STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Helen Ashburn
Hearing dates:	10-12 April 2017 at Port Macquarie Local Court
Date of findings:	6 June 2017
Place of findings:	State Coroners Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	Coronial Law; Policy and procedures for identifying domestic violence in hospital emergency departments.
File number:	2012/7052
Representation:	Mr Peter Aitken of counsel, instructed by Mr James Herrington, solicitor, Crown Solicitors Office – Counsel assisting. Ms Justine Hopper of counsel for the Commissioner of Police and individual police officers, instructed by Mr Deards, General Counsel, NSW Police. Mr Sergi of counsel, instructed by for Mid North Coast Local Area Health District, Dr Alan Forrester, Dr Tim Platt, Dr Tamara Brody, instructed by Mr Black, solicitor, Curwoods.
Findings:	On the balance of probabilities, I find that Helen Ashburn died from the prolonged effects and complications of a head injury which occurred on 25 October 2011. She died at Port Macquarie Base Hospital, Port Macquarie on 30 December

	2011. I am unable to determine the manner in which Ms Ashburn sustained her original injury.
Recommendations	I make the following recommendations **To the Director of the Mid North Coast Local Health District** 1. That the electronic/training booklet (e-booklet) presently provided by the MNCLHD to doctors at the commencement of their employment in Emergency Departments with the MNCLHD (including Kempsey Hospital) be modified to include a requirement mandating notification to police of reasonably suspected incidents of domestic violence in accordance with NSW Health Policy and Procedures for identifying and responding to domestic violence. 2. That the MNCLHD follow up the results of the trial of the emergency department domestic violence screening tool being carried out by the Northern NSW Local Health District at Lismore Base Hospital with a view to assessing its potential usefulness in the Mid North Coast Local Health District. **To the Minister for Health,** 3. That NSW Health give consideration to further exploring the viability and appropriateness of providing a means

	by which a patient's domestic and family violence history is the subject of an alert recorded on the patient's electronic medical record where that patient is at risk of serious threat resulting from domestic or family violence. Consideration of this proposition will understandably include examining the significant privacy concerns involved.

IN THE STATE CORONER'S COURT
GLEBE
NSW
SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

4. This inquest concerns the death of Helen Ashburn

Introduction

5. Helen Ashburn was the youngest child of Minnie and Ray Ashburn. She had two children James and Leisa. She was only 46 years of age at the time of her death and was living in the mid north coast area of NSW with her partner Doug Burnett. Over her lifetime Ms Ashburn had suffered a number of health issues including alcohol addiction, coagulopathy and seizures. At times she experienced relationships which involved domestic violence and had previously suffered a serious head injury. In recent years Ms Ashburn enjoyed being a grandmother and was in regular contact with her family.

Role of the coroner and the history of these proceedings

6. The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] In addition, the coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future.[2]

7. In this case there is no dispute in relation to the identity of Ms Ashburn, or to the date and place of her death. For this reason the inquest focussed on the manner and cause of her death. It was also necessary to consider related issues concerning the investigation of her death.

[1] Section 81 *Coroners Act* 2009 (NSW)
[2] Section 82 *Coroners Act* 2009 (NSW)

8. The inquest in relation to this matter was commenced by His Honour Magistrate Evans at Kempsey Local Court on 21 August 2012. A transcript of those proceedings [3] indicates that documents were tendered and evidence was taken from a number of witnesses at that time. The matter was adjourned for further investigations to take place and recommenced on 10 October 2012. On that day, the inquest was suspended. Evidence presented by the forensic pathologist, Dr Cala tended to support an inference that the likely cause of Ms Ashburn's injuries indicated the involvement of a third party. Dr Cala's opinion was based on the extent and nature of the injuries Ms Ashburn had suffered. Magistrate Evans subsequently referred the matter to The Office of the Director of Public Prosecutions. The ODPP subsequently declined to take action and on 14 September 2015 a decision was made to recommence coronial proceedings. The matter was initially set down for further hearing at Kempsey Local Court on 22 November 2016, however, just prior to that date the Court was informed that Ms Ashburn's partner, Mr Doug Burnett was seriously ill and in hospital and for this reason the hearing was vacated. Mr Burnett had been subpoenaed and had indicated that he was keen to attend. Unfortunately, Mr Burnett died shortly afterwards. This hearing subsequently recommenced on 10 April 2017, without the benefit of his further input.

9. Section 81 (1) of the *Coroner's Act* (2009) NSW requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of Helen Ashburn.

