is difficult and stressful, but I can't fix it so someone else needs to fix it for me." Unaddressed, this scenario is a recipe for disempowerment, disengagement and despair.

The airline industry has identified authority gradients within an aircraft cockpit as a cause of serious and fatal events and thus introduced systems such as Crew Resource Management (CRM) and graded assertiveness training to manage this, with very good results, as evidenced by the safety of this industry. These initiatives are an accepted part of airline safety culture, and have been introduced to some extent into healthcare, with perhaps the best example being the surgical checklist. Healthcare systems understand and use Team Resource Management and similar safety culture strategies, however the application of these techniques and initiatives has largely been confined to individual teams such as Trauma Teams, Retrieval Teams, and Operating Theatre teams, and not so much *between* teams or *across* organisations.

Effective leadership, education leading to understanding, and access to real time information are the best ways to address the issue of authority gradients, along with a focused approach on any areas where a dysfunctional power dynamic obviously occurs.

The current application of the *Ambulance Transport Policy* critically requires communication between and across different areas (silos) which is essential for effective decision making in this environment based on holistic risk assessment.

Tolerance of ambiguity:

Clinicians are genuinely concerned and/or stressed by the *potential* for an untoward patient outcome. Despite being unable to find any cases fitting Dr Pope's specific accusations, we were able to identify that this general concern appeared to relate significantly to a perception of uncertainty and the associated feeling of lack of influence and control.

Tolerance of ambiguity can be defined as the extent to which an individual is comfortable with uncertainty, unpredictability, and multiple demands (ambiguity). In essence, a tolerance for ambiguity is manifest in a person's ability to operate effectively in an uncertain environment, such as a busy ED. Although to some extent it can be learned, it is viewed as a personality variable with each person having an innate level of comfort with this state. Emergency medical care often requires decisions to be made rapidly, and often in the absence of full information. Individuals with a high tolerance of ambiguity tend to cope better in such an environment. As stress/complexity/unknowns increase, the number of people who move beyond their level of comfort with ambiguity increases, and signs of stress increase. This may be a partial explanation for the concerns expressed to us by some clinicians. This does not render those concerns invalid, but it is helpful to understand context and what is needed to manage these concerns.

Logically, if we can provide real time integrated system wide information plus an improved real time understanding of the system as a whole, including each person's place and role within it, this will decrease the levels of ambiguity, and thus both improve system function and decrease the stress experienced by people working within the system. Such information would also help to inform any necessary changes to structure, following the time-honoured principle of form following function.

Timing:

It is worth noting that decisions about relative urgency need to be judged based on knowledge available at the time of the decision rather than in retrospect. This does not mean we cannot learn from retrospective reviews, however understanding knowledge available at a given time is important in reviewing decisions made at that time.

As an example, two patients may present to the triage desk with problems of apparently similar urgency. However, after admission to ED and sometimes hours of history, examination, and investigation, one patient may be found to have a problem which is not as serious, while the other may be found to have a much more serious problem. This is not unexpected and has always been the case. The essence of triage is that it is a system which attempts to sort out patients in terms of relative urgency with minimal information; and as such, it can never be perfect.

It is wholly appropriate to reflect on cases where patients have died or had adverse outcomes and to identify anything which might have been done differently. It should not be underestimated how much clinicians worry about these cases. For many years, regular (clinical) audits have been held to review such cases and to, among other things, look for options to learn and to consider what might have been

done differently. These audits provide learning opportunities and allow clinicians to better understand the full context of the case, which in turn can lead to a decrease in levels of stress. Such reviews must however, take into consideration, and acknowledge, the information available at the time decisions were made, and not render judgments in retrospect.

We note again that in this review we did not find any examples of patients who had either died or who had an adverse outcome as a result of a decision to inappropriately prioritise unloading ramped patients over waiting room patients. Often, detailed analysis is necessary to understand the true specifics of a case compared with the perceptions surrounding the case. For example, we reviewed the case from over a year ago of a death in a patient who had spent a long time in the waiting room. This case has previously been reviewed extensively both internally and by an independent external team. We noted that for the relevant triage category, the average waiting time for patients presenting via the waiting room on that day was actually *less than* the waiting time for those of the same triage category presenting via ambulance. While, on what was a very busy day and this patient's time to be seen was certainly longer than ideal, this waiting time was not in any way a function of the specific situation Dr Pope alleged.

