IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 2831

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Amended pursuant to section 76 of the Coroners Act 2008 on 2 September 2021[1]

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Kylie Jane Cay
Delivered on:	25 May 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	9, 10, 11, 12 & 13 November 2020 [2]
Counsel Assisting:	R Nathwani Instructed by N Ngai, Coroners Court In-house Legal

[1] This document is an amended version of the Finding into Death with Inquest of Kylie Cay dated 25 May 2021. Corrections have been made to the wording "Code of Conduct" in paragraph 48 to "Code of Practice". These changes have been made pursuant to Section 76 of the *Coroners Act 2008* (Vic).

[2] This inquest proceeded as a WebEx hearing in accordance with the Coroners Court of Victoria Practice Direction 4/2020 in response to the COVID-19 pandemic. All Counsel and witnesses, save for Counsel Assisting, appeared via WebEx. Final submissions and submissions in reply were submitted in electronic format by 18 December 2020.

Counsel for the Cay family:	S Gold and M Williams Instructed by Robinson Gill Lawyers
Counsel for Ambulance Victoria:	P Halley Instructed by Minter Ellison
Counsel for the Emergency Services Telecommunications Authority:	N Hodgson Instructed by Lander & Rogers
Counsel for the Department of Justice and Community Safety:	M Isobel Instructed by Victorian Government Solicitor's Office
Counsel for Daniel Staff:	B Jellis Instructed by Meridian Lawyers
Counsel for Jarrod Freckleton:	S Keeling Instructed by HWL Ebsworth

CONTENTS

INTRODUCTION

1. Kylie Jane Cay was born in Rochester, Victoria, on 22 March 1972 and was 44 years old at the time of her death.

2. On 18 June 2016, Ms Cay was violently assaulted by her partner, Justin Turner. After receiving medical care at hospital, she was discharged home on 20 June 2016. The medical care did not diagnose a ruptured spleen, which was not visible on the computed tomography (**CT**) scan. Later that evening, at Mr Turner's mother's house, Ms Cay began to feel unwell. Mrs Turner called 000 and an ambulance, which was 700 metres away, was dispatched with Code 1, lights and sirens.

3. The Code 1 dispatch was downgraded to Code 3 and the ambulance was put on hold. The ambulance was subsequently cancelled, and Ms Cay was advised to attend the emergency department within four hours.

4. At 2.00 or 3.00am, Ms Cay walked to her home on the same the street. She was found there, deceased, by her son, Seth, and her mother two days later on 22 June 2016. The cause of her cause of death was a delayed ruptured spleen.

5. Ms Cay's death in June 2016 occurred shortly after Victoria's Royal Commission into Family Violence handed down its report and recommendations in March 2016. Ms Cay's death occurred in the context of her being a victim of significant family violence, the response to this by Ambulance Victoria was tone deaf and opportunities to prevent her death were missed by the down grading, then cancellation of the ambulance. At the time of the 000 call, the fact that Ms Cay was a victim of family violence was considered as either a neutral factor or not relevant by ambulance officers. The Report of the Royal Commission noted Ambulance Victoria at the time of its Report did not have a mandatory family violence field or flag in either its call-taking system or information recording system. [3]

6. On 28 April 2017, Mr Turner pleaded guilty to the manslaughter of Ms Cay in the Supreme Court. [4] On 23 June 2017, when sentencing Mr Turner, His Honour Justice Bell stated:

'*The circumstances in which the request for that ambulance was refused give rise to serious concern. Ms Cay was brutally beaten, attended hospital, discharged home after treatment,*

[3] Royal Commission into Family Violence: Report and recommendations p 22.
[4] Mr Turner was given notice of Inquest proceedings being held into Ms Cay's death.

called an ambulance in distress and extreme pain during the early hours of the next morning, the request was refused, she had no money for a taxi to the hospital and she died of her wounds later that day. In my view it is necessary to consider whether these circumstances should be the subject of a coronial investigation into the response of the emergency services.'[5]

7. At the inquest, the response by Ambulance Victoria is best summarised by the Executive Director of Operational Communications, Anthony Carlyon, who, in apologising to Ms Cay's family, stated:

'*On behalf of Ambulance Victoria I'd like to say how very sorry I am to Kylie's family … We always aim to be there when we're most needed and we failed Kylie on the night when she called us and required our care. Our systems weren't good enough and our understanding of domestic violence immature at the time.*'[6]

8. In addition to being the victim of violence from her intimate partner, Ms Cay's disadvantaged socio-economic position in regional Victoria and the gendered nature of family violence were factors which worked against her accessing services from Ambulance Victoria.

BACKGROUND

9. Ms Cay completed her early education in Hamilton, Victoria. After leaving school she worked in the catering industry and studied law via correspondence. Ms Cay had a son, Seth, with her husband, Shane Clay, however that relationship ended in the late 1990s. In the early 2000s, Ms Cay married Kelvin Kawau and returned to Hamilton. Ms Cay and Mr Kawau had two more children, Tane and Dallas, before the relationship ended.

10. Justin Turner lived with his mother at 31 Elizabeth Street, on the same street as Ms Cay in Port Fairy. On 23 September 2015, Mr Turner was found guilty of violent offences against his mother and was sentenced at the Warrnambool Magistrates' Court to three months imprisonment and a 15-month community corrections order (**CCO**).

11. Mr Turner was released from custody on 20 November 2015 and was inducted onto his CCO on 23 November 2015. The conditions of his CCO were:

    (a) to perform 100 hours of unpaid community work;

[5] *DPP v Turner* [2017] VSC 358; Coronial Brief (**CB**) 485.
[6] Transcript (**T**) 494.

(b) an alcohol exclusion condition that he not enter or remain on licensed premises;

(c) to attend Judicial Monitoring at Warrnambool Magistrates' Court on 29 February 2016;

(d) a residential exclusion condition excluding him from 31 Elizabeth street Port Fairy for a period from 22 November 2015 to 21 February 2017 and not to attend this address;

(e) supervision, treatment and rehabilitation from alcohol, drugs and mental health conditions;

(f) as well as conditions to attend programs to reduce re-offending and a residential withdrawal from alcohol program.

12. About the same time as being placed on the CCO, Mr Turner formed a relationship with Ms Cay. They were living in Ms Cay's rented property at 10 Elizabeth Street, Port Fairy, at the time of her death.

Chronology of police attendances and court hearings

13. There was a fraught history of family violence incidents between Ms Cay and Mr Turner between January and May 2016. Police attended the Elizabeth Street address on at least four occasions and on some of those occasions, Ms Cay or Mr Turner's mother would not make a complaint to police or presented as affected by alcohol or drugs. The circumstances of the family violence incidents were not clear.

14. On 21 January 2016, Victoria Police members attended a family violence incident involving Mr Turner and Ms Cay whereby Mr Turner was alleged to have thrown Ms Cay to ground and kicked her ribs. Police arrested Mr Turner and due to Ms Cay's erratic behaviour she was taken to hospital pursuant to section 351 *Mental Health Act 2014* (Vic). Police issued a Family Violence Safety Notice resulting in an interim family violence intervention order (**FVIO**) against Mr Turner protecting Ms Cay.

15. On 22 January 2016, Police interviewed Mr Turner, who denied the allegations and stated he acted in self-defence. Mr Turner was released on bail.

16. On 12 February 2016, a final FVIO was made at the Warrnambool Magistrates' Court against Mr Turner, protecting Ms Cay (with conditions allowing contact).

17. Victoria Police subsequently took out a cross intervention order to protect Mr Turner from Ms Cay. On 26 February 2016, a final 12-month FVIO was made against Ms Cay with conditions that she not perpetuate family violence against Mr Turner.

18. On 29 February 2016, Mr Turner attended a Judicial Monitoring Hearing at the Warrnambool Magistrates' Court in relation to his CCO. It appears the court was not provided with an accurate report of Mr Turner's compliance with his CCO conditions and was not advised about the family violence incident on 21 January 2016.

19. On 3 April 2016, Police again attended a family violence incident and Mr Turner and his mother were interviewed; Ms Cay was interviewed but refused to provide a statement to police. Police noted the FVIO in place protecting Ms Cay and took no further action.

20. On 19 April 2016, Police were called to a family violence incident between Mr Turner and his mother, with Ms Cay being present during the altercation. No assault was disclosed, and police advised Mr Turner's mother to apply for FVIO if required, and no further action was taken.

21. On 22 April 2016, following an internal audit of case management records, Community Correctional Services (**CCS**) Warrnambool decided to initiate contravention proceedings against Mr Turner for substantial non-compliance with his CCO conditions.

22. On 11 May 2016, Mr Turner was served with charge and summons for breaching his CCO, which was listed for first mention on 20 June 2016 but subsequently adjourned to 7 July 2016.

23. On 12 May 2016, Police were called to a family violence incident between Mr Turner and Ms Cay, whereby both appeared to be drug and alcohol affected. Neither party disclosed any offences, and neither was prepared to provide a statement to police. Police took no further action.

Final family violence incident leading to Ms Cay's death

24. On 18 June 2016 at approximately 8.30pm, Mr Turner had a violent outburst because he could not find his cigarettes. He assaulted Ms Cay by dragging her around the house by her hair, he held a knife to her throat, and stomped on the left side of her ribs. [7] When she curled up on the floor to protect herself, he hit her feet with a hammer.

[7] CB (Prosecution Summary page 13).

25. Ms Cay managed to crawl out of the house and into the backyard where she climbed into the dog kennel with her dog for protection. Ms Cay attended the Port Fairy Medical Clinic seeking medical treatment. At 10.05pm, Victoria Police members attended Port Fairy Medical Clinic to interview Ms Cay and take her statement. Ms Cay stated that Mr Turner: '…*punched me to the face, hit me with a hammer to the feet. Hit me in the ribs and collar bone. I hid in the dog kennel for an hour to get away from him before I could get to the hospital. Justin dragged me around by the hair he assaults me most days and usually hits me where people can't see. I have a black eye, bruising and possible broken bones….also had knife to throat.*'[8]

26. Ms Cay was transferred from Port Fairy Medical Clinic to South West Healthcare, Warrnambool Hospital, where she received treatment for multiple injuries, including rib fractures and a dislocated collar bone. The medical records note she had been *'hit with a hammer on her feet, kicked, punched in her right eye, hair pulled*.'[9]

27. At 10.30pm the same day, Mr Turner was arrested and taken to Warrnambool Police Station where he was interviewed. Mr Turner made several admissions during his interview and was charged and remanded in custody to appear at the Warrnambool Magistrates' Court on 20 June 2016.

28. Ms Cay was discharged from South West Healthcare on 20 June 2016 at approximately 12.40 pm.

29. On 20 June 2016 at approximately 6.00pm, Ms Cay attended Mr Turner's mothers' address. Later in the evening she complained of being in pain and needing an ambulance. Mr Turner's mother contacted emergency services at approximately 12.42am on 21 June 2016 and both she and Ms Cay spoke to the emergency 000-call operator.