Scope of the inquest

10. A list of issues relevant to Ms Ashburn's death was circulated prior to the inquest recommencing in April 2017. By that time, following a number of further inquiries, the issues had narrowed to some degree. The following questions were posed

- The manner and cause of the deceased Ms Ashburn's death
- The adequacy of the coordination and timing of certain aspects of the initial police investigation, namely crime scene investigation and canvassing of surrounding residents, and any lessons learned.

[3] Exhibit 1, Tab 8

- The relevance, interpretation and application of a) the NSW Health document "Policy and Procedures for identifying and responding to domestic violence" to the notification of local police by Kempsey Hospital of the injuries sustained by Ms Ashburn ; and (b) any other NSW Health or Local Health District policy requiring notification of suspicious injuries to police.

- Any recommendations considered necessary or desirable to make in relation to any matter connected with the death of Ms Ashburn, pursuant to s 82 Coroners Act 2009

The inquest proceeded over three sitting days. The transcript from the 2012 proceedings was tendered in full. A large number of written statements were tendered, as were expert reports, medical records and governmental policy documents. Oral evidence was also received, including from medical practitioners and police officers. Comprehensive oral submissions were received from all parties. The Mid North Coast Local Health District also requested and was granted an opportunity to complete written submissions in relation to a specific policy issue that arose during the course of the evidence. Those submissions were received by the Court on 30 May 2017.

Brief Background and medical chronology

11. Around 6.30am on 25 October 2011 Mr Doug Burnett, Ms Ashburn's partner called "000" requesting that an ambulance attend his home. He reported that Ms Ashburn was in bed unconscious and that he had seen her having a seizure. She appeared to be "jittering". Ambulance officers found her in bed, unconscious and unresponsive. [4] They did not record any signs of trauma or external bleeding. At that stage the ambulance officer thought that Ms Ashburn may have had a stroke, he also noted that the house appeared immaculate and nothing seemed out of order. Ms Ashburn arrived at Kempsey Hospital around 7.40am and was taken directly to the Emergency Department.

12. Ms Ashburn was initially seen by Dr Sharon Ford. Dr Ford did not see any signs of external head trauma, but noted that there was some blood staining on Ms Ashburn's teeth. Various investigations were conducted, including a CT scan which suggested that Ms Ashburn had likely suffered a significant blunt force trauma to the head, causing

[4] See Statement of Steven McMahon. Exhibit 1, Tab 28

extensive cerebral bleeding in multiple areas.[5] She was given medication to control any seizure activity and various neurological assessments were conducted. Ms Ashburn's blood was tested for coagulation.

13. Hospital staff spoke to Doug Burnett by telephone and were told that he had woken at 3am to find Ms Ashburn wandering and sitting on the bed. Later when he woke again she was seizing and unconscious. He reported that she had not had a drink for three days.[6]

14. Ms Ashburn was also seen by Dr Platt, the Director of the Emergency Department. He reviewed the CT scan himself and also had the benefit of Dr Chilton's report. Given the significant brain bleeding it was clear that Ms Ashburn should be taken to a tertiary hospital as quickly as possible.

15. Retrieval was arranged and Ms Ashburn was taken by helicopter to Royal North Shore Hospital. Further CT scans were obtained. Unfortunately these scans showed an increase in the size of the right subdural haemorrhage and increasing intraventricular haemorrhage. Ms Ashburn's coagulopathy was treated.

16. Ms Ashburn remained unresponsive in the Intensive Care Unit and was later transferred to a neurosurgical ward. She was fed by a nasogastric tube and an external ventricular drain was inserted to treat her intracranial bleeding.

17. A progress note from Royal North Shore Hospital on 27 October 2011 recorded for the first time bruising on Ms Ashburn's arm, shoulder, knees and chest area. She was subsequently found to have an undisclosed fractured sternum. Medical staff spoke again to Doug Burnett about how her injuries had been caused. A recording in the progress notes for 2 November 2011 states "partner reports finding her on bed - ? mechanism". It appears that staff may have questioned the mechanism of the injury and wondered how Ms Ashburn could have been found in bed, given the severity of her condition. Progress notes reveal that there was some contact with Kempsey Police on 7 November 2011 and that a social worker would "liaise".

[5] Report at Exhibit 1, Tab 38 (EMR)
[6] Exhibit 1, Tab 38 (EMR) 3/12

18. Ms Ashburn's health did not improve and she was extubated. On 11 November 2011 she was transferred back to Kempsey Hospital for possible palliative care. Her prognosis at that time was poor. She had significant brain damage and was at risk of aspiration pneumonia.

