MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Anton Lukacevich

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Anton Lukacevich;

b) Mr Lukacevich died in the circumstances set out further in this finding;

c) The cause of Mr Lukacevich's death was coronary atherosclerosis with early myocardial infarction; and

d) Mr Lukacevich died, aged 64 years, on 25 January 2022 at 114 Mountford Road, Mangalore, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mr Lukacevich's death. The evidence includes:

- Police Report of Death for the Coroner;
- Affidavits establishing identity;
- Report – Dr Andrew Reid, Forensic Pathologist;
- Affidavit – Ms Lisa Lucas, sworn 25 January 2022;
- Affidavit – Ms Gabrielle Lucas, sworn 25 January 2022;
- Medical Records – MyClinic, South Yarra; and
- Records and Correspondence Ambulance Tasmania (including 000 recordings).

Circumstances of death

On 25 January 2022 Mr Lukacevich suffered a heart attack whilst staying at his sister-in-law's home at Mangalore.

His wife rang 000 at 10:34 am seeking assistance from Ambulance Tasmania. In the call she told the operator the age of her husband (64 years), that he had developed sudden onset of sweating, shortness of breath and shoulder pain – all symptoms of a heart attack. Despite this clear information, the call was incorrectly entered into the Ambulance Tasmania Medical

Priority Dispatch System. Mr Lukacevich was categorised as being of "less apparent priority"[1] than other cases. Accordingly no ambulance was sent.

His wife phoned triple 000 again at 12:00 pm, by which time Mr Lukacevich had collapsed, was blue and not breathing. Despite the efforts of Mr Lukacevich's wife, sister and brother-in-law at CPR, by the time ambulance paramedics arrived he was dead and could not be resuscitated.

Investigation

Mr Lukacevich's body was formally identified and the fact of his death reported in accordance with the requirements of the *Coroners Act* 1995. His body was transported to the mortuary at the Royal Hobart Hospital.

At the Royal Hobart Hospital, the Tasmanian State Forensic Pathologist Dr Andrew Reid performed an autopsy. The autopsy revealed coronary atherosclerosis and features of early myocardial infarction. He saw obvious resuscitation related injuries including central chest abrasion on multiple sternal and rib fractures. I note such injuries are common when CPR is carried out effectively.

My investigation focused upon the response of Ambulance Tasmania. I have already set out my conclusions in relation to the response by Ambulance Tasmania to this emergency.

Comments and Recommendations

The circumstances of Mr Lukacevich's death require me to **comment** pursuant to section 28 of the *Coroners Act* 1995 that the failure by Ambulance Tasmania to afford the matter an appropriate priority (described in its initial response to a request for information as part of this investigation as being "non-compliant call taking") potentially meant Mr Lukacevich lost an opportunity for survival.

I convey my sincere condolences to the family and loved ones of Mr Lukacevich.

Dated: 18 August 2023 at Hobart, in the State of Tasmania.

Simon Cooper

Coroner

[1] Letter - Department of Health, Ambulance Tasmania to the Coroner's Office, 11 August 2022