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Deputy State Coroner English
Coroners Court of Victoria
65 Kavanagh St
SOUTHBANK VIC 3006

By email: ***cpuresponses@coronerscourt.vic.gov.au***

Dear Deputy State Coroner English

Finding into the Death of Kylie Cay with Inquest
Coroners Court Reference: COR 2016 002831

We write in response to Your Honour's recommendations to Ambulance Victoria, made following the coronial investigation into the death of Kylie Cay, with inquest, and detailed in Your Honour's finding, delivered 25 May 2021.

On behalf of Ambulance Victoria, we would like to express our sincere condolences to the family of Ms Cay for their loss.

Your Honour made four recommendations, pursuant to section 72(2) of the *Coroners Act 2008 (Vic)* (**the Act**), directed to Ambulance Victoria:

1. *To ensure clinicians and referral service triage practitioners are able to access all information taken by ESTA call operators, including ProQA codes and their descriptions in the Computer Aided Dispatch system.*

2. *To conduct an internal review to ensure all staff have received the training and education about the nature and effects of injuries and harm caused by family violence, as outlined in the PRO OPS 273 (approved 29 July 2020), to enhance their understanding of patients suffering from and at risk of family violence, recognising their particular difficulties and acute vulnerability in the community.*

3. *To use this Finding and in particular, the transcript of the call between Ms Cay and the RTSP for staff education and training purposes regarding the meaning of and effects of family violence, as well as learnings about active and empathetic listening.*

4. *To audit its policies and work instructions to ensure alignment between policies and actual internal compliance, to identify and address discrepancies so policies are meaningful and are reflected in actual process and practice.*

Ambulance Victoria has considered each of the recommendations and provides the following statements of action in response, as required by section 72(4) of the *Coroners Act 2008 (Vic)*.

Recommendation 1

To ensure clinicians and referral service triage practitioners are able to access all information taken by ESTA call operators, including ProQA codes and their descriptions in the Computer Aided Dispatch system.

Recommendation 1 is implemented.

Ambulance Victoria Clinicians and Secondary Triage Practitioners are able to access all information taken by ESTA call operators, including ProQA codes and their descriptions, in the Computer Aided Dispatch (CAD) system.

Ambulance Victoria Clinicians

Ambulance Victoria Clinicians (**AV Clinicians**) can access ProQA codes and their descriptions when viewing an event. The event code and its description appears in the 'event code' field. If the event code description is longer than the event code field, the AV Clinicians are able to 'click' on the drop down box beside the event code to read the description in its entirety.

In addition, all AV Clinicians have access to the Chronology for an event and they are able to read the full description in the Chronology.

All AV Clinicians have access to all structured call taking information obtained by ESTA call takers through use of the Structured Call Taking (**SCT**) button on their CAD terminals.

Secondary Triage Practitioners

On 30 August 2016, Ambulance Victoria issued a change request to ESTA Service Management that required ESTA to allow Ambulance Victoria Secondary Triage Practitioners to read the additional free text commentary/notes placed into ProQA by ESTA call takers. The change request sought access to the text commentary/notes via the use of the SCT button.

ESTA advised that the system was unable to be configured to enable Secondary Triage Practitioners to have access to the SCT button, however an alternative change in the system parameter was made, which resulted in all ProQA key question information being stamped into the 'Remarks' for an event. Secondary Triage Practitioners can access the Remarks for an event.

Communication Plan for staff in operational communications

While staff have been educated about how to access this information, and do access it, AV will develop a communication plan which will include a reminder for AV Clinicians in a regular weekly email update about how to access this information and a separate reminder for all Secondary Triage practitioners.

Recommendation 2

To conduct an internal review to ensure all staff have received the training and education about the nature and effects of injuries and harm caused by family violence, as outlined in the PRO OPS 273 (approved 29 July 2020), to enhance their understanding of patients suffering from and at risk of family violence, recognising their particular difficulties and acute vulnerability in the community.

Ambulance Victoria will implement recommendation 2.