As we noted in the section on tolerance of ambiguity above, having accurate knowledge is important to understanding the reality of a situation (as opposed to the perception), to learning, and to decreasing stress.

Structure:

It is said that every system is perfectly designed to deliver the results it produces. The unstated qualification to this is that these results will happen even if those results were not the intent of those who designed the system.

So, to produce different results, changes will need to occur.

While we have made recommendations (see below) within the narrow constraints of this review, many of the broader changes relating to system outcomes such as patient flow will need to be informed by data, and the insightful analysis of that data.

Future changes might or might not include many options. These will require input from the ground up and from multiple 'silos' to maximise their chance of success in improving or attaining desired outcomes. Understanding the impacts, issues and risks of decisions made in "our" silo on the wider system, will be essential.

The risks/costs/benefits of each such option will need to be considered, however in many cases, such an outcome analysis will only be possible once an initiative is trialled and assessed in real time.

The health system has changed significantly since COVID-19, and the delivery of healthcare and the way we deliver it needs to change and rapidly adapt to reflect these new system dynamics. We are aware of several initiatives being trialled and/or rolled out in the ED/ambulance ramping space and such efforts should be continued and encouraged with appropriate consideration, oversight and (real-time) evaluation.

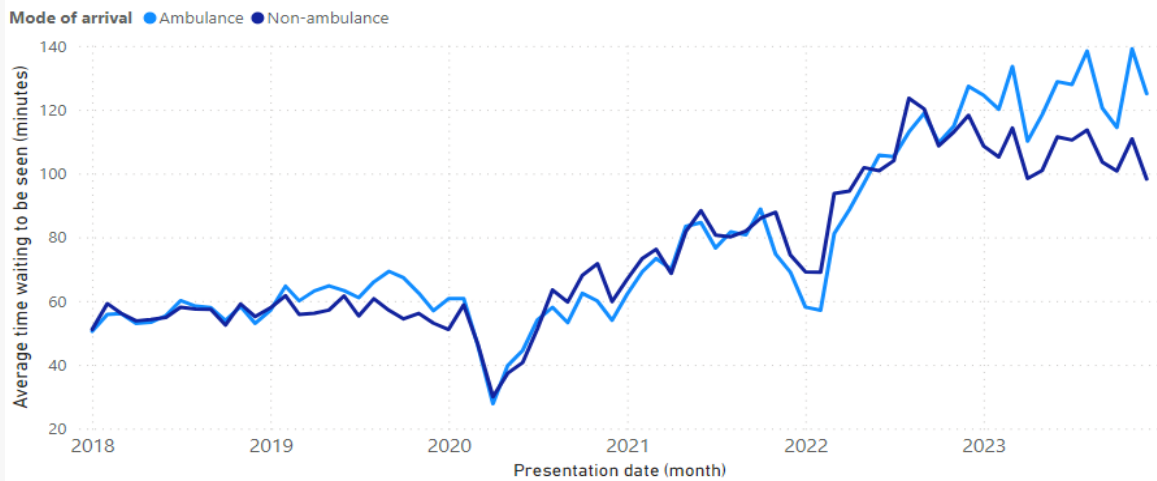
Recommendations:

1. Strengthen the wording in the *Ambulance Transport Policy* to explicitly state that the prioritisation of the care of any patient is a clinical responsibility, and that the senior clinical decision maker on shift has the responsibility and accountability for such decisions, made in context and with a view of the *relative risks that exist across the continuum of urgent and emergency care* (see the section on Silos above).
 - a. Reword the opening sentence of part b) of the policy to something akin to: *“Where clinically appropriate, if 2 patients are triaged (as per the Australasian Triage scale (ATS)) as an equal category, priority for placement should be assigned to a patient arriving via ambulance so as to free up that ambulance resource for community response.”*
2. A senior ED physician (and/or multidisciplinary team) on each shift be tasked with the relative risk assessment (triage) of offloading a patient from an ambulance or attending to a patient in the ED waiting room, and that such a triage assessment is made with cognisance of the *community need for SAAS response and the time spent in the waiting room*. This will require regular active assessment and reassessment of patients waiting in both the ED waiting room and on the ramp.
 - a. A multidisciplinary team undertaking this role would also increase the opportunity for diversion to other facilities/resources where appropriate.
3. In line with the above recommendation, that an evaluation/calculation of the risks existing *across the urgent and emergency care continuum* be developed such that an informed decision can be made regarding the place(s) of greatest risk across this continuum, and furthermore, that such a risk evaluation be a prime driver of patient flow decisions throughout the entire hospital, and of the need for further/incremental change.
4. The evaluation/calculation of risk across the urgent and emergency care continuum (recommendation 3) needs to be understood and shared in real time. Bottom-up input will be essential in making effective change, aligned with cross/whole system understanding. This sharing of information and understanding will inform better decisions and decrease both the level of ambiguity and the levels of personal stress within the system.
5. Conduct a review of the current organisation-wide approaches to Safety Culture particularly as it applies to authority gradients and communication between silos with a view to improving function and decreasing risks inherent in a traditionally hierarchical system. A focused approach to individual examples may be helpful in the short term.

Attachments:

Figure 1 shows the average time (minutes) waiting to be seen (for treatment) in ED for urgent (triage category 3) patients – the largest cohort of patients presenting to the ED - across most metro hospital EDs. There is no evidence of longer wait times for patients waiting in the ED over those arriving by ambulance.

Average time waiting to be seen for URGENT cases at major metro hospital emergency departments (excluding Lyell McEwin and Modbury hospitals*)



*Lyell McEwin and Modbury hospitals migrated to the Sunrise EMR in late 2022 and early 2023. During this time there was a clear change to the trends in the data, most likely due to process changes and data collection changes as a result of this migration. These hospitals are shown separately to avoid skewing the data for other hospitals. Note that Flinders and Royal Adelaide hospitals also completed Sunrise EMR migrations during the analysis period, but there was not a significant change to the data trends from these hospitals.

Figure 1: Average time waiting to be seen in the ED for URGENT (Triage Category 3) cases at major metro hospital emergency departments (excluding Lyell McEwin and Modbury hospitals)

Table 1: Average time waiting to be seen (in minutes) by triage category for ambulance and non-ambulance arrivals at major metro hospital emergency departments in 2023.

	Resuscitation	Emergency	Urgent	Semi- Urgent	Non-Urgent
Ambulance Arrivals	0.7	32	133	152	173
Non- Ambulance Arrivals	1.1	29	114	105	88

The analysis of the emergency department dataset showed no evidence of arrivals by ambulance systemically being treated prior to the non-ambulance arrivals.

Figure 2.