19. Somewhat surprisingly on 15 November 2011 Ms Ashburn began to regain consciousness. By 18 November she was still opening her eyes, but was unable to follow commands. By 19 November she was able to say her name and answer some simple questions. From that point she gave some conflicting accounts about what had happened. At one stage she said "Paul hurt me". She said it had happened yesterday. She also said that she had tripped. She spoke to police, but they found she was difficult to understand. At one stage she said that her partner had hit her over the head yesterday. Ms Ashburn was also suffering MRSA and displayed significant memory problems so no official statement was taken. Ms Ashburn continued to give varying accounts, at one point confirming her partner had hit her on the head and at another time that she had fallen down the stairs drunk. On 2 December 2011 she was described as confused and speaking a "word salad". By 4 December Ms Ashburn appeared to be deteriorating again. She was unable to follow commands and was at times unresponsive.

20. 21 December 2011 Ms Ashburn was transferred to Port Macquarie Base Hospital to have a feeding tube inserted. It appears around this time that it is likely that aspiration pneumonia developed. Although Ms Ashburn was transferred to Kempsey for a few days, she was taken back to Port Macquarie on 28 December 2011 for an attempted bronchoscopy to remove the mucus from her lungs. There was mucus in her upper airways and Ms Ashburn's condition continued to deteriorate. She died at Port Macquarie Hospital on 30 December 2011.

Dr Besser and the medical evidence in relation to cause of death

21. After Ms Ashburn's death an autopsy was conducted by Dr Cala. He found that Ms Ashburn died from the prolonged effects and complications from a head injury.[7] The injury pattern was not that of a spontaneous bleed or simple fall given the complexity

[7] Dr Cala Post Mortem Report, Exhibit 1, Volume 1, Tab 6

and severity of the injury. Dr Cala noted that the upper airway obstruction had caused hypoxia as the ultimate complicating feature, but also noted severe coronary atherosclerosis and a cirrhotic liver. Dr Cala gave evidence at the initial inquest, stating that the head injuries were "much more likely" to be caused by an assault or a number of assaults within two to three hours before she was found having seizures than by a spontaneous bleed or a simple fall. Although Dr Cala took into account that Ms Ashburn had abnormal blood clotting he was not directly questioned about the extent to which this may have contributed to the extensive nature of the brain bleed nor was he asked to specifically consider a fall downstairs.

22. More recently the coroner obtained the expert assistance of a consultant neurologist, Dr Besser. Dr Besser indicated that in his view Ms Ashburn's death was a reasonably expected outcome of her injuries. He was of the view that the most likely cause was blunt trauma assault. However, he stated that he could not exclude the mechanism of a fall downstairs or even a simple fall, particularly in the context of Ms Ashburn's coagulopathy. He concluded that while it seemed to him unlikely, he simply could not exclude it. In a supplementary report he expressed the view that if Ms Ashburn had fallen downstairs, she would almost certainly have lost consciousness and therefore he could not envisage her being able to get back into bed.

23. Various other medical matters were investigated[8]. Associate Professor Sheridan, a neurosurgeon also provided a report commenting on the cause of death and the appropriate management of Ms Ashburn's seizures.[9] After careful consideration of the issue he was not critical of the management of her seizures. Associate Professor Sheridan considered that Ms Ashburn's death was the inevitable outcome of her head injuries compounded by her pre-existing comorbidities.

24. Having taken into account all of the relevant medical evidence, this Court cannot conclusively establish the cause of Ms Ashburn's injuries by reliance on the medical material. While a severe assault remains a likely cause of her injuries, the medical

[8] See for example evidence that Ms Asbburn may have been given incorrect medication, statement of Yolanda Batterson Exhhibit 1, Volume 1, Tab 37. This matter was investigated and found to have no relevance to her cause of death.
[9] Report of Professor Sheridan, Exhibit 1, Volume 4, Tab 75A

evidence alone does not establish this to the requisite standard and an accident of some kind, while somewhat less likely, cannot be ruled out.

Helen Ashburn and Doug Burnett's accounts

25. Doug Burnett took part in a voluntary interview with police on 3 January 2012[10]. He said that Helen had fallen over 3 or 4 days prior to being taken to hospital and had been brought home by people from the local caravan park. She was bruised up the arm. He said that after dinner on the night of 24 October 2011, having had approximately six VB beers that afternoon, Helen took some Panadol and her usual medication and went to bed. Mr Burnett said that he slept on the lounge as "Helen was not feeling well". When he awoke at 6 AM he went to check on her and saw her in the bed having a seizure. He remembered that earlier in the night, about 1:30 AM he had heard her getting her clothes and walking around.

