IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2009 / 2742

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: FELIX HUA

Delivered On:	28 November 2013
Delivered At:	Coroner's Court of Victoria, Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	24-27 June 2013
Findings of:	HEATHER SPOONER, CORONER
Representation:	Mr Sean Cash - Counsel for Southern Cross Care (Vic) Ms Sara Hinchey - Senior Counsel for City of Yarra Ms Michelle Wilson - Counsel for Mr Vipula Mudiyanselage
Police Coronial Support Unit	Leading Senior Constable Amanda Maysbury

I, HEATHER SPOONER, Coroner having investigated the death of FELIX HUA

AND having held an inquest in relation to this death on 24, 25, 26, 27 June 2013
at Melbourne
find that the identity of the deceased was FELIX HUA
born on 16 March 1995
and the death occurred or about 2 May 2009
at Yarra River, Deep Rock
from:

1 (a) DROWNING

in the following circumstances:

1. Felix was aged 14 when he died. He lived with his mother and sister at 34 Alexander Street, Collingwood. Felix had a past medical history that included severe autism with no functional communication and little understanding of anything going on around him.[1]

Brief Background

2. Felix received respite care from the City of Yarra (the Council) who outsourced part of their respite services to Southern Cross Care (Vic) (SCC). On 30 May 2009, a Community Support Worker (CSW) employed by SCC took Felix to the Yarra Bend Park in Fairfield. The park adjoins the Yarra River. The carer left Felix unattended for a short time and Felix went missing. A comprehensive air and land search was commenced. Felix was found deceased in the Yarra River on 2 June 2009.

Police Investigation

3. An investigation was conducted into the circumstances surrounding the disappearance and drowning. It was apparent that Felix suffered from severe autism and an intellectual disability. He lived with his mother Ms Nhon Phan and sister Julie Hua. He had no contact with his father. Ms Phan's native language is Vietnamese and she has limited English language skills. Felix had no functional communication and limited understanding of the things going on around him. Felix displayed a number of challenging behaviours including

[1] Dr Chan, Felix Hua's General Practitioner in a letter to Senior Sergeant Loveridge dated 27 November 2011.

wandering off, tantrums when he did not get his own way and he had a fascination with water.[2]

4. The investigation revealed a number of details about the respite care, in particular the management by the Council and their service providerSCC.

City of Yarra's assessment of Felix for respite care

5. On 12 September 2007, Centrelink referred Felix to the Council to be assessed for respite care under the Home and Community Care (HACC) program. The Council provide some HACC through Community Support Workers (CSWs) employed directly by the Council and other care is provided by CSWs from an external provider under a contract. In 2007, the contracted service provider was Calvary Silver Circle.

6. On 27 September 2007, a Council Assessment Officer assessed Felix as being suitable for care and recorded his needs and care tasks in the Home Care Task Sheet (HCTS). On 10 October 2007, the Council asked Calvary Silver Circle to provide respite care to Felix. Calvary Silver Circle advised that they could not meet the request. It is unclear from the police brief of evidence why the Council did not follow up on this.

7. In early March 2008, Felix's school, the Brunswick Special Development School (BSDS), contacted the Council to find out the status of the referral. On 5 March 2008, Felix was again assessed as being suitable for care. On 14 March 2008 Nga To attended Felix's home to introduce Council Assessment Officer, Trang Dang, to Felix and Ms Phan as the contact person for Ms Phan at the Council.[3] On 20 March 2008, Trang Dang asked Escapade Care[4] to contact Ms Phan to explore additional respite options.

8. This was the end of Felix's assessment period and two female Council CSWs were allocated to take Felix on excursions for two hours on Saturday and two hours on Sunday.

Difficulty managing Felix and finding appropriate care

9. On the weekend of the 29-30 March 2008, the two Council CSWs complained to the Council about the difficulty in managing Felix. One of the workers asked to be allowed to

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[2] See, statement of Nhon PHAN, page 3.