30. Emergency Services Telecommunications Authority (**ESTA**) confirm receiving a call from Ms Cay requesting ambulance attendance and the ESTA operator triaged the call as an urgent Code 1 and an ambulance was dispatched.

31. An Ambulance Victoria clinician then reviewed the call and downgraded the urgency from an urgent Code 1 to non-urgent Code 3. This was on the basis that the clinician noted the

[8] CB 78 Kylie Cay's statement to police 18 June 2016.
[9] Port Fairy Medical clinic records p 48.

description of symptoms, being abdominal and shoulder pain and recent hospital admission, and formed the view this did not require urgent care or transportation to hospital.

32. The clinician referred the call to the Ambulance Victoria Referral Service and the triage operator called Ms Cay back at approximately 12.59am. During a conversation with Ms Cay, the triage operator determined that Ms Cay did not require an ambulance and she should organise her own transport and present herself to the emergency department at the local hospital within four hours. As Ms Cay had no means of transport, he offered to call Ms Cay a taxi, which she accepted. This was not heard by the triage operator. The call appeared to stall and was then disconnected on Ms Cay's end.

33. Ms Cay walked home at approximately 2.00am or 3.00am on 21 June 2016.

34. On 22 June 2016 at approximately 3.00pm, Ms Cay was discovered deceased at home by her mother and son, Seth.

35. Dr Heinrich Bouwer, Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, provided a report that concluded that the cause of death was bleeding from a ruptured spleen due to blunt force trauma inflicted on Ms Cay's torso.

THE CORONIAL INVESTIGATION

36. Ms Cay's death was reported to the coroner as her death appeared to be unnatural or violent or to have resulted from injury and therefore was within the definition of a reportable death pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**).

37. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[10] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[11]

38. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[12] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[13] or to determine disciplinary matters.

[10] Section 89(4) *Coroners Act 2008* (Vic).
[11] Preamble and section 67 *Coroners Act 2008* (Vic).
[12] *Keown v Khan* (1999) 1 VR 69.
[13] Section 69(1) *Coroners Act 2008* (Vic).

39. The expression '*cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

40. For coronial purposes, the phrase '*circumstances in which death occurred*'[14] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

41. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of comments and recommendations by coroners.

42. The coronial investigation in this case was undertaken by a member of Victoria Police who was appointed as the coroner's investigator, Homicide Squad Detective Senior Constable Lisa Metcher. A coronial brief was prepared.

43. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[15] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[16]

44. Following Ms Cay's death, the State Coroner had original carriage of this investigation. In March 2019 Coroner Carlin took over the investigation and held a Directions Hearing on 22 August 2019. Following Coroner Carlin's appointment to the County Court in September 2019, I took over this investigation.

45. As Mr Turner had been charged with an indictable offence in relation to Ms Cay's death, this was not a case where an inquest was mandatory. [17]

46. Mr Heath Cay, Ms Cay's brother, requested an inquest. Following consideration of the submissions from the parties and the expert report, I granted his application to hold an inquest. A further Directions Hearing was held on 5 August 2020 to finalise the scope of the inquest and witness list.

[14] Section 67(1)(c) *Coroners Act 2008* (Vic).
[15] Re State Coroner; ex parte Minister for Health (2009) 261 ALR 152.
[16] (1938) 60 CLR 336.
[17] Section 52(3)(b) *Coroners Act 2008* (Vic).

SCOPE OF THE INQUEST

47. As a result of advice from the Coroners Prevention Unit and the expert report from Mr Akhtar Sayed-Hassen, it appeared that Ms Cay's medical management at Port Fairy Medical Centre and the Warrnambool Hospital was reasonable. On this basis, Ms Cay's medical management did not form part of the inquest scope.

48. The Coroners Prevention Unit Victorian Systemic Review of Family Violence Deaths (**VSRFVD**) also reviewed the Victoria Police responses to the reports of family violence between Ms Cay and Mr Turner. The review was critical of Victoria Police for taking a cross application family violence order out against Ms Cay as a result of the family violence incident they were called to on 21 January 2016. The Victoria Police Code of Practice for the Investigation of Family Violence, in operation at the time, stated that police must not *'make cross applications for intervention orders.'* The Code of Practice places emphasis on identifying a history of family violence in the relationship, including incidents not reported to police and the history of violence to other members of the family. As at 21 January 2016, Mr Turner had an extensive history of violence towards his mother, which was known to police. He was described by police as the most dangerous offender in Port Fairy and was on a CCO for family violence offences. Taking a cross application out against Ms Cay appears to be in breach of the Victorian Police Code of Practice. Owing to the lack of causal connection and lack of proximity to Ms Cay's death I include this for noting only. The VSRFVD review did not identify any other issues regarding police responses to the family violence incidents between Ms Cay and Mr Turner and did not identify any missed opportunities for intervention. For this reason, the police involvement in the family violence incidents prior to 18 June 2016 did not form part of the scope of the inquest.

49. Two issues emerged for consideration at inquest. Firstly, the decision by the Ambulance Victoria clinician to down grade the response to Ms Cay's 000 call from Code 1 to Code 3 and the decision by the triage operator to cancel the ambulance attendance. Secondly, the management of Mr Turner's CCO by Community Corrections Victoria with regards to monitoring and responding to his non-compliance with conditions of the order.

50. The scope of the inquest was formulated as follows:

    (a) What was Emergency Services' decision-making process in downgrading Ms Cay's request for an Ambulance from Code 1 to Code 3 and eventually cancelling Ambulance attendance?

(b) What Emergency Services training, policies and procedures have changed since Ms Cay's death?

(c) Was Ms Cay's death preventable if an Ambulance had responded to the Emergency Services call from Ms Cay on 21 June 2016?

(d) Whether Corrections Victoria training, policies and procedures have changed since Ms Cay's death in response to:

(i) the recording and monitoring of non-compliance by Mr Turner on his CCO;

(ii) the timeliness of actions taken to address non-compliance by Mr Turner on his CCO;

(iii) the use of family violence risk assessments as they relate to the case management of Mr Turner on his CCO;

(iv) the recommendations made by the Correction's Internal Management Report dated 8 August 2016; and

(v) similar issues of non-compliance by offenders managed by Community Corrections in four other open coronial investigations that tend to identify a systemic trend in monitoring and responding to non-compliance.

Evidence from Ambulance Victoria

51. In coronial investigations involving organisations which serve the public, such as Ambulance Victoria and Community Corrections, the coroner is interested in any internal reviews conducted by those organisations and what, if any, changes have been implemented since the fatal incident.

52. To that end, by letter dated 10 November 2017, Coroner Carlin requested Ambulance Victoria provide relevant policies, procedures and training materials and advice whether the actions taken by Ambulance staff were in accordance with policies, procedures and training and whether Ambulance Victoria had conducted any internal review and any changes implemented.

53. The information provided to the coronial investigation from Ambulance Victoria about the internal reviews was incomplete and piecemeal. Statements about the reviews rather than the reviews themselves were provided, which did not always accurately reflect the review

findings.[18] On day four of the Inquest, I was provided with four internal reviews conducted by Ambulance Victoria.[19]

54. I acknowledge the experience and organisational knowledge of the Ambulance Victoria officers who conducted the internal reviews, or who gave their assessment as to whether action by staff complied with policies.

55. From an organisational learning and prevention perspective, I have had regard to the recommendations and subsequent changes implemented by Ambulance Victoria following Ms Cay's death.

56. On reflection, the evidence at the Inquest would have been much clearer if Ambulance Victoria had responded to the initial request from the court for information by providing all the internal and any external reviews conducted, including any recommendations and changes implemented. It was ultimately unhelpful to have multiple statements from staff, each giving their assessment of the appropriateness of staff action against policies and procedures, in addition to the multiple internal reviews, including those produced mid way through the inquest.

57. It is unclear why Ambulance Victoria undertook the number of internal reviews it conducted, in addition to an external Investigation report and Root Cause Analysis. Coronial investigations would be assisted by greater clarity from Ambulance Victoria regarding its internal and external investigation methodology.

FINDINGS

Identity of the deceased pursuant to section 67(1)(a) of the Act

58. On 22 June 2016, Seth Clay visually identified his mother, Kylie Jane Cay, born 22 March 1972.

59. Identity is not in dispute and requires no further investigation.

[18] Suffice to refer to Robert Fergusson's statement at CB 1010 compared with Exhibit 38.
[19] Riskman clinical review (the Jennings report) 8 September 2016 (Exhibit 27), Minor communication case review (of referral service triage) report 27 July 2016 (Exhibit 37), Clinical case review report by R Ferguson & G Robertson 13 December 2017 (Exhibit 38), Clinical case review report Full, 27 July 2016 (Exhibit 39), Clinical case Review Report 23 June 2016 (Exhibit 40).

Medical cause of death pursuant to section 67(1)(b) of the Act

60. On 23 June 2016, Dr Heinrich Bouwer, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination and provided a written report, dated 6 October 2016. In that report, Dr Bouwer concluded that a reasonable cause of death was "*Haemoperitoneum due to ruptured splenic subcapsular haematoma in the setting of blunt force trauma to the torso*".

61. The toxicology results were non-contributory to death.

62. I accept Dr Bouwer's opinion as to cause of death.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the Act

Was Ms Cay's death preventable if an ambulance had responded to the Emergency Services call on 21 June 2016?

63. Mr Akhtar Sayed-Hassen, Director of Surgery at Eastern Health, provided an expert report for the coronial investigation regarding whether Ms Cay's death was preventable. He concluded:

'*At 1243 on the 21 of June 2016 the situation was clearly reversible. At 0300 am it remained so, if it was addressed promptly with resuscitation. A few hours later that would become increasingly less so*.'[20]

64. As Ms Cay had been able to walk home at approximately 3.00am, he stated:

'*It is unlikely that she would be able to achieve this if she was in a state of significant haemorrhagic shock at that point.*

If she was collected by ambulance in that time frame and fluid resuscitation started it is likely that she would have reached hospital in a reasonable state. Once having reached a hospital, if there were no further major delays then a procedure performed in the subsequent hour or so is likely to have been successful.'[21]

65. Mr Sayed-Hassen stated symptoms, such as worsening abdominal pain after discharge from hospital, should be of concern. Other symptoms such as left shoulder pain, shortness of breath and restlessness were subtle and complex symptoms, concluding that *'the changes in multiple*

[20] CB 1106.
[21] CB 1101.

symptoms would point to an evolving situation. It would be difficult over the phone to establish what that situation might be.'[22]

66. In cross examination Mr Sayed-Hassen maintained his position that, as Ms Kay was able to walk home from Mrs Turner's house at 3.00am, '*So we know her blood pressure was okay at about 3 am…*'[23] suggesting she was not in shock at this point.[24] He was of the view Ms Cay's condition became irreversible sometime after 3.00am[25] and agreed by an 'educated guess' that this occurred probably between 4.00am and 5.00am.[26]

67. A discrepancy arose regarding the timeline of events as the 000 call was made at 12.43am – Mrs Turner stated that Ms Cay stayed at her place for about 'an hour' and that Ms Cay walked home at 'about 0300'.[27] The question arose as to whether Ms Cay went home at 2.00am or 3.00am. An 'educated guess' by Mr Sayed-Hassen as to when Ms Cay's situation became 'irreversible,' between 4.00am and 5.00am does not alter his expert evidence that her death was preventable if an ambulance had attended following the 000 call at 12.43am.