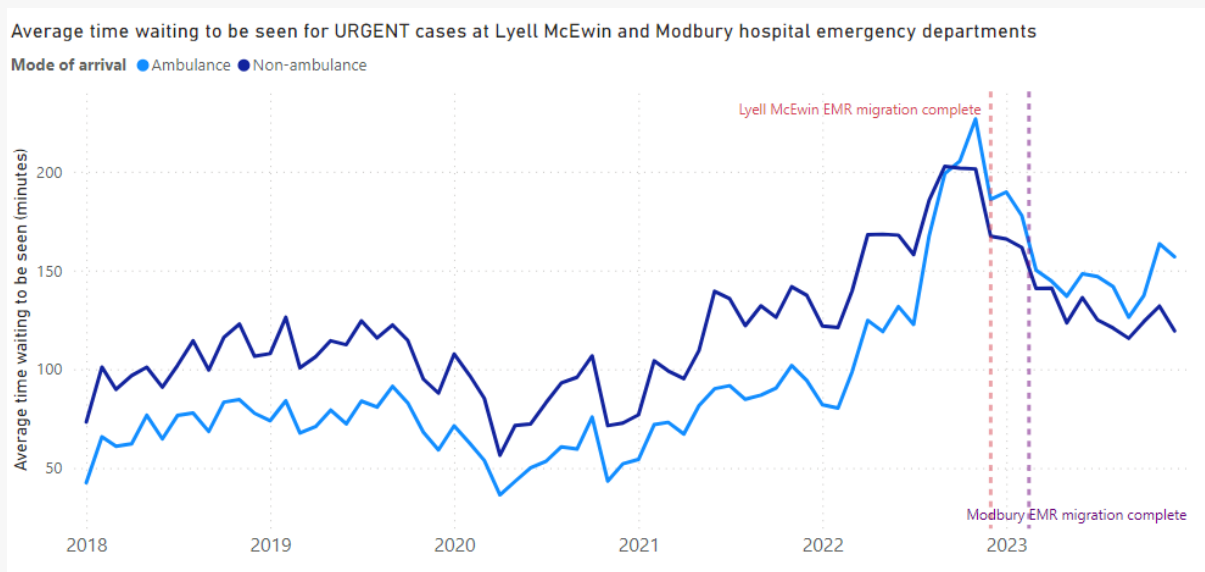
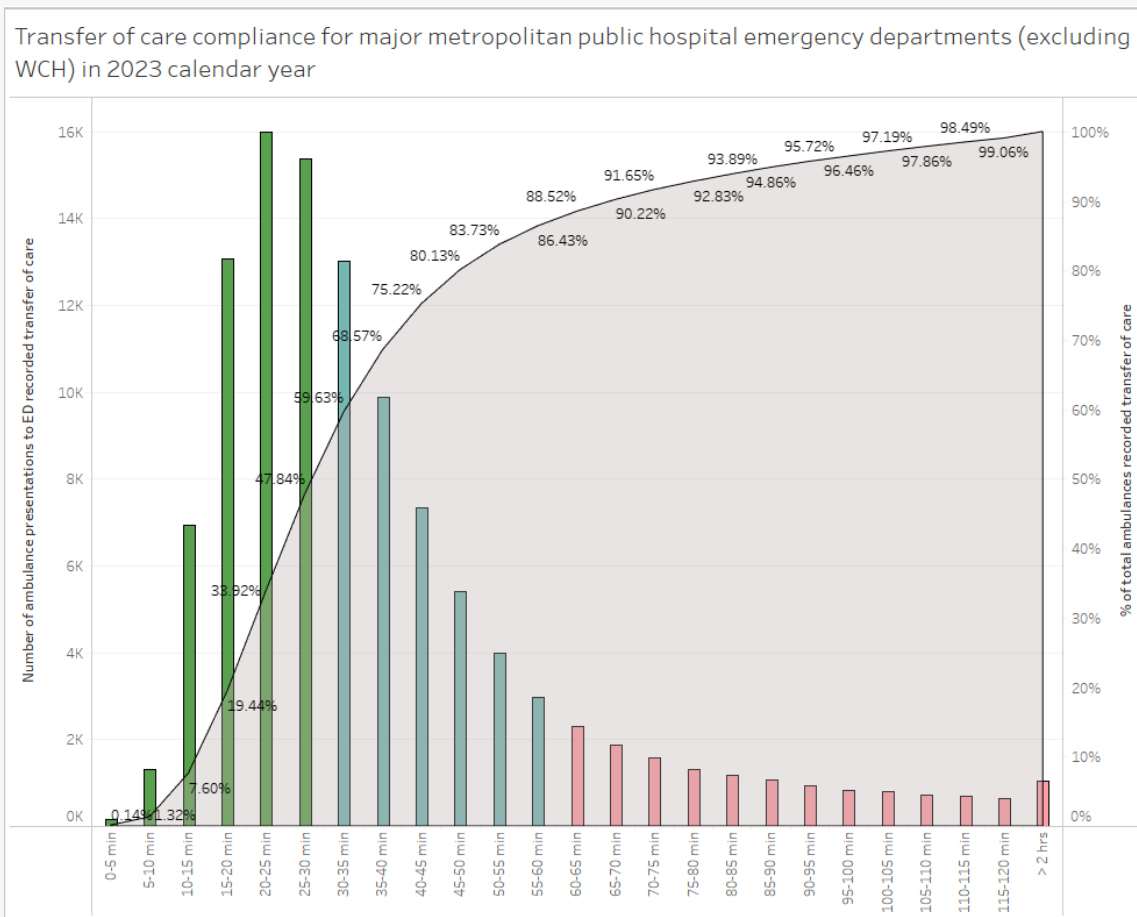