[3] Statement of Adrian MURPHY, paragraph 16.6-16.8

[4] Escapade Care is provided by Milparinka disability services, their respite care is provided to clients in small groups, see,

http://www.milparinka.org.au/secure/linkclick/linkclick.php?function=services

provide respite to Felix in his own home or to have a family member accompany them on outings. Ms Phan said that if care could not be provided outside of the home, she would prefer to cancel the service. The service was cancelled on 8 April 2008. Ms Phan was advised to call Escapade Care.

10. On 12 May 2008, the Council contacted Interchange, a specialist service provider of care of young people with disabilities with high management needs, to ask them to provide respite care for Felix. They were unable to provide assistance as Felix was not registered with Interchange. The CPU understands that Interchange Northern require clients to pay for respites services or receive government individual support packages and be registered on the disability support register, it is understood that this is what was meant by Felix was not registered.[5]

11. On 15 May 2008, the BSDS contacted the Council to express their concern that respite services had been cancelled for Felix. Ms Trachtenberg, from BSDS and Ms Dang spoke at length about behaviour management strategies for Felix. Ms Trachtenberg emailed a copy of the BSDS's behaviour support plan for Felix and a video clip of him at the school to Ms Dang for the information of the Council.

The handover to Southern Cross Care

12. On 23 May 2009, the Council contracted SCC to provide the HACC services that had formerly been provided by Calvary Silver Circle. Felix was referred to SCC in a hand-over meeting on 29 May 2008. In that meeting the Council claim to have provided SCC information about dealing with Felix including a copy of the HCTS, and the behaviour support plan and video clip provided by the BSDS. SCC agreed to provide respite care for Felix. Felix's first respite care session with SCC occurred on 14 June 2008.

13. On a date between 6 and 8 August 2008, Ms Phan reputedly told the Council that the service was going well.[6] Apparently, the service was going well from the BSDS's perspective as well.[7]

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[5] See, Interchange Northern (2012) Purchased Respite Care
http://www.interchangenorthern.org.au/ServicesandPrograms/PurchasedRespite.aspx

[6] Statement of Adrian MURPHY, paragraph 16.23

[7] Statement of Adrian MURPHY, paragraph 16.23

Respite care provided by Southern Cross Care to Felix Hua

14. As part of SCC's tender to provide HACC services to the Council, they stated their intention to employ as many of the current provider's (Calvary Silver Circle's) employees to ensure continuity of care. SCC fulfilled this commitment by interviewing, and subsequently employing many Calvary Silver Circle employees that had previously worked under the Council contract. SCC is primarily an aged care provider.

15. Vipula Rajakaruna Mudiyanselage ('Mr Vipula') worked for Calvary Silver Circle from November 2007 and was employed by SCC in approximately May 2008. Mr Vipula was first rostered to provide care to Felix on 4 October 2008.[8] At the time that Mr Vipula was rostered to provide that care, he was logged in SCC's computer system, 'Gold Care', as providing home care services only, which meant that he was not permitted to provide care to children, respite or personal care.

16. Mr Vipula stated that his co-ordinators, including Ms Rose Memet[9], at SCC asked and encouraged him to work with children even though they knew he did not have any training in working with children. Mr Vipula said that the co-ordinators assured him that it would be okay, and so he agreed.

Vipula Rajakaruna Mudiyanselage's(Mr Vipula) First Respite Session with Felix

17. In October 2008, Mr Vipula started providing respite care to Felix. According to Mr Vipula, at his first respite session with Felix, he met Felix's mother, Ms Phan, at her house and asked her where she usually takes Felix. Ms Phan spoke some English and said that she takes Felix to places such as parks, supermarkets and the beach. Mr Vipula decided to take Felix to Victoria Gardens Shopping Centre.

18. Mr Vipula recounted his experience at Victoria Gardens Shopping Centre in his statement. He stated that he was shocked and embarrassed as Felix grabbed food from people's trays in the food court, threw a box, and dropped on the floor and started to dig at the floor. Felix took items from the shelf at K-mart and tried to leave without paying and ran into the ladies toilets. Ultimately, after 3 hours of dragging, lifting and chasing, Mr Vipula managed to physically force Felix into the car to return Felix to his home.