68. Mr Sayed-Hassen confirmed cases of secondary splenic injury and delayed rupture *not* in the context of a car accident were '*exceedingly rare*,' and '*… in fact the number of cases in the literature worldwide would be probably in a number of fingers on a hand*'.[28]

69. This diagnosis however was not necessary for the purposes of the Ambulance Victoria response, which was to determine whether Ms Cay needed to be transported to hospital given her presenting symptoms.

70. On this point Mr Sayed-Hassen was asked about his summary at point 3 of his report where he states:

'*The second call to the patient was quite instructive to me insofar that the paramedic was trying to establish detailed clinical findings that a lay person would probably not be able to understand or answer. Let alone a distressed person who was in pain*.'[29]

[22] CB 1103.
[23] T 445.
[24] T 449.
[25] T 450.
[26] T 451.
[27] CB 449.
[28] T 462.
[29] CB 1106.

71. In cross examination he noted:

> '*So, this scenario I actually was concerned about, in the sense that the person was asking her fairly deep questions about potential complications of rib fractures … The problem was once she couldn't answer them, and the second thing was the determination would be, in my mind, where's the line drawn in terms of, 'We need to see this person in hospital' and compared to trying to make a diagnosis over the phone, which is difficult and impossible …*'.[30]

Conclusion

72. I accept Mr Sayed-Hassen's expert opinion and find that Ms Cay's death was preventable if an ambulance (or taxi) had responded to the 000 call and taken Ms Cay to hospital.

What was Emergency Services' decision-making process in down grading Ms Cay's request for an ambulance from Code 1 to Code 3 and eventually cancelling ambulance attendance?

73. The inquest heard direct evidence from Jessica Taylor from the Emergency Services Telecommunications Authority (**ESTA**) and Daniel Staff and Jarrod Freckleton from Ambulance Victoria.

000 call

74. ESTA provides call-taking and dispatch functions for Ambulance Victoria, as well as Victoria Police and Fire services. The ESTA call takers receive calls for ambulance assistance from members of the public via Telstra's E000 service.

75. The calls are processed by ESTA in accordance with Ambulance Victoria Service Delivery Requirements (**SDR**), which comprise Standard Operating Procedures (**SOP**).[31] The SOPs outline the procedure to be followed for the taking and dispatching of calls for ambulance attendance.[32] The Ambulance Victoria SDRs require ESTA to use a formal structured methodology to question and answer calls, the software version is ProQA which populates the Computer Aided Dispatch (**CAD**) operated by ESTA call takers.[33]

76. ProQA is a Medical Priority Dispatch System which has 32 different protocols for the call-taker to select from. The key questions are specific to the protocol and designed to obtain relevant

[30] T 465.
[31] CB 1108.
[32] CB 1109.
[33] Although Ambulance Victoria provided the SDR's and SOP's to ESTA, and require ESTA to use ProQA software, there are differences in the 'screen view' and information contained therein, viewed by ESTA staff and Ambulance Victoria staff.

information which the call taker updates in the protocol. The answers are selected from a drop down list of answers. [34] Based on the answers to the questions accepted in the CAD, the program provides an event type determinant. The event type determinant determines the priority dispatch ascribed to an event in accordance with the response grid determined by AV.[35] The dispatcher then allocates a resource.

77. The ProQA software is utilised to reduce human error and human discretion in decision making: it records the information inputted and analyses the information to determine the appropriate response determinant. The remarks on the Dispatch Event Information screen is auto-populated as the ESTA call taker enters the answers to questions. Other relevant information can be typed in free hand. [36]

78. During the 000 call at approximately 12.42am on 21 June 2016, the ESTA call taker followed the appropriate ProQA questions to arrive at the event type and created Ambulance event type '30 D3 *Traumatic injuries, chest or neck inj (with diff breathing)*,' the priority dispatch was Code 1 and Priority 1.

79. The call took one minute and 31 seconds, initiated at 12.42am and 11 seconds and the call taker dispatched the ambulance at 12.43am and 47 seconds.[37] Ambulance Unit MYNE7453 was dispatched, which was recorded as 700 metres away from Ms Cay. The Unit was marked as *en route* at 12.45 am and 55 seconds.

80. At 12.46 am and 38 seconds, Daniel Staff changed the event priority from 1 to 3.[38]

Ambulance Victoria response

81. Mr Staff was the Ambulance Victoria MICA Clinician on duty on 21 June 2016. One of the roles of the Ambulance Victoria Clinician is to '*triage assistance via monitoring the Computer Aided Dispatch system and identifying cases that may require reassessment.'*[39] The Ambulance Victoria clinician is '*authorised to assess and alter this coding, where he or she has information that suggests that ESTA's case acuity may not accurately match with a case's event coding*.'[40] Triaging is about '*trying to match the patient's requirements with the best outcome for that*

[34] T 50.
[35] CB 1109.
[36] T 65.
[37] CB 1111.
[38] CB 1126.
[39] Daniel Staff second statement dated 5 November 2020, paragraph 14(c).
[40] Daniel Staff second statement dated 5 November 2020, paragraph 15.

patient and for the community … more broadly.'[41] Mr Staff estimated over a 14-hour midnight shift he could downgrade '*anywhere between a dozen and 50 cases*.'[42]

82. Robert Fergusson listed the clinician's duties in seven bullet points, which include 'Ensuring the clinical needs of patients are appropriately resourced'; and, 'On receipt of additional information, changing response determinants as required.'[43]

Decision to down grade

83. On 21 June 2016, Mr Staff was looking at the Dispatch Event Information screen when Ms Cay's case was generated. He noted the event was entered at 12.43am and his first entry is 12.46am, which '… *suggests I was looking at that screen as the job was created*.'[44] He was looking at the remarks, which detailed the following pieces of information:

'Shoulder & abdo pain, pt has broken ribs. 44 yo female. Pain due to domestic violence episode 4/7 ago,[45] *pt has been to hospital for inj, pain worsening. Offender not o/s. NFD*.'[46]

84. When 'NFD' (no further details) was entered by the ESTA call taker, Mr Staff decided to downgrade the call,[47] taking a minute to make that decision, which he considered was reasonable.[48] He was looking at the information on the Dispatch Event Information screen in the CAD system[49] (which he described as *'... probably the best example of the exact screen shot I was looking at …*').[50]

[41] T 325.
[42] T 112-113.
[43] CB 1011
[44] T 87.
[45] The reference in the remarks to the domestic violence episode being four days ago ('4/7 ago') was not interrogated at inquest. It is unclear why this piece of information recorded by the ESTA operator was inaccurate. The facts establish the violence against Ms Cay occurred on 18 June 2016 so when the 000 call was made in early hours of 21 June 2016 the incident was closer to two and a half days prior. In the transcript of the 000 call (at CB 167) Ms Turner tells the ESTA operator the attack happened 'a couple of days ago.' The reference to '4/7 ago' has then played a role in Mr Staff's decision making. This information was corrected somewhat when Mr Freckleton spoke with Ms Cay and she told him the attack had been, 'A couple of days, one day, I don't know.' (CB 177) Mr Freckleton replied to her 'So given what you've been telling me that this happened a few days ago and you've been in hospital.' (CB 178).
[46] Exhibit 10.
[47] T 113.
[48] T 114.
[49] CB 1123; T 83.
[50] T 83.

85. The information that Ms Cay had been to hospital previously was determinative for him:[51] '*… that particular entry … four days ago and patient been to hospital I think were significant factors, … in my decision to … refer this case for secondary triage*.'[52]

86. In his evidence he stated he did not assume there was no change to Ms Cay's condition following her discharge from hospital,

'*… but at no stage did I exclude the possibility that this patient was potentially very unwell … It would be more accurate to describe my opinion as being that there was a relatively small probability that there had been a secondary deterioration to the patient's condition*.'[53]

87. Mr Staff explained that in considering this small risk, he considered the time criticality, given the injuries were four days old and that the patient had attended hospital,

'*… there was a reasonable chance … those injuries … at the point in time the call was made … were not of a time critical nature … there existed a window of opportunity within which to gather more information …*'.[54]

88. This position is consistent with his statement where he notes rib fractures remain painful and increasing pain without analgesia may be expected,

'*I therefore considered that there was a need to determine whether this patient's condition had deteriorated in a clinically significant manner, or whether she simply required further analgesia.*'[55]

89. Mr Staff agreed that both the discharge from hospital and the description of the four-day old injury operated to reassure him that '*this may of been of less acuity than the dispatch suggested*.'[56]

90. Although he was concerned about the '*pain worsening'*, '*I considered it was … a reasonable course of action to downgrade and refer.*'[57]

[51] T 87.
[52] T 87.
[53] T 92.
[54] T 147.
[55] Exhibit 14 paragraph 25.
[56] T 98, agreeing with Mr Halley.
[57] T 125.

'Difficulty breathing'

91. An issue arose as to whether Mr Staff was aware that the description of the event type, *Traumatic injuries, chest or neck inj* included the words '*with diff breathing'* when he was making his assessment of the coding on the Dispatch Event Information screen.[58] He could not recall how much of the event code on that screen he could see,[59] '*I can't specifically confirm whether the whole part of 'with difficulty breathing' was … visible to me or not.*'[60] He did not recall whether by scrolling over the event type on the Dispatch Event Information screen he would have been able to see the whole text.[61]

92. In any event, although he did not recall seeing the reference to '*with diff breathing',* he stated that this:

'*… would not have altered my assessment of this case in any way. A report of difficulty breathing is a common symptom for a patient reporting broken ribs and pain, following discharge from hospital (indeed, it would have been surprising if the patient had reported no difficulty breathing in the circumstances). It would not have changed my view that this case was appropriately triaged.*'[62]

93. In evidence Mr Staff did not think being aware of Ms Cay having difficulty breathing would have made a significant difference to his decision because:

'*… in the setting of a patient who's been diagnosed with broken ribs I would take it into consideration … it's very common … to have difficulty breathing with broken ribs, … especially when inadequate … analgesia … is on board.*'[63]

94. At 12.46am, Mr Staff downgraded the case from Code 1 'lights and sirens' to Code 3, and at the same time, he cancelled the Air Ambulance response.[64] He did not have regard to the proximity of an ambulance 700 metres from Ms Cay when he made the decision to down grade the event.[65]

[58] Exhibit 9.
[59] T 84.
[60] T 85, Mr Staff repeated he could not recall whether he could see this text or not again at T 102 and T 107.
[61] T 103.
[62] Daniel Staff second statement dated 5 November 2020, paragraph 26.
[63] T 94.
[64] CB 297.
[65] T 111.