26. At the initial inquest Mr Burnett told the coroner that Ms Ashburn had had a fall some days prior and had skin off her knees and some bruises. He said the kitchen was upstairs in the house, but that they lived downstairs. He said that something woke him at about 3 AM and that he found Helen putting on clothes and mumbling. She lay back down on the bed under the covers. In the morning he found her angled across the bed, out of the covers. It should be stressed that Mr Burnett was reported to be keen to attend and assist the resumed inquest. He told police that he was innocent of any suggestion that he had harmed Ms Ashburn.

27. As has been noted, Ms Ashburn gave a number of confused and conflicting accounts of her injuries. It was Dr Besser's view that given her serious medical conditions, her accounts could not have been relied upon.

28. It appears that Ms Ashburn's family did not suspect she had been beaten at the time and certainly made no complaint to police to that effect. However, during the more recent investigations some concerns were raised indicating in general terms that Ms Ashburn may have been subject to some violence in her relationship with Mr Burnett.[11] No specific allegations relating to the period just prior to her death were revealed.

[10] Transcript of interview with Doug Burnett, Exhibit 1, Tab 32
[11] See later statements from family members, Exhibit 1

Police involvement and the adequacy of the investigation

29. One of the central issues for the inquest was the adequacy and timeliness of the police investigation. The purpose was not to blame any individual officer but to identify if there were any systemic problems which arose in the conduct of the investigation. It is important to acknowledge that it has not been established that a crime was committed. It follows that it is impossible to say that police could have found further evidence about the events leading up to Ms Ashburn's hospitalization, even if the surrounding circumstances had been investigated immediately. However, the question remains as to whether or not an inadequate police response at the time, now hinders the coronial process by making it more difficult to establish the cause and manner of Ms Ashburn's death.

30. Police had not been notified of Ms Ashburn's admission to Kempsey Hospital on 25 October 2011, so no action could have been taken in the immediate aftermath of Ms Ashburn's hospitalisation. Police were first notified of Ms Ashburn's situation on 7 November 2011. Sergeant Luke Baker gave evidence that he was performing duties as custody manager on that day when he received a call from a nurse at RNSH[12]. He was informed that Ms Ashburn was a patient in the Intensive Care Unit. Her life support would be removed shortly and it was likely that she would die. The nurse wanted to advise police that Ms Ashburn had suffered some kind of head trauma, but that the cause was unknown. The nurse stated that she did not know if police had been informed of the situation. It is not now clear who that nurse was, as the corresponding Hospital note suggests that contact was first made to them by police.

31. Sergeant Baker spoke to his supervisor and got some advice from the local detectives. He then attended Kempsey Hospital and spoke with someone in medical records. At that time he received only basic information about the attendance of the ambulance which he recorded in his police note book. He created a COPS event and over the next few shifts he attempted to identify who the relevant ambulance officers were. The matter was not treated as urgent at this stage.

[12] Statement of Sergeant Luke Baker, Exhibit 1, Volume 4, Tab 49 and evidence at Inquest 10/4/17

32. On 17 November 2011, Sergeant Baker spoke to Dr Brodie. He was advised that Ms Ashburn was back at Kempsey Hospital and was now likely to live. Sergeant Baker stated that Dr Brodie said "it appears that Helen Ashburn sustained injuries as a result of being beaten or hit with a blunt object and that she had a number of bruises and bleeding to her head that were consistent with being beaten."[13]

33. Once this contact was received, it is clear that the Kempsey Detectives were formally notified and became involved in the investigation. Detective Halverson briefed Detective Inspector Clarke on the evening of 17 November 2011. She outlined a number of appropriate lines of inquiry including attending and assessing the possible crime scene, canvassing local residents and obtaining statements from the usual residents of the house. Detective Inspector Clarke did not approve overtime for the inquiries to commence that day, but it was agreed that investigations would get underway the following day.

34. Around this time Detective McArdle completed a SITREP. He was the officer assisting in relation to the investigation and given that Detective Halverson commenced leave on 18 November, it was Detective McArdle who continued investigation the following day. He executed a search warrant for Hospital records and followed up an ambulance officer.