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[8] Statement of Jonathon MORRIS, paragraph 15

[9] Vipula refers to 'Ross Memet' however he may mean 'Rose Memet' who was his team leader at SCC.

19. When Mr Vipula returned Felix to his home, he tried to explain to Ms Phan what had happened. Ms Phan laughed and expressed her gratitude to Mr Vipula. Mr Vipula had almost resolved not to provide ongoing care but decided to continue because Ms Phan was so nice and appreciative.[10]

20. Mr Vipula stated that after this first session he spoke to SCC management about the trouble that he had with Felix and told them that he intended to keep trying. He said that management did not offer him any advice or assistance. Ms Nicole Ryan, a SCC roster clerk, stated that she had not received any feedback from Mr Vipula about working with Felix Hua.[11] All of the other statements from SCC employees are silent as to whether Mr Vipula raised concerns about working with Felix.

Ongoing Respite Care to Felix

21. Mr Vipula continued working with Felix and started to develop techniques for minimising his disruptive behaviour. He found that Felix enjoyed playing with dirt and was less disruptive if there were few other people around. He also tried to keep Felix away from major or busy roads. In light of this, Mr Vipula would ordinarily take Felix to Fairfield Park on Yarra Bend Road and Felix would sit contentedly and play in the dirt for two or more hours. Mr Vipula would stay near-by but would not constantly watch Felix.

22. The Council's records show that SCC provided 53 respite care sessions for Felix Hua between 14 June 2008 to 23 May 2009 and that Mr Vipula provided 30 of these sessions.[12]

The date of the incident

23. On 23 May and 30 May 2009 there were football matches being played at Fairfield Park and so Mr Vipula decided to take Felix to Yarra Bend Park instead. On 30 May 2009 Felix played in the dirt and Mr Vipula walked around the area. After about 25 minutes of Felix playing in the dirt, Mr Vipula decided to go to the car to get some biscuits for Felix. To get to the car Mr Vipula had to turn his back to Felix. Mr Vipula had left Felix playing in the dirt on many previous occasions and Felix had not moved. On this occasion when Mr Vipula returned from the car Felix was missing. Mr Vipula estimates that Felix went missing between approximately 10.45am and 11.00am.

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[10] Statement of Vipula, page 5

[11] Statement of Nicole RYAN, paragraph 30

[12] Statement of Adrian MURPHY, Paragraph 17

The search

24. After realising that Felix was missing, Mr Vipula asked the people in the vicinity if they had seen a boy and to help him look. After approximately 20 minutes, Mr Vipula called the police. The police arrived approximately 20 minutes later and began searching. The ranger arrived and began searching as well. At approximately 12:30pm the police attended Felix's family home, and his mother and sister arrived at Yarra Bend Park shortly afterwards. Mr Vipula called SCC office headquarters, the police spoke to the headquarters on Mr Vipula's behalf. Multiple managers from SCC arrived at Yarra Bend Park. One of these managers was Mr Jonathon Morris. Council managers also attended the park and arranged food and interpreters for Felix's family.

25. The police air wing, K9 and special solo unit were involved in the search as were the water police and the SES. The park was thoroughly searched through the daylight hours on Saturday and Sunday. The police also utilised the media in this time to appeal for public assistance. On Monday 1 June 2009, a decision was made to focus the search on the water. On Tuesday 2 June 2009, a witness contacted police and told them that he had seen someone fitting the description of Felix on the bank of the Yarra at approximately 10.50am on Saturday 30 May 2009. The witness attended the park and took police divers to the spot where he saw Felix. The part of the river that was identified was approximately 3.4 metres deep and had zero visibility. The search and rescue divers located Felix's body at this part of the river at approximately 11.10am on Tuesday 2 June 2009.