95. At 12.47am, he referred the case to Ambulance Victoria Referral Service for secondary triage as per *AV procedure*.[66] When he downgraded the code from code 1 to code 3, he *pre-empted* the ambulance, meaning it was put on hold pending the results of the investigation.[67] He explained this was not an ultimate cancel but put on hold pending further information,[68] meaning the ambulance crew '*would have been informed by the dispatcher that they weren't required at that time*.'[69]

Mr Staff agreed someone might leave hospital and then deteriorate, which was why he referred the case to secondary triage[70] because: '… *what were are attempting to do by performing secondary triage, is to … get … just is to fine tuning that diagnosis to work out whether it's a clinical level of difficulty breathing or whether it's just sore ribs … from inadequate analgesia.*'[71]

96. I find Mr Staff could not recall if he could see the ProQA coding referring to Ms Cay's difficulty breathing, but that even if he did see it, he stated it would not have altered his decision to down grade the case.

97. Given the time spent during the inquest attempting to clarify what information from ESTA was available on the clinician's screen I intend to make a recommendation to the effect that Ambulance Victoria ensures clinicians and referral service triage practitioners are able to access all information taken by ESTA call operators, including the ProQA codes and their descriptions in the Computer Aided Dispatch system.

Compliance with relevant Ambulance Victoria policy

98. The applicable Ambulance Victoria work instruction is Work Instruction Operation (Win Ops) 072.[72] Win Ops 072 details the procedures for the clinician to follow when altering an event priority. It states:

'Where the clinician becomes aware of additional information that suggests the case acuity conflicts with the current response or case coding, he/she:

[66] CB 297.
[67] T 141.
[68] T 141-142.
[69] T 142.
[70] T 132.
[71] T 94.
[72] Exhibit 15.

- *Must investigate and may decide to alter the Event Priority (which could result in a change to the response code and resources dispatched) …* '[73]

99. Mr Staff stated the information he considered was on the Dispatch Event Information screen in the CAD system.[74]

100. Mr Staff stated he 'delegated' the investigation to the Referral Service,[75] and that Ambulance Victoria gave him the authority to delegate that responsibility.[76] He further stated, '*I was … requesting further investigation by them …*'.[77] In his view, referring the case for secondary triage rather than investigating it himself was consistent with processes and procedures applicable at the time for the clinician's role.[78] Mr Staff's evidence was that Ambulance Victoria gave him '*authority to delegate that responsibility.*'[79] Mr Staff also cited an email from Ambulance Victoria Operational Communications Support dated 5 May 2014 confirming, '*it was perfectly acceptable for clinicians … to refer cases to REFCOM … for the specific purpose of performing that … triage and investigation.*'[80]

101. In his internal review, Mr Fergusson notes:

'*It should be noted however that the Clinician's downgrade was possibly not in accordance WIN/OPS/072, subsection 2.4 which says they 'must investigate' prior to deciding to alter the evnt priority. The extent of investigation is not clarified and there is an apparent conflict with subsection 2.1.*'[81]

102. In his evidence, Mr Fergusson did not accept the clinician could delegate the requirement to investigate in Win Ops 072 at 2.4, although he noted in the report the meaning of *investigate* was not clarified.[82] In any event, his review concluded; '*There are no issues with the actions of the clinician.*'[83] He found the clinician's decision to down grade found it was reasonable and accorded '… *with AV policy and usual practice at the time.*'[84]

[73] CB 1229, Exhibit 15.
[74] Exhibit 9.
[75] T 133.
[76] T 134.
[77] T 164.
[78] T 150.
[79] T 134.
[80] T 152.
[81] Exhibit 38 page 3
[82] T 253.
[83] Exhibit 38 page 6
[84] CB 1014.

103. Lindsay Bent, an Ambulance Victoria clinician, stated the three Ambulance Victoria policies and procedural requirements for clinicians as at June 2016, detailed in Win Ops 072, 108 and 302, '*were met by the AV clinician*.'[85]

104. I find Mr Staff downgraded the event priority from grade 1 to grade 3 without any *additional information* or undertaking any *investigation*.

Whether family violence was a consideration

105. Mr Staff was asked about the significance or relevance that Ms Cay's injuries were caused by domestic violence. He described this information as a *neutral* factor in his consideration to down grade the case priority.[86]

Conclusion

106. Mr Staff agreed that down grading a Code 1 to a Code 3 was '… *definitely … not a decision that's taken lightly …*'[87] It is evident that Mr Staff had taken significant comfort that Ms Cay's injuries were four days old, and her recent hospital attendance, but not so much that he discounted the possibility of a subsequent deterioration. I accept his explanation that Ms Cay's *difficulty breathing* was to be clarified at triage whether this common symptom of broken ribs was an indicator of an actual deterioration or one merely requiring pain relief.

107. Whilst Mr Staff's decision-making process was explained, it is clear he did not comply with the Win Ops 072 policy which, at 2.4, requires consideration of additional *information* and an *investigation*. He only had regard to the remarks on the Dispatch Event Information screen, he did not click on any other screens in the CAD system, and he did not investigate. Mr Staff downgraded the code from Code 1 to Code 3 before the additional information was sought. His evidence was that he delegated the investigation to the triage operator. It was conceded by Mr Fergusson that 'investigate' is not explained.

108. Ambulance Victoria has accepted, as an organisation, it failed Ms Cay and her family. It has defended the actions of its staff including Mr Staff, on the basis that he '*acted in a manner that did not depart from the expected norm as at the time … given the system that operated at the*

[85] CB 1640.
[86] T 131.
[87] T 111.

time.'[88] The witnesses from Ambulance Victoria, Mr Fergusson and Mr Bent, attested Mr Staff's actions were '*in accordance with AV's policy and usual practice at the time*.'

109. Given the evidence of Mr Staff, and the wording of the work instruction, his actions were clearly not in accordance with the applicable Ambulance Victoria policy at the time. The position of both Ambulance Victoria and senior staff supported Mr Staff's decision making as complying with the policy and usual practice. This suggests an organisational awareness that the practice in place for downgrading priority events by referring cases to secondary triage was knowingly inconsistent with workplace policy.

110. It was not raised in evidence why this might be so, but Mr Staff gave evidence of referring 12 to 50 cases the referral service for secondary triage each shift. This suggests many decisions may have been made, not in accordance with the written Ambulance Victoria policy. This is surprising for an organisation that uses IT tools such as the ProQA questions for ESTA operators and Care Enhanced Call Centre (**CeCC**) triage tool for triage practitioners, both of which are designed to enhance the uniformity of decision making and reduce or remove individual discretion.

111. The evidence that a significant number of cases (up to 50) may be down graded and referred to secondary triage per shift reflects the time pressured nature of the decision-making environment. This was also confirmed by Mr Fergusson's evidence that when the clinician makes a decision to refer a case to secondary triage, based on the remarks by the ESTA operator, there was no expectation that a clinician would 'scroll on an event type' or 'open a second screen.'[89]

112. Policies are generally formulated to shift organisational norms and ensure best practice and a consistency of decision making in organisations against a prescribed criterion for the delivery of services. The Ambulance Victoria internal documents are called 'Work instructions' suggesting they are the practical applications of policy. Ambulance Victoria and its senior staff described Mr Staff's non-compliance, as the '*expected norm*', '*given the system that operated at the time'*. Senior staff went further actually describing Mr Staff's actions as '*in accordance with AV's policy*.' Ambulance Victoria should consider an audit to ensure alignment between policies and internal compliance, and the need to address discrepancies with specific training

[88] Ambulance Victoria submission dated 4 December 2020.
[89] T 331-2.

and education so that policies are meaningful and reflect process. I intend to make a recommendation to this effect.

Referral to the Referral Service

113. The primary role of the Referral Service, or the 'RefCom paramedics' is to conduct secondary triage on 'Code Three' cases. The RefCom operator must send an ambulance if the triage CeCC tool requires such.'[90]

114. Jarrod Freckleton was the Ambulance Victoria paramedic from the Referral Service, the Triage Practitioner, who took the referral from Mr Staff.

115. On 21 June 2016 at 12.55 am he rang and initially spoke with Ms Turner and then he spoke with Ms Cay.[91]

116. At 1.08am and 47 seconds the chronology notes: '*AV not required; patient advised to attend the ED via pvt means … patient disconnected*.'[92]

117. Mr Freckleton was questioned closely about his decision making during his call to Ms Cay. The recording of the call was played during the inquest and the transcript is in the coronial brief.[93]

Chest injury guideline questions

118. The relevant Ambulance Victoria work instruction was Win Ops 303. [94] This details the referral service triage process by the Triage Practitioner and includes information about making contact with the caller, introductions, asking about presenting symptoms, applying the appropriate guideline, priority rating, conclusion and closure, as well as scripts for opening and closing calls.

119. On 21 June 2016, Mr Freckleton reviewed the information on the Dispatch Event Information screen and asked Ms Cay about her main complaint or the reason for the 000 call, then chose the Chest injury guideline:[95]

[90] CB 1012-3.
[91] CB 305.
[92] CB 1126.
[93] Exhibits 19 and 20.
[94] Exhibit 21.
[95] CB 1264.

'... and in this case Kylie said she had pain in her chest, ... more in her ribs and ... that was secondary to an assault. ... therefore, a chest injury, and that was the guideline I applied. I searched that guideline based on those symptoms.'[96]

120. The triage system is such that questions are asked, and answers are inputted, and a computer-generated response or code is created.

121. Mr Freckleton stated:

'Following our triage guidelines, it recommended that the patient needed to see a doctor with 4 hours. Given the time of the day, I escalated her case and recommended she return to the emergency department via alternative means to obtain further analgesia.'[97]

Mr Freckleton confirmed whilst he could upgrade a case to a higher disposition he could not downgrade it.

122. In applying the triage guideline questions, Mr Freckleton was aware that Ms Cay had '*… medical contact, and an assessment and been discharged and cleared to return home*.'[98] He entered 'no' to the question whether the injury was blunt trauma from a high energy mechanism.

