From: Stella Jennings
To: transferofcare
Cc: Anita Dow
Subject: Submission to the Select Committee on Transfer of Care Delays
Date: Thursday, 12 October 2023 1:45:43 PM
Attachments: Pedler A Coroner Report.pdf

Att: The Secretary, Select Committee on Transfer of Care Delays (Ambulance Ramping), House of Assembly, Parliament House, Hobart, Tas. 7000

Dear Sir/Madam,

I would like to make a submission in relation to the ambulance ramping situation at the Launceston General Hospital (LGH). My mother, Anne Pedler, died on August 6th 2022 after being ramped at the LGH for in excess of 8 hours. There has since been a coroners report regarding this, and I and my husband have attended meetings with the LGH CEO, Assistant Medical Director and CEO of Ambulance Tasmania. Subsequent meetings with Minister for Health, Guy Barnett, (new) CEO of the LGH and the Head of Emergency Department, then an additional meeting with Shadow Health Minister Anita Dow was attended.

I have attached the full Coroner's Report, however, in summary, my mother presented to the LGH with a working diagnosis of a pulmonary embolism (PE), which is potentially life threatening, and despite being triaged as urgent, she was not transferred to the care of the LGH at any stage, even when she had rapidly deteriorated and subsequently passed away. At the initial meeting at the LGH with the CEO, Asst Medical Director and CEO of Ambulances Tasmania, they went through the Root Cause Analysis they had prepared, and informed us that the main issue had been a delay caused by waiting for pathology results, which were never followed up. It transpires that there is no 24/7 pathology on site at the LGH, so this is "outsourced" and can go to a lab on the mainland, or even overseas. The tests were ordered but, as my mother was not an admitted patient, there was no one assigned to follow the results up. Medication for the PE was withheld pending these results, which, the coroner notes, would have increased her chances of survival as "*30% of untreated patients die, while only 8% succumb with effective therapy*". Even had the pathology results been returned, she would then have likely been sent for a scan, which again, would likely have been delayed as there is also no 24/7 radiology on site at the LGH, and an "on-call" service is used, causing further delays in patient care and, presumably, wait times for patients to be transferred to the care of the LGH. My family have questioned the hospital and the Minister for Health as to why, in a hospital as large as the LGH, covering an area as wide as the LGH, they do not have critical services such as pathology and radiology staffed 24/7. Neither party were able to provide a satisfactory answer, and the Minister and new LGH CEO agreed to review this urgently. That meeting was in August, and, to my knowledge, there has still been no advertisement placed to fill these roles and current practices remain in place. It is worth noting that even the Mersey Hospital in LaTrobe has these 24 hour on site services.

The lack of these services must logically impact the ability of the emergency department to treat patients in a timely and effective manner, thus impacting the flow of patients through to admission or discharge, and thereby contributing to the ambulance ramping. In our case, this did not just cause a delay or an inconvenience, it cost us my mothers life. My mother was a wonderful, warm hearted person who lived a simple life, loved her grandchildren and family, and who had spent her life working with children, and always helped others whenever she could. Her loss has devastated our family, and, although nothing can bring her back to us, we know she

would want us to share her story in the hopes of preventing this happening to other families, particularly in view of the fact the Coroner explicitly stated that "*until issues associated with the resourcing of emergency departments and access to general practitioners are resolved, by those with the responsibility and power over such issues, cases like this one will continue to occur*". We welcome this Committee's work into determining and rectifying the issues that have caused my mothers death, and many other cases with serious detrimental outcomes.

I would be happy to speak to the Committee and provide further information and context if required.

Yours Sincerely,

Stella Jennings
[redacted]