Figure 2: Average time waiting to be seen in the ED for URGENT (Triage Category 3) cases at Lyell McEwin and Modbury hospitals noting the pattern change coinciding with introduction of the EMR (the reasons for which require further analysis).

Figure 3.

In 2023 calendar year, 48% of ambulance transports to major metropolitan emergency departments have a recorded transfer of care within 30 minutes, and 86% within 60 minutes.





Government
of South Australia
Hon Chris Picton MP
Minister for Health
and Wellbeing

MHW-H23-5438

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Keith and Bill

Dear Prof McNeil and Dr Griggs

Thank you for agreeing to undertake a review following the comments made by Dr David Pope, President of SASMOA on 7 December 2023.

As you are aware, Dr Pope made comments of concern to the community, including:

"...they've gone down this path of trying to direct clinicians to unload ambulances when there's higher priority patients that need to be seen."

"Deaths have happened — I can think of two or three cases like that. People who have been waiting many hours in the waiting room, who are time critical, end up having a cardiac arrest and dying. It is not uncommon."

"It is a new thing, we've never had this in the past, we've always been able to you know see people on clinical priority and now we're being undermined and can't do our jobs."

"It compromises care. Prioritising patients according to need is incredibly important, but this is political and it is just awful."

There is existing SA Health policy that covers this issue, the Ambulance Transport Policy dated 28 July 2023, specifically section 3.1. This says:

In instances where a hospital has been determined as the most appropriate destination, every effort must be made to support the release of ambulances for further tasking to reduce the risk to other patients in the community requiring emergency or urgent care by:

- a) *Moving patients from the ambulance to an appropriate place in the receiving hospital (which may include triage, assessment/treatment area or waiting room) as soon as possible.*

- b) *Prioritising ambulance patients for placement, where clinically appropriate, if the patient has arrived via ambulance and is triaged (as per the Australasian Triage Scale (ATS)) as an equal category to those patients already in the waiting room. For example, where two patients have been triaged as ATS Category 4 (one arriving via ambulance and one walk-in), the ambulance patient will be considered for placement first to allow the attending Paramedic or Ambulance Officers to be available for further tasking.*

This is largely consistent with the previous SA Health “Ambulance Distribution for Demand Management Policy Directive” dated 30 July 2020, section 3.11.3.

There was also a previous legal direction that was in place from 25 November 2011 under previous Chief Executive Dr Chris McGowan under section 33(4) of the *Health Care Act 2008* that instructed that 75 percent transfer of care from all ambulances to ED within 30 minutes of ambulance arrival, and no longer transfers longer than 60 minutes.

As you are aware, SA Health patients are in the hospital, the emergency department, the waiting room, the ambulance ramp and in the community waiting for an ambulance. It is important that policies and practices weigh up patient safety across all of those patient cohorts.

I therefore ask you to conduct a short review of the following:

1. Assessment of the evidence regarding statements from Dr David Pope on 7 December 2023, to the effect that hospital administrators have directed clinicians to unload ambulance patients over someone who is a higher clinical priority in the waiting room – and that this had led to deaths of several patients;
2. Adherence with the current SA Health policies
3. Best practice management of managing the clinical safety risks between the ambulance ramp, the waiting room and ensuring coverage for community emergency cases.

I ask that you complete a report that is able to be publicly released.

I understand that you have also reached out to Dr Pope and SASMOA for their evidence.

I will ask Dr Lawrence to ensure that you have appropriate permissions and access to information – as well as information from SA Health as appropriate.

Thank you for agreeing to undertake this work and I look forward to receiving your report.

Yours sincerely



Chris Picton MP
Minister for Health and Wellbeing

12/12/2023