123. He entered 'no' to the second question, of whether there is there new or worsening signs and symptoms that may indicate shock as he assessed Ms Cay as having a significant amount of pain that needed to be managed.[99] He did not believe she was confused in her answers. With respect to Ms Cay saying she can '*hardly breath please hurry up*'[100] and '*I'm about to go unconscious mate*'[101] he stated, '*I thought the way she was answering the questions and using her words in sentences indicated she had ... she was breathing quite well. It was restricted due to pain*.'[102]

124. One question was whether there was 'blunt trauma and deformed chest wall or pain with each breath or any other difficulty breathing.' Mr Freckleton did not ask Ms Cay whether or not she

[96] T 200.
[97] CB 305.
[98] T 211.
[99] T 216.
[100] CB 177.
[101] CB 177.
[102] T 218.

had pain with each breath, however she had told him it hurt to breath, and he conceded he should have entered 'yes', or 'not answered'. [103]

125. If he had entered 'yes,' the disposition given would have been *'Attend ED immediately.'*[104] Despite this Mr Freckleton stated, '*I still would … probably have suggested and started where I did with private means and then the taxi, I don't think it would have changed my approach to start with*'[105] or '*a non urgent ambulance to transport her*.'[106]

126. When asked about his knowledge of the availability of taxis at 1.00am in Port Fairy, he stated if a taxi was not available, he would have suggested a non-urgent ambulance to transport her.[107] Mr Freckleton did not hear Ms Cay ask him to go ahead and call a taxi for her.[108] Mr Freckleton was not aware what taxi services were available in a rural area at that time of night. He did not explore transport options when Ms Cay said she could not attend hospital by her own means.

Recent hospital attendance

127. Like Mr Staff, Mr Freckleton was reassured by Ms Cay's recent hospital attendance, and did not regard it as a cause for concern.[109] He stated it was '*really significant'* that Ms Cay told him, in the conversation prior to him selecting the chest injury guideline,[110] that she had been discharged from hospital today, '… *cause they've been deemed medically safe … to return home*.'[111]

128. From the Dispatch Event Information screen[112] he could see that the ambulance had been 'pre-empted' and was pending.[113] He could also see Ms Cay's injuries were considered to be four days old and had been assessed in hospital, which he said was '*re-assuring*.'[114] He explained, '… *as far as I would have been aware and what I was thinking, based on that information, is that they've been assessed in hospital and cleared and discharged to go home*.'[115]

[103] T 221.
[104] T 222.
[105] T 223.
[106] T 224.
[107] T 224.
[108] T 225.
[109] T 230.
[110] T 203.
[111] T 203.
[112] CB 1123; Exhibit 9.
[113] T 192.
[114] T 193.
[115] T 193.

129. When Mr Feckleton spoke with Ms Cay she told him the attack had been, '*A couple of days, one day, I don't know.*'[116] Mr Freckleton replied to her a little later, '*So given what you've been telling me that this happened a few days ago and you've been in hospital.*'[117]

130. Mr Freckleton was aware Ms Cay had been in hospital that day and stated it was *uncommon* for people to significantly deteriorate once they have left hospital.[118]

131. Mr Fergusson made the point that the guidelines '*mainly address primary incidents. They do not factor in patients who have been treated in hospital and discharged with a diagnosis and management plan*.'[119] Mr Fergusson regarded this as a potential weakness with the guidelines, '*because largely … we respond to primary incidents and so it is I guess complicated by the fact if someone's already had … a previous diagnosis or hospital admission*'.[120]

Disconnection of the call

132. The applicable policy is Win Ops 308, and at 2.1.5 states:

> '*Where secondary triage is terminated by the caller: if triage reached a disposition below 'activate 000' and this has been advised to the caller then this is the final disposition / health management outcome and the case is to be closed in CAD.*'[121]

133. Mr Freckleton did not confirm with Ms Cay that all symptoms had been discussed, and he did not provide care advice and risk management advice to re-establish contact with 000 in the event of a change in her condition.[122] He did not have the opportunity to do this as there was a period during the call when he believed she was discussing options with the person with her, and then he '*waited on the line for someone to return and they never did and the call disconnected before I did*.'[123] Mr Freckleton did not call Ms Cay back.

134. The triage guidelines recommended the patient see a doctor within four hours, given the time of day he stated, '*I escalated the case and recommended she return to the emergency*

[116] CB 177.
[117] CB 178.
[118] T 194.
[119] CB 1018-1019.
[120] T 297.
[121] CB 1251.
[122] T 225; CB 1247.
[123] T 227.

department via alternative means to obtain further analgesia.'[124] He offered to contact a taxi which Ms Cay declined due to financial reasons.

'*After speaking about the taxi the patient disconnected the call. The Operational work Instructions were such that 'when we have reached this above point and the patient disconnects, we are not required to return their call and we cancel the ambulance request.*'[125]

135. The guideline stated if a call was terminated and the disposition had been decided then the case was to be closed.[126]

136. Mr Freckleton stated he did not hear Ms Cay drop the phone and he did not hear her say '*Go ahead, please*' after he offered to call her a taxi.

Whether family violence was a consideration

137. Mr Freckleton was aware Ms Cay was the victim of domestic violence, he agreed '*it simply wasn't relevant*' to the task he was performing, other than in relation to mechanism of injury.[127] However, he did not ask her how the injuries had been caused to ascertain the mechanism of how the domestic violence had caused her injuries.

138. Mr Becker noted that in June 2016 neither the training nor the procedures offered to Referral Service Triage Practitioners or the relevant procedures '*emphasised the need for RSTP's to ensure that vulnerable patients could carry out recommended actions with regards to self-care.*'[128] He noted that 'All Referral Service Triage Practitioners and Team Leaders undertook a 2 day face to face training program on vulnerable patients and communication techniques.'[129]

139. Mr Freckleton was not able to confirm whether he had completed the training program on vulnerable patients and communication techniques.[130] I intend to make a recommendation that Ambulance Victoria audit their training implementation to ensure all staff have completed the training referred to by Mr Becker.

[124] CB 305.
[125] CB 306.
[126] T 242.
[127] T 230.
[128] CB 1605-1606.
[129] CB 1606.
[130] T 230-231.

Conclusion

140. Mr Freckleton was reassured by the fact Ms Cay had been to hospital. This was significant information to him compared to what Ms Cay was telling him. Mr Staff had similarly taken the view the information about hospital attendance was 'determinative.'

141. Mr Freckleton acknowledged he should have answered *yes* to the chest injury question regarding whether Ms Cay had blunt chest trauma and difficulty breathing. This impacted the priority allocated to the call, which was to attend Emergency Department immediately, rather than attend Emergency Department in four hours.

142. In my view during the phone call he dismisses the information Ms Cay is relaying to him, telling her, '*for this you don't need the emergency ambulance*' and when she replies '*I do, I'm telling you*,' he replies '*No, no, not – not for this you don't because this isn't a medical emergency you need some pain relief.*'

143. She states '*I can barely hold that phone …'* and that she has taken pain relief an hour ago, the pain is in the ribs and shoulder blade, the pain medication is not working, it has occurred as a result of a domestic violence incident, '*I can hardly breath please hurry up'*, '*I can't talk … I'm about to go unconscious*', '*nearly vomiting*', '*I need an ambulance now … pain*,' '*I've had pain relief and it's not working',* she says offside (presumably to Mrs Turner), '… *they won't send an ambulance'* and then when told by Mr Freckleton, '*our suggestion is that you need to see a doctor*' she states '*Are you fuckin' kidding me?*'. The call ends.

144. Mr Freckleton did not hear Ms Cay state '*go ahead'* to order a taxi for her. This was a prevention opportunity lost for Ms Cay to be driven to hospital for treatment for her injuries.

145. As the call ended at Ms Cay's end, the closing remarks in the script, including to call 000 back were not communicated to Ms Cay. In any event, Ms Cay would not have been able to call 000 back once she left Mrs Turner's house as Mr Turner had previously smashed her mobile phone.[131]

146. Mr Freckleton did not listen to Ms Cay's answers: he missed crucial information by not noting the importance of her stating she can '*hardly breath*,' further, when she tells him the incident

[131] CB 435-436.

occurred '*two days, one day, I don't know*' which he re-states to her as '*a few days ago*,' and when she said to him to go ahead and call a taxi.

147. There is a period prior to the call ending, which comprises some 30 seconds of muffled sounds, with Ms Cay was still on the line, but not speaking into the phone. At no point during that period did Mr Freckleton say her name or call out in an attempt to elicit a response or attract her attention. The call fades out and disconnects. By not calling Ms Cay back when the call was disconnected Mr Freckleton was complying with the terms of Win Ops 308.

148. The call is not an example of either active listening or an empathetic approach. Ms Cay appeared to have difficulty understanding and responding to some questions. Her language and expression indicate she was not able to effectively advocate on her own behalf. When Ms Cay states '*I can't get to the hospital*' she then states, '*there's no-one to take me,*' to which Mr Freckleton says, '*Is there someone I can call for you*,' to which she re-states: '*…no, you don't understand, there's no-one to take me*.' [132] Mr Freckleton's responses demonstrated a lack of listening.

149. This attitude appears to have been addressed to some extent by the implementation of training described below. Mr Fergusson's evidence was that today there would be greater understanding of that background of domestic violence,[133] and in his view it would have some effect on the triage practitioner as there has been subsequent education and training around domestic violence, vulnerable patients and *'they are referred to specialist call takers to handle that call.'*[134] It was his understanding a similar call by someone in Ms Cay's position today would be referred to a mental health nurse.[135]

150. In his report, Mr Fergusson states: '*It should be noted that since this case, additional training has been provided to RSTP's in the form of 'sensitivity training'. This was conducted by a psychologist with the emphasis on finding a balance between empathy and logic. Had this been in place prior to this incident it might have better equipped JF to respond to the emotional circumstances of the patient.*' [136]

151. Mr Anthony Carlyon, Executive Director, Operational Communications, Ambulance Victoria made a statement and gave evidence about the recommendations implemented by Ambulance

[132] CB 180.
[133] T 320.
[134] T 321.
[135] T 322.
[136] Exhibit 38 page

Victoria following a London Protocol investigation following Ms Cay's death. One of the recommendations was to train RefCom operators and clinicians to recognise and manage vulnerable patients. Mr Carylon noted that '… *our understanding of vulnerability and family violence, domestic violence now is far greater than it was at the time*.'[137]

152. Mr Fergusson and Mr Becker both vindicated Mr Freckleton's decision making. Mr Fergusson confirmed his conclusion that Mr Freckleton undertook his management of Ms Cay '*in accordance with the Ambulance Victoria guidelines*'[138] and Mr Becker stated, '*It is my view that the procedural requirements that were in place at the time, were met by the AV RSTP triaging this case*.'[139]

153. I find that if a taxi or a non-urgent ambulance had been sent by Mr Feckleton, it is highly likely, given Mr Sayed-Hassen's opinion, that Ms Cay's death would have been prevented.

154. It appears the ProQA software system utilised by ESTA arrived at the correct code, namely Priority 1, Code 1 for Ms Cay in this case. It was the capacity for human discretion in the decision making, firstly by Mr Staff who downgraded the priority from Code 1 to Code 3, and then by Mr Freckleton who cancelled the ambulance, that led to Ms Cay not receiving the ambulance she needed. The ProQA computer program arrived at the correct result.