35. Police also responded to further information received from medical staff. Ms Ashburn had made a number of other, at times contradictory statements about what had happened to her. On 22 November 2011 police attended Kempsey Hospital to speak with her. Detective Stewart reported that Ms Ashburn said "Dougie had hit her over the head" but she had obvious issues with her memory and could not be relied upon. Appropriately, no formal statement was taken at that time.

36. Unfortunately, the canvass and crime scene investigation had somehow fallen off the list of things to do. The court heard from a number of involved officers in an attempt to understand whether these omissions were the result of systemic issues that needed to be addressed or were the result of human error and poor handover in a busy office.

[13] Statement of Sergeant Luke Baker, Exhibit 1, Volume 4, Tab 49, paragraph 10.

37. At the end of inquest, it appeared that the COPS system had sufficient mechanisms that could be used to assist investigating officers to keep track of outstanding tasks and that identified inadequacies in this case were more likely to have been the result of human error.

The cause of the incomplete investigation and changes made since Ms Ashburn's death

38. There was candid recognition by all police officers who gave evidence that there was an unfortunate delay in completing investigative tasks once police became aware of the concerns that had been properly raised by medical staff. In particular the failure to conduct a canvass or to inspect the potential crime scene was below the standard of best practice. Even though a significant period of time had already been lost, these tasks should have been given some priority given the potential seriousness of the crime if it had been committed. It is clear that these important investigative tasks had been properly identified at an earlier stage but they fell by the wayside for a variety of reasons. I accept that Kempsey Detectives were short staffed and under resourced at the time. I accept that leave arrangements impacted on the successful handover of tasks and that there were a number of unfilled positions and competing demands.

39. There also appeared to be a lack of clarity as to who was responsible, when crucial members of the team were either on leave or away from the local area. Somehow as matters were dropped off the original action list, there was no properly operating supervisory system functioning that identified the gaps in the plan. However, on reflection, it seems more a question of human error than any easily recognisable systematic failure. The court certainly heard evidence of a number of mechanisms in the COPS system which could have been used to keep track of the initial plan.

40. Detective Superintendent Steven Clarke gave evidence and appeared to accept that some of the investigations should have been carried out in a more timely manner. A crimes scene order and canvass should have been done as close as possible to the time Ms Ashburn was taken to Hospital. [14] Detective Clarke gave evidence that there were "no excuses to be made". The matters should have been pursued. He suggested that

[14] Transcript 11/4/17 page 183, line 8

when people are overworked, things can unfortunately slip through the cracks. However, he was of the view that "more robust" systems were now in place.[15]

41. He gave evidence that there were a number of changes within the Mid North Coast Local Area Command which meant that the particular issues that arose in this investigation would not be likely to recur. One of those improvements was that there was now a Crime Coordinator and that morning review meetings took place. He said,

> " I guess with hindsight, your Honour, you look at some things and…There was considerable workload at the time, as has been established, I think – and we've obviously thrashed this out significantly – the introduction of the morning briefings …in my opinion, definitely facilitates the process a lot better than what we had in 2011."

Detective Superintendent Clarke also gave evidence that while there was provision within the system for 28 day case reviews, in reality a matter such as this should perhaps be followed up more quickly to prevent it falling through the cracks. His suggestion was that perhaps 14 day case reviews would be more appropriate. While it was pleasing to see the Superintendent actively engaged in exploring solutions, the Court did not consider that it had sufficient evidence about the system to make any corresponding recommendation.

42. After hearing Detective Superintendent Steven Clarke's evidence I accept that there have been changes made which will reduce the risk of matters such as this falling through the cracks. Police are to be commended for the open way they discussed the issues involved. On the basis of the evidence presented, no systemic issue was identified that has not already been ameliorated by changes to local staffing arrangements.

Health policy and procedures in relation to suspected domestic violence

43. It is accepted at the outset that the medical staff working at Kempsey Hospital at the time of Ms Ashburn's arrival on 25 October 2011 were faced with the complex presentation of a gravely ill woman. Their urgent task was to assess her quickly,

[15] For discussion of this issue see his evidence at Transcript 11/4/17, page 169 at line 1 onwards.

provide immediate treatment and arrange for her medical evacuation to a tertiary hospital, as soon as possible. They achieved this goal.

44. Dr Platt told the court that he did not recall being suspicious that Ms Ashburn's significant head injuries were the result of an assault. He stated "any suspicion I may have had in this regard are likely to have been ameliorated by Helen's history of recurrent falls and coagulopathy issues leading to bleeding".[16]

45. One of the issues explored at the inquest was whether or not earlier identification by medical staff of possible domestic violence was called for in the circumstances of the presentation. The task involved examining local policy and procedure in relation to identifying patients who may have been the victims of family or domestic violence and clarifying the role and responsibilities of medical staff in contacting police.