Ambulance Victoria's Quality Audit and Assurance team, supported by Operational Capability, has planned and will undertake an audit of Ambulance Victoria's earlier family violence training program.

The purpose of the earlier family violence training program was to enable all staff to understand their responsibilities in relation to family violence. It was rolled out in support of Ambulance Victoria's now

superseded Family Violence and Child Abuse Policy (POL/OPS/040). The policy and training was informed by legislation including the *Children, Youth and Families Act (CYFA) 2005* and the *Crimes Act 2014*, in addition to extensive consultation with industry leaders. Paramedics were given an education session that introduced the policy and the Ambulance Victoria Family Violence Clinical Practice Guideline to support victims of family violence in a clinical context. This session included a model of "Recognise, Respond, Refer" in the setting of family violence. Referral contact numbers to external specialist and support services were provided to support patient management. The sub-topics of the earlier training program included victimology, patient assessment, response, validation, barriers to disclosure, referral, documentation, dynamic risk assessment and self-care.

The audit to be undertaken will provide a baseline of all staff who completed the past family violence training and will inform the development of the new mandatory family violence training program that Ambulance Victoria is currently preparing in response to new family violence legislation, for inclusion in its Continuing Education program in 2022. The new mandatory family violence training program will be rigorous. It will include online modules as well as face-to-face learning.

In early 2021, Ambulance Victoria created a Safeguarding Care Program and appointed a Safeguarding Care Senior Lead to ensure organisational oversight of Ambulance Victoria's Family Violence Multi-Agency Risk Assessment and Management (MARAM) maturity and all family violence and child safety improvement activities.

Recommendation 3

To use this Finding and in particular, the transcript of the call between Ms Cay and the RTSP for staff education and training purposes regarding the meaning of and effects of family violence, as well as learnings about active and empathetic listening.

Ambulance Victoria will implement recommendation 3 by developing and delivering the mandatory family violence training session for inclusion in the continuing education program for 2022. The case-based program will be delivered face-to-face. It will include training on the issues of vulnerability and intersectionality and it will incorporate the learnings from this case.

Recommendation 4

To audit its policies and work instructions to ensure alignment between policies and actual internal compliance, to identify and address discrepancies so policies are meaningful and are reflected in actual process and practice.

AV will implement recommendation 4 by conducting an audit of the following operational work instructions and procedures that are of particular relevance to this case:

1. PRO OPS 273 Family Violence
2. WIN OPS 029 Referral Service: Computer Aided Dispatch Management
3. WIN OPS 303 Referral Service: Performing Secondary Triage
4. WIN OPS 072 Altering Event Priority

The purpose of the audit will be to determine compliance with these operational work instructions and procedures. Ambulance Victoria's Quality Audit and Assurance team will define the audit scope and conduct the audit, with the support of subject matter experts from Operational Communications. The audit report will include any recommendations for improvement; it will have an intended completion date of 31 January 2022.

Continuous improvement

Ambulance Victoria continues to invest and improve its systems and processes across its Call Taking and Dispatch and Telephone triage systems.

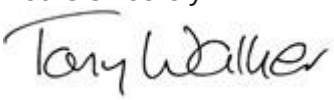
Vulnerable callers are very much an ongoing focus of Ambulance Victoria, with an expansion of Ambulance Victoria's Mental Health pathways and the implementation of a Complex Caller framework recently introduced. Ambulance Victoria is also enhancing processes for welfare call backs to callers, where delays to a response might occur, as well investing in technology to undertake video triage as part of its evolving care pathways.

Ambulance Victoria has also developed an audit tool to periodically test the competency of its Secondary Triage Practitioners.

Quickly evolving technology is likely to be a feature and continuously shape how Ambulance Victoria assesses and uses information and systems to ensure the quality and safety of the service it provides to the Victorian community.

If you have any questions or concerns in relation to the details provided, please contact AV's Coronial Lead at avlegal@ambulance.vic.gov.au and we would be happy to assist further.

Yours sincerely



Professor Tony Walker ASM
Chief Executive Officer

cc *Coroner's Team 4* *team4@coronerscourt.vic.gov.au*