What Emergency Services training, policies and procedures have changed since Ms Cay's death?

155. The Royal Commission heard evidence that Ambulance Victoria had commenced work to develop a clinical practice guideline and policy framework to support the identification and management of patients who are either experiencing or at risk of family violence.[140]

156. The Root Cause Analysis recommendations were:

(a) credentialing the AV clinician's role (to be completed by 2019);

(b) training of REFCOM and clinician staff to recognise and manage vulnerable patients (to be completed 31 December 2018);

(c) specialist mental health staff to be available for referral and advice for family violence and mental health cases (has been implemented);

[137] T 509.
[138] T 349.
[139] CB 1605.
[140] Report of the Royal Commission in Family Violence, volume 4, pp 21-22.

(d) implement a peer to peer audit system for all referral staff to access (due for completion 31 November 2018); and

(e) implement a process to ensure all calls that are dropped or hung up on by patients are re-called (has now occurred).[141]

157. The most recent iteration of Win Ops 072 was approved on 11 September 2020.[142] This outlines the clinician's responsibilities when considering changing an event priority. This now contains a special note:

'*Event downgrades in association with patients who have re-presented for the same non-acute/sub-acute complaint should be performed with extreme caution, taking into consideration all clinical possibilities and potentially emerging clinical deterioration due to a clinical assessment that may have missed a critical aspect of potential cause*.'

158. As noted, Ambulance Victoria identified, '… *that this work instruction lacked detail regarding specific steps the Clinician must undertake when assessing events potentially suitable for downgrade*.'[143] Win Ops 072 includes the *Special Note*, and the intent of the change was to capture the cohort of patients who may have sought some clinical care, and then re-presented for an ambulance, and that such cases should be approached with *extreme caution*.[144] This change was *'certainly prompted'* by the death of Ms Cay.[145] This change is in direct response to the false comfort taken by Mr Staff and Mr Freckelton who were both reassured by Ms Cay's earlier hospital presentation. It is now regarded as a red flag rather than a reassuring factor. [146]

159. The updated Win Ops 072 now requires the clinician to follow 10 steps when altering event priority to inform decision making. This now clarifies what is meant by *investigation* which includes accessing all the information available, include reviewing the structured call taking window, event details and remarks in the CAD and, if appropriate, seeking additional information from the caller if clarification is required. Further, the clinician must review where the allocated responding unit is and how far away they are from arriving. This is presumably in response to this case, where the ambulance initially dispatched was only 700 m away from Ms Cay's location.

[141] CB 1024.
[142] Exhibit 29.
[143] CB 1642, 1643.
[144] T 360.
[145] T 361.
[146] T 380.

160. Mr Staff regarded family violence was a *neutral* factor in his decision-making. This reflected Ambulance Victoria's lack of policies or flags at the time of Ms Cay's death.

161. Mr Bent detailed reforms such as a document, *DHHS Vulnerable people in emergencies 2018*, which has now been included as part of the clinician training program.

162. Mr Fergusson noted the AV internal review recommended that where a Clinician is considering whether a case is to be downgraded by two levels, '*the Clinician will call the patient back and confirm through their clinician assessment to down grade the case or leave it as requiring a Code 1 response*.'[147] Mr Fergusson confirmed this has been implemented.

163. Further, work is underway to develop a Clinician credentialing process to make it more robust and align to a national standard, due for completion in November 2020. Mr Bent's statement also refers to the Clinician model being re-designed, '*taking on a State-wide approach to pre-hospital health care and enhanced clinical oversight and governance*.' [148] It is not clear what is meant by this.

164. Mr Becker made a statement which included *Improvements made to AV policies and procedures.* He gave evidence that the CeCC triage application has been replaced and the new system uses a Vasium logic, which '…*allows for a far more … conversational … triage …*'.[149]

165. Mr Becker explained under the 2016 version if you did not get a yes or no answer, then you could not progress to the next button.[150] This meant that when there was partial, conflicting or ambiguous information it was difficult for the Ref Com operator to progress.

166. Mr Becker detailed that training about vulnerable patients has been introduced for RTSPs and Team Leaders. The new triage application includes questions to examine 'non-clinical' aspects of the vulnerable patient, including *'Has there been an 'In Hospital emergency or admission in the last 2 weeks?'*[151] His evidence was the new system was introduced in 2018 and includes questions regarding domestic violence aimed at identifying patients at risk. [152]

[147] CB 1015.
[148] CB 1642.
[149] T 378.
[150] T 385.
[151] CB 1606.
[152] CB 1606.

167. In his view the call to Ms Cay would have been handled differently today because of the questions and logic of the new program.[153]

168. Further, AV will now pay for taxis if self-presentation is deemed a reasonable disposition and the patient has no access to a means of transport. The family's submissions expressed concern about the lack of regional knowledge about transport options, such as taxis outside Melbourne, including whether a taxi service will agree to take a patient to hospital some distance away.

169. Mr Becker noted Ambulance Victoria has implemented a process whereby if self presentation is deemed a reasonable disposition but the patient has no access to means of transport then taxi transport will be arranged at the expense of Ambulance Victoria and tracked by Ambulance Victoria in real time to assure patients of their booking and ETA to confirm the taxi's arrival at the destination. A data base of suburbs and the taxi provider account code has been made available to all referral service triage practitioners. [154]

170. Mental health nurses are now embedded in the Referral service and referral service triage practitioner's may refer a caller who is affected by family violence.

171. There is also a new process if a call drops out or callers hang up for the referral service triage practitioner to conduct a follow up call. [155]

172. It was of some concern that despite the evidence from Ambulance Victoria about the new policies and training implemented following Ms Cay's death, Mr Freckleton was not able to confirm whether he had completed the training program on vulnerable patients and communication techniques.

Role of Community Correctional Services Victoria

173. The inquest scope considered the role of Community Correctional Services (**Community Corrections**) in its management of Mr Turner's compliance with his Community Corrections Order (**CCO**).

[153] T 401.
[154] CB 1606.
[155] T 186; Exhibit 18 & Exhibit 36.

Recording, monitoring and timeliness of actions to address the non-compliance by Mr Turner on his Community Corrections Order

174. Mr Turner was assessed for a CCO at Warrnambool Magistrates' Court on 23 September 2015. He said he would be living with Ms Cay, who lived in the same street as his mother. The assessment report notes:

'*This service has concerns about his intentions of residing a very short distance from his mother's house, and of his intentions of moving in with a partner he has been in a relationship with for a short time and the safety /welfare of her 13 year old son.*'[156]

Mr Turner was sentenced to a three-month term of imprisonment and commenced his CCO on 20 November 2015.

175. Prior to Mr Turner being inducted onto his order, Victoria Police emailed Community Corrections dated 18 November 2015. The email described Mr Turner as, '*the highest risk and worst offender they [police] deal with in Port Fairy and they have major concerns when he is released on 20/11/2015*.'[157]

Community Correctional Services – first review 29 December 2015

176. Sandra Rudge gave evidence about Community Corrections management of Mr Turner's CCO. On 29 December 2015 she conducted a case review of Mr Turner's order which she described as opportunity for the Community Corrections case manager and supervisor to discuss the case. Mr Turner was high-risk priority 1 status.[158] As a high-risk family violence offender, Mr Turner was automatically on an Offender Behaviour Program.[159] The report noted Mr Turner had a long history of family violence against his mother. The report concluded that as Mr Turner is a high-risk offender continually monitored by Port Fairy Police, Community Corrections should *'continue to closely monitor Mr Turner*.' In her evidence, Ms Rudge confirmed Community Corrections did not '*continue to closely monitor Mr Turner*.'[160]

177. Community Corrections' role regarding CCO's is detailed in the *Deputy Commissioner's instruction to the case management of court orders*,[161] which notes that Community Corrections

[156] CB 868.
[157] CB 735; Exhibit 48.
[158] CB 795; T 569.
[159] CB 796.
[160] T 576.
[161] Exhibit 45.

administers the sentences of the court, '… *with an emphasis on ensuring order conditions are implemented and failures to comply are addressed*.'[162] The instructions allow for some latitude, for example when deciding to initiate breaches, and that overall compliance with an Order be taken into account when considering, for example, a positive urine screen result.[163]

Community Corrections review of Mr Tuner's compliance

178. Following Ms Cay's death, Ms Rudge conducted an internal management review and an audit of the Community Corrections file. Ms Rudge pointed out that Community Corrections does not have the power to compel or force an individual to comply with a Community Corrections Order or a power to arrest.[164]

179. I propose to make a recommendation that Community Corrections implement an electronic case management system to enhance their ability to monitor compliance with Community Corrections Orders. One need look no further than Ms Rudge's hand written calculations of Mr Turner's compliance in the review she conducted following Ms Cay's death, tendered as Exhibit 49 [165] as evidence in support of this recommendation.

180. The terms of reference of the review conducted by Ms Rudge included reviewing Mr Turner's 20 unacceptable absences, the management of Mr Turner's compliance with the mental health condition, his compliance with the condition for drug and alcohol counselling and attendance at the Sliding Doors program, whether Mr Turner's non-compliance was discussed at his Judicial Monitoring hearing on 29 February 2016, and whether a contravention was warranted at that stage.

181. The *Deputy Commissioner's instructions for noncompliance management of court orders*[166] required that, as a priority 1 offender, any non-compliance by Mr Turner had to be investigated on the day the case worker found out about it.[167] When a priority 1 offender has had three or more unacceptable absences, there are tiered levels of intervention available, such as a compliance meeting or a contravention. The *Deputy Commissioner's instructions* state that if a priority 1 offender has three or more unacceptable absences, activating an intervention should

[162] T 530; Exhibit 45.
[163] T 531.
[164] T 527.
[165] CB 622-626.
[166] Exhibit 46.
[167] T 539.

be considered.[168] If a contravention decision is made, a case manager has two weeks to approve the contravention, and then six weeks to issue a summons.[169]

182. An analysis of Mr Turner's compliance indicated that:

(a) 5 January 2016 - he had accrued two unacceptable absences and a positive urine screening, meaning at that point it was a flag for some action to be taken by a senior officer.[170]

(b) 2 February 2016 - Ms Rudge stated there should have been '*at minimum a compliance meeting which would have explored more of the risk factors*.'[171]

(c) 13 February 2016 - Mr Turner had three unacceptable absences which should have triggered an intervention.

(d) 18 February 2016 - there was a need for a senior caution, should the situation get worse, which it did immediately after 1 March 2016.[172] 26 February 2016 a manager's warning could have been given.[173]

(e) 31 March 2016 - Mr Turner had 14 unacceptable absences[174] and should have been referred for an administrative review hearing, which would have taken two to four weeks to organise.[175]

(f) 17 April 2016 - Mr Turner had accrued 18 breaches.