Dr Forrester's evidence of the relevant health policies

46. The Court was greatly assisted by the evidence of Dr Alan Forrester. He is the Network Director, Emergency Departments for the Mid North Coast Local Health District. Part of this role includes overseeing the emergency departments at Kempsey and Port Macquarie Hospitals. He has been in this role since 2006, but had no direct involvement in Ms Ashburn's treatment.

47. Dr Forrester identified two relevant NSW Health policy documents, firstly "Policy and Procedures for identifying and responding to domestic violence" [17] (published 2006) and secondly "Coroners Cases and the Coroners Act 2009". [18] Both policies were in place at the time of Ms Ashburn's death. Neither had been altered by any local policy.

48. The Domestic Violence policy is a comprehensive and detailed policy dealing with the issue of domestic violence and how it may affect all aspects of health policy. It aims to reduce the incidence of domestic violence and to minimise the trauma that people living with domestic violence experience. It acknowledges the prevalence of domestic violence and also the fact that it often remains hidden from view.

[16] Statement of Dr Tim Platt, Exhibit 1. Volume 4, Tab 79, paragraph 30 and evidence at Inquest 11/4/17
[17] Exhibit 1, Tab 83
[18] Exhibit 1, Tab 84

49. The Court was taken to clause 4.1 which makes it clear that the normal principles of patient confidentiality may not apply in circumstances where health workers hold "genuine and realistic concern about a patient being harmed." Clause 4.2 requires health workers to report instances of domestic violence in situations including where "serious injuries have been inflicted such as broken bones, stab and gunshot wounds" even where such a report is against the wishes of the victim.

50. It was very clear that Dr Platt was aware of this policy and while he took the issue of confidentiality very seriously he agreed that Ms Ashburn's injuries were certainly sufficient to trigger this waiver had he held a genuine concern at the time, which he did not.

The trial of DV screening in emergency departments

51. Dr Forrester gave evidence that while electronic records were only in their infancy at the time of Ms Ashburn's death, they were now widely used across NSW. In 2011 any domestic violence screening tools that had completed in other departments would not have been accessible to the emergency department on the morning of Ms Ashburn's admission to Kempsey Emergency Department. However, it is now possible that records from other areas such as departments such as Drug and Alcohol Services, Women's Health and Mental Health Services may be available electronically.

52. The Court heard that the Mid North Coast Local Health District currently implements the Domestic Violence Screening Program to women attending across four health streams, the Mental Health Service, the Drug and Alcohol Service, the Midwifery Service and Child and Family Services. A purpose of the tool is to provide information for clients at risk of violence. The screening tool expressly states that information given by a client will remain confidential except where there are serious concerns for the client or the clients' children.

53. The inquest heard that there was discussion within the Health Department of the usefulness of routine screening directly for domestic violence in emergency departments, as has been done in areas such as women's health, maternity, child and

family health for many years.[19] There are diverging views as to its efficiency in emergency departments especially in small departments where social workers are not routinely available.

54. It was Dr Forrester's experience in New Zealand that screening all people for family and domestic violence who attend an emergency department may not provide any significant health benefit to the patient. Focussed screening, as it already occurs in the Mid North Coast Local Health District, where there can be appropriate follow-up, such as in a mental health or maternity unit may prove more worthwhile. [20] Nevertheless Dr Forrester gave evidence that there is currently a trial for domestic violence screening in emergency departments taking place at Lismore Base Hospital in the Northern NSW Local Health District. Dr Forrester appeared committed to following the analysis and evaluation of that process.

Training of staff

55. The Court heard that the Department of Health had easily accessible training modules in relation to family and domestic violence. However, one of the difficulties in initiating comprehensive training, especially in rural and regional areas, was the transitory nature of the medical staff, particularly the doctors. While there has been an e-learning module "Recognising Domestic and Family Violence" designed to be delivered to all clinical staff in the ED since 2015, not all doctors working in the Mid North Coast Local Health District would have a chance to complete it prior to moving out of the area.

56. Dr Forrester gave evidence that at Port Macquarie and Kempsey Emergency Departments close to 90% of the medical staff were locums.[21] This made it difficult to monitor what mandatory training they had completed. For this reason an orientation/training booklet was created which alerted new staff to certain important and mandatory reporting requirements and policies. These included scheduling processes under the *Mental Health Act*, reporting of deaths to the Coroner, and reporting of violence against children.