Issues

26. The investigation disclosed shortcomings in the Council and SCC's service provision to Felix and I requested the Coroners Prevention Unit (CPU)[13] to conduct a review:

The City of Yarra's assessment and referral process

27. The Council is responsible for assessing the needs of HACC clients that are referred to them. As at June 2009, the Council's assessment process involved a Council assessment officer attending the client's home, evaluating and documenting the client's needs and

[13] The Coroners Prevention Unit is a specialist service for coroners created to strengthen their prevention role and provide them with professional assistance on issues pertaining to public heath and safety.

capacity so that this information could be provided to the CSW. The key document for the CSW is the home care task sheet (HCTS). The HCTS contains information about:

- services required;
- respite care tasks;
- times of service;
- payment; and
- additional comments, instructions or worker requirements.[14]

28. Once the assessment officer has completed their assessment, they determine whether the service should be provided by in-house CSW, by the contracted service provider's CSW or outsourced from a specialist provider. Some clients may choose to involve an advocate who speaks to the Council on their behalf. This process is ordinarily supposed to take three days from the time of referral to assessment and then services should commence in the following two to six weeks.[15] In a review of disability services, the Victorian Auditor General's Office found that the assessment times across disability services are highly variable and clients are often not told the reasons for delay.[16]

29. The assessment of Felix did not follow this process. Centrelink referred Felix to the Council on 12 September 2007. On 27 September 2007, a Locum Council Assessment Officer conducted an in-home assessment of Felix. On 10 October 2007, the Council requested the then contractor, Calvary Silver Circle to provide care. Calvary Silver Circle could not provide care. It was unclear from the Police Brief of Evidence why Calvary Silver Circle was unable to provide care. The Council did not progress Felix's referral over the next five months until March 2008 when Felix's school, the BSDS, contacted them to find out why Felix was not receiving respite care.

30. On 5 March 2008, a Council Assessment Officer, Nga To attended Felix's home and spoke with Felix's mother without Felix being present. Nga To decided that care should be provided. On 12 March 2008, Nga To modified the previous HCTS. Ms Trang Dang was assigned as Ms Phan's contact person at the Council as Ms Dang spoke fluent Vietnamese. On 14 March 2008, Nga To and Ms Dang attended Felix's home to introduce Ms Dang to Ms Phan.

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[14] See, attachments 3 to 7 (dated September 2007 to October 2008).

[15] City of Yarra (2012) Information and Referral procedures, paragraph 16.

[16] Victorian Auditor General's Office (2012) 'Carer Support Programs' accessed on 17 August 2012 from http://www.audit.vic.gov.au/publications/20120815-Carers/20120815-Carers.html

31. Ms Dang requested the Council in-house CSWs to provide care to Felix. On 20 March 2008, Ms Dang referred Felix to Escapade Respite Services for additional care. According to Adrian Murphy, Escapade Respite Services were supposed to contact Ms Phan but it is unclear whether this occurred.[17] The two Council service workers who provided care to Felix on 29-30 March 2008 complained to the Council that Felix was too difficult. The Council suggested to Felix's mother that they could provide respite care to Felix at Ms Phan's home, however she refused, and care was cancelled on 8 April 2008.

32. In May 2008, the Council approached Interchange Northern to provide specialised care to Felix. Interchange Northern could not provide services.[18] The HCTS was modified again, but no services were provided to Felix.

33. On 15 May 2008, the BSDS called the Council requesting that services be provided to Felix. The BSDS provided some behaviour management strategies to the Council. On 29 May 2008, the Council requested that SCC provide care for Felix. SCC agreed and commenced providing respite care to Felix in June 2008.

Training of HACC Community Support Workers (HSW):

Vipula Rajakaruna Mudiyanselage's training

34. Mr Vipula's training and qualifications did not meet the standards required under the HACC program or the service agreement between the Council and SCC. Mr Vipula had started a Certificate III in Home and Community Care when he was working with Calvary Silver Circle. SCC told Mr Vipula that they would assist him to complete the course when he started working with them in May 2008. Team Leader, Ms Memet stated that it was her responsibility to ensure Mr Vipula completed the Certificate III course in HACC, however she did not do so.[19] An induction session was the only training that SCC provided Mr Vipula. When Mr Vipula started working with SCC he had no experience working with children and had not undertaken a working with children check.

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[17] See statement of Adrian Murphy, paragraph 16.9.