(g) 22 April 2016 - the decision was made to breach Mr Turner[176]

In hindsight, Community Corrections determined Mr Turner should have been breached or intervention should have occurred on 5 April 2016.[177]

[168] CB 1383.
[169] T 542.
[170] T 558.
[171] T 563.
[172] T 600.
[173] T 654.
[174] T 590.
[175] T 654.
[176] T 587.
[177] T 595.

183. I accept the submissions by Ms Cay's family that a contravention should have been considered as early as February 2016, either by way of an administrative review hearing, or an interview and case manager's warning during supervision. [178]

184. The policies in force in 2016 were such that Mr Turner could have been held to account by Community Corrections regarding his non-compliance with his Community Corrections Order, whether by a warning, a caution, or an administrative review hearing, but he was not.

185. The case manager's internal compliance with managing the order was audited with scores for compliance of 67.86% in February 2016, 56.25% in June 2016 and 59.38% in August 2016. Community Corrections considered a score of 80% compliance was acceptable. Ms Jenny Roberts, Acting Executive Director, West Area Justice Services, Department of Justice and Community Safety, stated that training and support for staff has since been strengthened and that Mr Turner's case would have been managed differently today.[179] Despite the deficiencies identified by the internal audit in February 2016 , many remained unaddressed in June 2016.

Mr Turner's judicial monitoring

186. At Judicial Monitoring on 1 March 2016, Mr Turner's recent noncompliance was not recorded in the Report for the magistrate, nor was the incident involving police on 22 January 2016 and the subsequent intervention order. It did not accurately reflect Mr Turner's non-compliance, for example the report referred to five unacceptable absences which by the time of the hearing should have been eight[180] and it implied that he had complied with his mental health condition and had participated in two appointments, when this had not been confirmed. Mr Turner had failed to attend for two inductions to the 'Sliding Doors program' and these dates were not included in the Judicial Monitoring report. The review by Ms Rudge found the information was presented in a way that indicated Mr Turner, despite the absences, was addressing his risk factors and was engaging in supervision. Ms Rudge agreed the report could potentially have misled the judicial officer because it did not paint the complete picture.[181] A senior caution or an administrative review would have been appropriate given the content of the Judicial Monitoring report.[182]

[178] Cay family submissions, page 8.
[179] T 681.
[180] T 581.
[181] T 584-585.
[182] T 601.

187. Breach proceedings against Mr Turner were authorised in April 2016 and a charge and summons was issued on 3 May 2016. The first listing of the case at court was 20 June 2016, which was two days after the assault that resulted in Ms Cay's death.

188. The Sentencing Advisory Council 2017 report, *Swift, Certain and Fair approaches to sentencing family violence offenders*, recommended a fast-tracking listing process in the Magistrates Court for charges for contraventions of CCOs imposed for family violence offences.[183] In her evidence, Ms Jenny Roberts, agreed it would help Community Corrections if high risk offenders were dealt with in a speedier manner before the courts. The precursor to this, of course, requires Community Corrections to commence breach proceedings in a timely manner. A time comparison was drawn to a breach of a condition of parole where a report to the Parole Board may be made within hours or days. I intend to make a Comment endorsing the Sentencing Advisory Council's recommendation for a fast-tracked listing process.

Compliance review findings

189. The internal management review report confirmed appropriate noncompliance steps had not been implemented, nor had action been taken to address noncompliance. '*Mr Turner's absences have not been addressed in a timely manner contributing to a large number of absences accruing prior to his order being placed in contravention*.'[184] After six unacceptable absences and a positive urine screen a compliance conference should have occurred. Further, many noncompliance reports were missing.

'*The major concern with the management of this file is the failure to address Mr Turner's absences in a timely manner, in particular the absences from drug alcohol treatment, supervision and urine testing.*'[185]

190. The report found that:

'*Due to the lack of appropriate action being taken to address the absences, Mr Turner was not held accountable for his actions, nor had discussion occurred in relation to how his non-compliance could be addressed*.'[186]

[183] T 684.
[184] T 597.
[185] CB 1596.
[186] CB 1597.

191. The report also found that Mr Turner's case manager had 23 days of unplanned leave in January and April which affected his ability to meet the requirements of case managing Mr Turner's order.

192. Ms Rudge noted in 2016 case workers had about 60 cases, this has now reduced to 25 to 30.[187] Further, under the changes initiated in 2017, Mr Turner would have been supervised by an Advanced Case manager without the extra 'dual' role which was common in 2016. There is now a new Professional Practice Stream, an Enhanced Supervision Framework, a new Court Case management model and a Collaborative Practice Framework. The Collaborative Practice Framework was developed in June 2019 to '*enhance and clarify collaborative practices between CCS, the Drug and Alcohol sector and Community Offenders Advice and Treatment services*.'[188]

193. The review found more should have been done to ensure Mr Turner complied with his mental health and drug and alcohol counselling conditions. I accept and agree with Community Corrections acknowledgement that it was not sufficiently proactive or assertive in managing Mr Turner's compliance with his CCO.

The use of family violence risk assessments in case management of Mr Turner's Community Corrections Order

194. Ms Rudge confirmed that risk is continually assessed by a case officer and a basic principle was that those individuals assessed as high risk should be afforded less latitude for any breaches.[189] The *Deputy Commissioner's instructions* in relation to risk management required a holistic consideration of risk however several red flags were missed indicating that Mr Turner's risk was escalating such as his use of illicit substances and involvement in a significant family violence incident.

195. Ms Rudge conceded that the family violence incident on 21 January 2016, that resulted in intervention orders against Mr Turner and Ms Cay, should have flagged a review of Mr Turner's situation and prompted discussion with him. Community Corrections had an obligation to manage his risk of committing family violence.[190] As noted, Community Corrections had also been advised by police on 18 November 2015 that Mr Turner was '*the highest risk and worst*

[187] T 620.
[188] Final submissions of the DOJ&CS p 6.
[189] T 535.
[190] T 661.

offender they [police] deal with in Port Fairy and they have major concerns when he is released on 20/11/2015.'[191]

196. The evidence confirms when Community Corrections addresses the noncompliance with a CCO, the latitude to apply the least interventionist step possible does not apply when an offender is a priority 1 (high risk) and where the circumstances suggest more immediate action is needed to protect the community. In these cases, more weight should be given to taking contravention action. The policy in place in 2016 listed circumstances to be considered when deciding which intervention to take. The current policy states that immediate contravention proceedings can be considered when, amongst other things, '*the risk to the community is too high*.'

197. With the benefit of hindsight, given the nature of Mr Turner's offending, his high-risk rating, the number of absences that were accruing and continuing to accrue and his involvement in the family violence incident on 21 January 2016 demonstrate a steady escalation of his risk which should have prompted consideration of more urgent intervention.

198. I understand that information sharing between Victoria Police and Corrections has improved since May 2019 when both organisations were prescribed under the Family Violence Information Sharing Scheme.

The recommendations made by Community Correction's Internal Management Report dated 8 August 2016

199. Warrnambool Community Corrections has developed an action plan to implement changes in the five areas identified in Ms Rudge's Internal Management Report. I have been advised that each item in that action plan has been implemented.[192]

200. From January 2017, the *Deputy Commissioner's Instructions* has been replaced with five new practice guidelines which regulate how Community Corrections now manage court assessments, contraventions, prosecutions and judicial monitoring and applications to vary or cancel a Community Corrections Order.[193]

201. If Mr Turner was on a Community Corrections Order today he would be managed differently. Changes were implemented at Community Corrections in 2017 as there were increasing

[191] CB 735; Exhibit 48.
[192] Final Submissions by Department of Justice and Community Safety p 4.
[193] Final Submissions by Department of Justice and Community Safety p 4-5.

numbers of offenders being released on CCOs.[194] Inexperienced and junior staff meant reforms were required to ensure case management was based on offender management and was compliance driven. Now, a high-risk priority 1 offender would be managed by an advanced case manager. Ms Roberts described upskilling of staff and a professionalisation of practice, '*… to invent integrity around the case management professionalisation of us …*'.[195]

202. With respect to family violence, Ms Roberts advised that today this case would have been part of a risk assessment management panel, with Victoria Police, a specialist family violence service provider, and other specialist agencies, including Community Corrections. This meant there would have been shared understanding of the risk which would have resulted in *'... a consultation either with professional practice stream or in fact a discussion at a risk review meeting to look at some of those strategies and to strengthen them …*'.[196]

203. When asked about the Victoria Police email to Community Corrections describing Mr Turner as the '*highest risk person in Port Fairy*' and the family violence incident between Mr Turner and Ms Cay on 21 January 2016, Ms Roberts stated at a minimum there would have been *'a new management meeting to discuss strategies and response to that incident …*'.[197]

Were there similar issues regarding the noncompliance of offenders on Community Corrections Orders in other coronial investigations?

204. Four other coronial cases, where people had killed their victims during 2014-2016 whilst on a CCO were summarised and tendered to the inquest.[198] These cases were drawn together to illustrate concern of a potential systemic issue regarding Community Corrections management of CCO's. Ms Roberts agreed that in all four cases there was poor compliance with CCO's, including unacceptable absences, and other conditions such as non engagement drug treatment, alcohol treatment, or mental health treatment or in some cases, all treatment.[199] Despite the poor compliance, there was significant latitude with respect to breaches.

205. Ms Roberts agreed that in two of the cases, the CCO's were not subject to appropriate contravention action. [200] Ms Roberts stated that since 2017 new initiatives had been taken by

[194] T 664.
[195] T 666.
[196] T 668.
[197] T 669.
[198] Exhibit 56.
[199] T 671.
[200] T 673 The death of Matthew Johnstone was distinguished by Ms Roberts as that case involved was a low risk offender who was homeless and Community Corrections had taken significant action to engage with her.

Community Corrections to prevent the repetition of the situation in Mr Turner's case. However, she was not surprised to hear of other coronial cases with similar issues, and explained:

'*…we can't control people … what we seek to do is to engage them in a way in which we … attempt to motivate them to engage and to address their criminal behaviour … returning matters to court for … noncompliance that is by conditions is typically done as a last resort.*'[201]

Conclusions

206. The *Deputy Commissioner's instructions* applicable in 2016 required intervention if a priority 1 offender had three or more unacceptable absences, as in Mr Turner's case, but this was not actioned by the Community Corrections case manager. As early as February 2016 Community Corrections should have been taking action to acknowledge and confront Mr Turner about his non-compliance.

207. I find that Community Corrections failed to adequately monitor and manage Mr Turner's non-compliance with his CCO by failing to take intervention action earlier. Given there is no knowing the outcome of interventions such as sanctions or breach proceedings, it is not possible to link this failure with Ms Cay's death.

208. By Community Corrections providing an inaccurate report to the magistrate conducting Mr Turner's judicial monitoring, I find there was an opportunity lost for the effectiveness of that condition, either by way of a verbal admonishment from the Bench, or by the setting of a further date for Judicial monitoring. Again, it is not possible to link this failure to Ms Cay's death.