[19] See screening tool, Exhibit 1
[20] For discussion of this issue, see Dr Forrester's evidence at Transcript 11/4/17, page 139, line 19 onwards.
[21] Transcript 11/4/17, Page 136, line 36 onwards

57. Dr Forrester gave evidence that it would be possible to modify this document so that it also alerted staff to consider the requirements of the relevant NSW Health Policy in relation to notifying police in relation to reasonably suspected incidents of domestic violence.

Other Domestic Violence Initiatives

58. Dr Forrester also gave evidence of other initiatives in the local area to strengthen measures to support victims of family and domestic violence. Since 2015, a position of District Manager, Integrated Child and Family Wellbeing has been filled. This position has responsibility for the Domestic Violence Portfolio in the Local Health District. The position is currently filled by Ms Cormick who has launched interagency safety action meetings concerning domestic violence. The Court was also informed that the local area had recently become accredited as a White Ribbon Workplace.[22] The Court accepts that the Mid North Coast Local Health District is committed to continuing to strengthen its response to family and domestic violence.

Consideration of a specific electronic Medical Record (eMR) alert.

59. Dr Forrester raised an issue in evidence that had not been contemplated before the inquest commenced. He was a thoughtful and impressive witness. He volunteered a policy change for consideration that he thought might have the capacity to improve the likelihood of medical staff alerting police to the possibility of suspected domestic violence at an early stage. He had come to the idea when reviewing the circumstances of Ms Ashburn's case.

60. It was clear that Dr Platt, while busy managing Ms Ashburn's care at the time of her first attendance at Kempsey Hospital, had not considered whether her presentation could have been the result of violence. However, Dr Forrester suggested that there was a possibility that by adding a specific alert to the patient's eMR, extending the existing alert system, a doctor in Dr Platt's circumstances could be appropriately triggered to give consideration to this important issue.

61. He said:

[22] See Exhibit 3

> "…every time you open the person's chart – which is- it's integral to how you work in an emergency department now – an alert will come up… I have been trying to think of, you know, within reason, what the opportunity and that's where I think …it'd be impossible to open the person's chart and type away without seeing that alert"[23]

62. The proposal was developed to some degree and involved the idea that if a clinician was alerted to the simple fact that the patient had previously experienced domestic or family violence then it could trigger immediate consideration of the Department's policies and procedures in relation to reporting suspected violence in certain circumstances. It should be noted that it was not envisaged that further and perhaps confidential narrative be immediately available.

63. Dr Forrester explained his idea in the following way.

> "When I've tried to rerun this case and think, "Okay, where was the opportunity?" I think the person had had a number of contacts with community health and mental health – the screening tool had taken place and if that screening tool had unmasked previous abuse, then I think that's probably one piece of information that clinicians here, had they had that in front of them, would've gone, "oh, so that person's previously screened positive for domestic violence and now they've come in with this. Maybe we should really be thinking about domestic violence in the circumstance. I think that's probably where the opportunity lies…"[24]

64. It was compelling evidence, even emerging as it did, without having been previously considered by others from the Local Health District assisting the inquest. From the outset, counsel appearing for The Local Health District flagged the need to seek further instructions about what is undoubtedly a complex issue. The "alert system" forms part of the patient's electronic Medical Record. Clearly the question of whether or not the alert system should contain a person's domestic and family violence history raises a number of important issues, both practically and philosophically.

[23] Transcript 11/4/17, Page 136, line 14 onwards
[24] Transcript 11/4/17, Page 128, line 35 onwards

65. The Court was firstly alerted to the potential privacy concerns. Public hospitals must operate within the constraints of the *Privacy and Personal Protection Act* 1998 and the *Health Records and Information Act* 2002. This means that there are important privacy principles which must be adhered to. During submissions the Court was taken to the NSW Health Privacy Manual for Health Information which provides operational guidance to assist with compliance with privacy legislation.[25] A copy of the NSW Health Policy Directive "Health Care Records – Documentation and Management (PD2012_069) was also subsequently provided.

66. The alert system operates to inform medical staff who need to access a patient's eMR of certain relevant information. At present it can be used for purposes including infection prevention and control risks, patient behavioural issues which may pose a risk to themselves or others, allergies and various child protection reasons. The alert will be reviewed at each admission, including presentations at an emergency department. It is clear that alerts can be used for ongoing or static conditions, such as an allergy alert or in certain limited situations an alert can touch upon potentially more dynamic issues such as a patient's social history where for example a high risk birth alert can be attached to a patient's eMR. The use of alerts in child protection is not entirely dissimilar to the use under consideration in relation to family and domestic violence envisaged here.