[18] Interchange Northern provide support to young people with disabilities and their families. They offer respite care on a full cost recovery basis – usually the client has state government funding under the individual support packages scheme. It is understood that Felix was not in receipt of an Individual Support Package, See statement of Adrian MURPHY, paragraph 16.13 see also,

http://www.interchangenorthern.org.au/ServicesandPrograms/PurchasedRespite.aspx

[19] Statement of Rose MEMET, paragraph 31.

35. Mr Vipula states that in approximately October 2008 SCC management Ms Memet[20] and Angela approached him and encouraged him to work with children. Mr Vipula states that he told them he had no experience with children but ultimately reluctantly agreed to provide care for Felix Hua.[21] At no stage did SCC offer Mr Vipula additional training in working with children or disabled people. Mr Vipula had his first working with children check in January 2009 when SCC realised that he did not have one. Mr Vipula cared for another child from November 2008 without issue.

Required Training Standards:

State and Federal HACC requirements

36. The State and Commonwealth Governments jointly fund the HACC program. Prior to 1 July 2011, the State Governments had partial policy and full operational responsibility for the administration of the HACC program. As part of the National Health Reform the Commonwealth Government has taken over policy, funding and operational responsibility for the delivery of the HACC program in all of the states except for Victoria and Western Australia.[22]

37. At the time that Mr Vipula commenced employment as a CSW, the HACC program in Victoria was governed by the Victorian Home and Community Care (HACC) Manual (2003).[23] That manual provides that "The appropriate Certificate III is the minimum standard of qualification required for HACC program funded community care workers."[24] The requirements were reviewed in 2010 but the minimum training requirement has not changed.[25]

Training Requirements in Council – SCC service agreement

38. The requirement for CSWs to hold a Certificate III in Home and Community Care was also set out in the service contract between SCC and the Council. Under the service contract, CSWs who were in the process of completing their Certificate III of Home and Community

[20] Vipula refers to 'Ross Memet' however he may mean 'Rose Memet' who was his team leader at SCC.

[21] Statement of Vipula, page 3.

[22] See, Department of Health and Ageing 'Your Health The Commonwealth HACC Program' accessed on 17 August 2012 from http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/hacc-transitionupdate

[23] Vic HACC manual 2003

[24] P.49; see, also, p.153, Department of Human Services (2007) Community Care Workers Human Resources Kit

[25] See, Department of Health (2010) HACC Community Care Worker Training and qualifications, accessed on 21 August 2012 from www.health.vic.gov.au/hacc/downloads/pdf/hacc_training.pdf.

Care were only permitted to provide home care, not personal or respite care and only if they completed that course within six months of being employed.[26]

39. The Council required that SCC employ staff with demonstrated skill or experience in caring for children.[27] In their tender documents, SCC wrote that support workers are not rostered to work with younger service users unless they have demonstrated skill and interest in working with younger service users and have a current working with children check.[28] SCC further wrote that workers employed to assist with younger service users receive additional training as required and usually bring with them experience from previous employment roles in the disability field.[29]

Information management and support by Southern Cross Care (Vic)

40. A failure to properly collect, manage and communicate information about Felix Hua and CSWs may have compromised Felix's safety during his respite care. Under the agreement between the Council and SCC there were established processes for client assessment and referral. If the Council decide to refer the client to SCC then a Council assessment officer met with a SCC team leader at a handover meeting. The Council's Assessment Officer Ms Dang and SCC team leader Mr Ward attended the handover meeting regarding Felix and Ms Dang provided Mr Ward with documents about the management of Felix.[30] After the meeting, Mr Ward was supposed to enter the client's information to SCC's computer system and store it in hard copy. Mr Ward should have then briefed a roster clerk about the newly referred clients. The roster clerk was then supposed to use the information stored in the computer and the team leader's verbal instructions to develop rosters for the CSW. The Roster Clerk should have then provided the CSW. If the CSW had been assigned any new clients then the team leader should have briefed the CSW about the new clients. At some stage the relevant SCC team leader changed from Mr Ward to Ms Memet. It was not altogether clear when or why this occurred.