209. The four similar coronial cases from 2014-2016, and including Ms Cay's case, raise concerns of potential systemic issues within Community Corrections regarding the failure to take appropriate action or sanction against offenders non-compliance with their CCO's, and then proceeding to kill others.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Ambulance Victoria

210. In 2014 a study of 50 paramedics assessed the understanding and preparedness of paramedics to respond to family violence. Only 22 per cent reported they felt confident in responding to situations of family violence and the vast majority of participants stated that they felt additional

[201] T 676.

education or training would be most helpful for improving their ability to respond to family violence. [202]

211. During the inquest Mr Staff's evidence was that domestic violence was a 'neutral factor.' Mr Freckleton was aware Ms Cay was a victim of domestic violence but stated this did not inform his clinical judgement and was in fact 'not relevant' to his task, other than providing information regarding the mechanism of injury, which he did not inquire about.[203] He did not know about the face to face training on vulnerable patients and communication techniques referred to in Mr Carlyon's statement, although he agreed any extra training is beneficial.

212. When Mr Freckleton asked Ms Cay '*How did this happen*,' she stated, '*A domestic violence incident*.' Given the generic and inexact meaning of 'domestic violence' I am surprised by Mr Freckleton's lack of further inquiry about how the injuries were caused, other than him asking, '*You were attacked*?' Aside from the necessarily gendered nature of family violence where the predominant number of victims are women, I am of the view that if the symptoms of *broken ribs, pain worsening*, being *hardly able to breath* and about to *pass out*, were described as the result of a recent car accident, or a workplace incident, Ms Cay's call may not have been so quickly downgraded as a need for pain relief.

213. The expressions 'family violence' or 'domestic violence' are ubiquitous but almost euphemistic through their lack of specificity. The evidence given at the inquest describing family violence as a 'neutral' or 'not relevant' factor is not in fact neutral *in effect* because it minimises and ignores the specificity of how the injury has occurred in a way that does not apply to other causes of harm.

214. Ms Cay's family submitted that even in 2016 the context of family violence should have been recognised in Ambulance Victoria policies, training and procedures as a relevant factor when assessing the urgency of a call and the vulnerability of a patient. I accept this submission, particularly given specific legislation to counter family violence has been in place in Victoria since 1987, [204] and more recently the recommendations following the Inquest into the death of Luke Batty [205]handed down in 2015 and the Royal Commission into Family Violence, which handed down its report in February 2016.

[202] Royal Commission into Family Violence, Volume IV, March 2016, p 22.
[203] T 229-230, 234.
[204] Crimes (Family Violence) Act 1987
[205] COR 2014/0855

215. It was a combination of poor policies that did not align with process, lack of training and staff errors that contributed to the failure to prevent Ms Cay's death.

216. In the submissions by Ambulance Victoria it is acknowledged that:

> *'… at the time of Kylie calling for assistance from Ambulance Victoria, the system Ambulance Victoria had in place did not adequately address issues pertinent to domestic violence/vulnerable patients and the impact that such circumstances may have on an injured person's ability to: (i) comprehend advice given, (ii) follow advice given; and (iii) access services. '*

217. In the Cay family's submissions, they reinforced the need for AV training in dealing with patients who are marginalised, vulnerable and in distress. The family supports initiatives aimed at protecting patients suffering from and at risk of family violence, recognising their particular difficulties and acute vulnerability in the community. [206]

218. On 29 July 2020 Ambulance Victoria approved the Pro Ops 273 Family Violence Procedure. This document provides all Ambulance Victoria staff with comprehensive guidance on how to identify family violence, family violence risk factors and how to respond to incidents where family violence becomes known. This procedure reflects the principles and guidance provided by the Multi Agency Risk Assessment (MARAM) Framework which was developed by the Victorian Government and is considered best practice in responding to incidents of family violence. To support staff to develop their practice in relation to family violence, the Pro Ops 273 Family Violence Procedure also stipulates that the Director of Operational Capability will ensure that staff have access to relevant education and training. This document is also supported by additional policies and a clinical handbook aimed at supporting staff to respond effectively to family violence.

Community Corrections

219. The community's faith in the administration of justice depends on judicial officers, when sentencing offenders, having confidence that sentencing orders such as Community Corrections Orders, are managed fairly, efficiently and proactively by Community Corrections.

220. The community's faith in the administration of justice also depends on judicial officers, when including conditions in a Community Corrections Order such as Judicial Monitoring, having

[206] Written submissions on behalf of the family of Kylie Cay page 6.

confidence that the Judicial Monitoring reports prepared and provided by Community Corrections contain accurate and up to date information regarding an offender's progress and compliance with a Community Corrections Order.

221. The outcomes of an Internal Management Review Report provided by the Secretary to the Department of Justice and Community Safety to the court stated that 'all staff at the Barwon South West Region be provided with training regarding the composition of the Judicial Monitoring Reports in efforts to improve the quality of these documents' and that the training had been attended by all case managers at Warrnambool Community Correctional Services. [207] Given the importance of the accuracy of Judicial Monitoring Reports for all Victorian courts and the administration of justice, I intend to make a recommendation that this training be expanded for all Community Correctional Services staff who prepare Judicial Monitoring Reports.

222. Community Corrections detailed the 'least interventionist' approach taken when addressing the noncompliance by offenders with Community Corrections Order conditions. However, the existing policy in 2016 was such that a priority 1 high risk offender such as Mr Turner, should have had some intervention regarding his noncompliance as early as February 2016, however none was taken.

223. In the Cay family's submissions, they note with concern that a high-risk offender such as Mr Turner, would be given latitude in his compliance with a Community Corrections Order. They also note their concern that breach action for non-compliance by a high risk and family violence offender is not fast tracked.

224. The evidence suggested Community Corrections was heavily reliant on paper files. Ms Rudge's evidence confirmed that the only electronic system referenced throughout the inquest was e.Justice which is a shared limited database between Corrections and Victoria Police which provides access to: risk warnings, risk flags and LEAP criminal and family violence information maintained by Victoria Police. The audit document prepared by Ms Rudge when reviewing Mr Turner's compliance, referred to at paragraph [177] above demonstrates the limitation of the antiquated nature of the case management system. With respect to Mr Turner's unacceptable absences, multiple absences were not printed for the file until 22 April 2016, when contravention proceedings commenced. An automated process for both line supervisors would mean that issues regarding noncompliance with Community Corrections Orders could be dealt

[207] CB 1293

with earlier rather than awaiting manual file reviews. This system would allow any case manager the ability to enter the offender's details and immediately be presented with the option of a report that shows the current state of progress of the offender's compliance with their CCO conditions.

225. An overhaul of the current paper-based system with the appropriate prompts for compliance, would greatly improve the efficient case management of Community Corrections Order offenders to ensure that non-compliance does not get out of control and continue for long periods of time unchecked.

226. The Cay family's submissions noted with concern that Community Corrections was not able to readily determine whether an offender is complying with a CCO.

227. Community Corrections has acknowledged the progress report provided to the supervising magistrate for Mr Turner's Judicial Monitoring hearing was misleading regarding the number of his unacceptable absences and his general compliance. It is essential for judicial officers to be able to rely on the accuracy of these reports. In this case, the magistrate had the power to order a further judicial monitoring hearing. It appears that Mr Turner's non-compliance with his Community Corrections Order accelerated following the conclusion of the Judicial Monitoring hearing.

228. I note the Sentencing Advisory Council 2017 report, *Swift, Certain and Fair approaches to sentencing family violence offenders*, recommended a fast-tracking listing process in the Magistrates' Court for charges for contraventions of Community Correction Orders imposed for family violence offences. I endorse that recommendation. I note it relies on Community Corrections to bring the breach proceedings in the first place, and in this case contravention proceedings against Mr Turner were instituted too late. Once the contravention proceedings are actioned, the fast tracking of listings in Magistrates' court of contraventions of Community Corrections Orders imposed for family violence offending sends a powerful message prioritising the safety of the community.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

Pursuant to section 72(2) of the Act, I make the following recommendations:

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

2. To **Ambulance Victoria**: 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 on 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 **Ambulance Victoria:** To use this Finding and in particular, the transcript of the call between Ms Cay and the referral service triage practitioner, (Exhibit 20), 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 **Ambulance Victoria**: 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.

5. To **Corrections Victoria:** To introduce an electronic case management system to enhance Community Correctional Services management of an offender's compliance with their Community Corrections Order. The system needs to address issues identified in this case such as the lack of awareness of non-compliance, lack of supervision and the supervisors' awareness of non-compliance, and the ability to address non-compliance early. The system should allow case managers the ability to create a schedule outlining how each condition will be completed and contain key milestones that must be reached. This will ensure that starting at induction, case managers and offenders will have a clear case plan to complete and comply with conditions. The system should also allow supervisors the ability to oversee the management of serious offenders with an automated overview of their compliance which allows early interventions to occur when non-compliances are logged.

6. To **Corrections Victoria:** To implement training for all Community Correctional Services staff state-wide who are involved in preparation of Judicial Monitoring reports, regarding their composition and contents to improve the quality and accuracy of these reports.

CONCLUSION

1. Having investigated the death, and held an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Kylie Jane Cay, born 22 March 1972, died on 22 June 2016 at 10 Elizabeth Street, Port Fairy, Victoria, from hemoperitoneum due to ruptured splenic subcapsular haematoma in the setting of blunt force trauma to the torso in the circumstances described above.

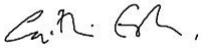
2. I convey my sincere condolences to Ms Cay's family for their loss.

3. Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the Rules.

4. I direct that a copy of this finding be provided to the following:

Cay family, Robinson Gill Lawyers
The Secretary, Department of Justice and Community Safety
Her Honour Judge Lisa Hannan, Magistrates' Court of Victoria
Ambulance Victoria, Minter Ellison
Mr Jarrod Freckleton, HWL Ebsworth
Mr Daniel Staff, Meridian Lawyers
Dr Joanne Brown & Dr Nicholas Van Zyl, South West Healthcare
Ms Eleri Butler, Family Safety Victoria
The Honourable Natalie Hutchins, Minister for Corrections
Ms Debra Coombs, Victorian Government Solicitors Office
Detective Sergeant Adam Bell, Sergeant Sharon Wade, and Detective Sergeant Stephen Phelan, Victoria Police Professional Standards Command
Alex McCulloch, Emma House Domestic Violence Services Inc
ESTA, Lander & Rogers
Ms Laura D'Amico, on behalf of the Chief Commissioner of Police
Mr Justin Turner
Sentencing Advisory Council
Detective Senior Constable Lisa Metcher, Victoria Police, Coroner's Investigator.

Signature:



CAITLIN ENGLISH
DEPUTY STATE CORONER
Date: 25 May 2021