67. Counsel for the Local Health District raised a number of specific concerns, namely

> "First DFV issues must be kept private for the person's safety. Secondly, DFV typically involves questions of confidentiality relating to clients who are adults not minors (for whom others may act *in loco parentis*) Thirdly, any DFV must be readily reviewable and removable."[26]

68. The Court understands that issues of confidentiality are important in this context and require further consideration. However, on Dr Forrester's evidence information may already be potentially available from DV screening tools (completed in other departments) if the practitioner has time to look for it. The beauty of the alert system

[25] Exhibit 4
[26] Supplementary written submission provided by the Mid North Coast Local Health District

would be that it could act as an immediate trigger in an emergency department for clinicians too busy to fully review past records.

69. Building trust in the context of a positive and therapeutic relationship is undoubtedly important and the intent of the alert system raised by Dr Forrester was not to disclose the detail of counselling records or past treatment. Rather the intent is to offer a trigger that would be particularly useful in situations such as that faced by a patient like Ms Ashburn, who although adult, was because of her injury or condition unable to speak for herself at the relevant time. Over the years the legislature has come up with a variety of ways to protect confidential communications made in a therapeutic relationship[27]and I have no doubt creative legal minds could grapple with an alert system which both protects the building of trust and assists clinicians in an appropriate way. Similarly, the real problem of how an alert could be reviewed or indeed removed may be solvable. The management of alerts in relation to child abuse and high risk birth alerts, already in operation, may be instructive here.

70. The Court accepts that there are a number of significant issues which require further thought and for that reason carefully considered the submission made by the Local Health District that it should refrain from making any recommendations on this issue. However, even on the limited facts available, I am of the view that further consideration by the experts in this field is warranted.

Findings made pursuant to section 81 of the *Coroner's Act* 2009 (NSW)

71. On the balance of probabilities, I find that Helen Ashburn died from the prolonged effects and complications of a head injury which occurred on 25 October 2011. She died at Port Macquarie Base Hospital, Port Macquarie on 30 December 2011. I am unable to determine the manner in which Ms Ashburn sustained her original injury.

Recommendations pursuant to section 82 of the *Coroner's Act* 2009 (NSW)

72. I have carefully considered whether or not to make any formal recommendations in relation to this matter. Counsel for the Local Health District expressed the view that it was unnecessary to deal with the modification to the training booklet by way of a

[27] See for example, in another context, legislation protecting sexual assault communications privilege

formal recommendation given the simple nature of the proposed change and Dr Forrester's obvious support for the idea. Similarly, it was submitted that a formal recommendation seeking follow up of the trial currently being carried out at Lismore Base Hospital Emergency Department was unnecessary, in the light of Dr Forrester's evidence. While Dr Forrester's support is positive, I nevertheless intend to formalise the recommendation. Staff change from time-to-time and ideas are easily lost in a busy environment. By making the suggestion a recommendation, this Court is able to follow up whether or not it has been reviewed in a timely manner.

73. For reasons set out above I make the following recommendations to

The Director of the Mid North Coast Local Health District

74. That the electronic/training booklet (e-booklet) presently provided by the MNCLHD to doctors at the commencement of their employment in Emergency Departments with the MNCLHD (including Kempsey Hospital) be modified to include a requirement mandating notification to police of reasonably suspected incidents of domestic violence in accordance with NSW Health Policy and Procedures for identifying and responding to domestic violence.

75. That the MNCLHD follow up the results of the trial of the emergency department domestic violence screening tool being carried out by the Northern NSW Local Health District at Lismore Base Hospital with a view to assessing its potential usefulness in the Mid North Coast Local Health District.

76. Despite counsel for the Local Health District's thoughtful and helpful submissions on this issue, for reasons stated above I also make the following recommendation to

The Minister for Health

77. That NSW Health give consideration to further exploring the viability and appropriateness of providing a means by which a patient's domestic and family violence history is the subject of an alert recorded on the patient's electronic medical record where that patient is at risk of serious threat resulting from domestic or family violence. Consideration of this proposition will understandably include examining the significant privacy concerns involved.

Conclusion

78. Finally, I offer my sincere condolences to Ms Ashburn's family. I thank them for their attendance and active participation in this process. I thank Mr Ward for bringing me a picture of Ms Ashburn. The care and love he showed for his mother was evident.

79. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
June 2017