41. The circumstances of Felix's death reveal deficiencies at each stage of this process. These deficiencies have been grouped into five broad headings:

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[26] Southern Cross Care (Vic) (2008) Yarra City Council : Contract No 969 – Home Care Services, Schedule 11, p 69.

[27] Yarra City Council (2007) Home Care Services: Specification, p 35.

[28] Southern Cross Care (Vic) (2008) Yarra City Council : Contract No 969 – Home Care Services, p 42.

[29] Southern Cross Care (Vic) (2008) Yarra City Council : Contract No 969 – Home Care Services Schedule 12, pp 89-90.

[30] Statement of Adrian MURPHY, paragraph 16.20.

- Team leader-roster clerk relationship
- Computer system
- Information provided to the CSW
- Support provided to the CSW
- Communication with the client's family

Team Leader-Roster Clerk Relationship

42. Team leader Ms Memet stated that she expected that roster clerks would look at the hard copy of the HCTS as well as the information entered into the computer system. It is unclear whether the roster clerks did this. It is likely that if the roster clerk did not look at the HCTS they would miss information and therefore may not pass it on to the CSW, which would compromise the care provided to the client.

43. On 4 October 2008, a team leader, Ms Angela Spicer, assigned Mr Vipula to work with Felix Hua.[31] It is unclear what information Ms Spicer relied on when assigning Mr Vipula to Felix.

44. Ms Memet, the Team Leader, was unaware of the video that BSDS had provided to the Council and therefore this information may not have been available to the roster clerk or the CSW.[32]

45. Following the death of Felix Hua, SCC commissioned Alecto Consulting Pty Ltd to conduct an external independent review of all Community Support Services. Alecto Consulting Pty Ltd found that the turnover of managers and team leaders led to inconsistencies in the application of SCC processes. The report further noted that the physical office space was unsuitable and may have contributed to staff turnover and operational hurdles. The report did not comment on the content of SCC's information management policies or procedures.

Computer system

46. Mr Vipula was registered in the SCC's computer program 'Gold Care' as only to provide home care, not respite or personal care. Regardless of this, Mr Vipula was assigned to provide respite care to Felix. Mr Vipula also did not have a working with children check. It was not clear whether the computer records were accurate in relation to Mr Vipula's

[31] Statement of Marita SCOTT, paragraph 17.
[32] Trang Dang states that behaviour support plan and CD were given to SCC, it is unclear what happened to the items though, see Statement of Trang DANG, paragraph 22.

working with children status. SCC acknowledged that they experienced considerable difficulties in managing electronic files in relation to Council clients and it is likely this contributed, in part, to Mr Vipula being inappropriately assigned to work with Felix.[33]

47. Under the service contract, SCC agreed to introduce new software that would facilitate the sharing of information between SCC and the Council and also the management of information within SCC.

48. SCC agreed to implement the system and for it to be fully operational by mid-April 2008 and ready for the transition of Council information in mid-May 2008. This was a short timeframe and the transition was not entirely successful. SCC had difficulty transferring data from the previous provider.[34] There was also difficulty transferring paper based clients. These problems caused SCC to conduct an audit of all 600 files in mid-2009, which identified the need to update information in approximately half of all files.[35]

Information provided to CSW

49. Mr Vipula stated that he never received any details about Felix's disability. Mr Vipula stated that the SCC would call him and ask him to take a new client. They would provide him with the client's name and address.[36] Mr Vipula maintained that management never went into details about Felix's disabilities, needs or places to take him.[37]

50. Mr Jonathon Morris, SCC Manager, expected that CSWs would be provided with a task list and/or care plan and any other relevant information about their clients.[38] Ms Rose Memet, SCC Team Leader, expected that CSWs would follow a task sheet that the roster clerk would give to them.[39] Ms Nicole Ryan, a SCC Roster Clerk stated that some carers would receive a HCTS and others would not, depending on whether the CSW attended the office and whether there was time to send the HCTS prior to the CSW meeting the client. Ms Ryan

[33] Alecto Consulting (presented by Martina Stanley) (2010) Evaluation and Continuous Improvement Review: Community Support Services: Final Report for External Stakeholders Southern Cross Community Care (Vic), p 6.
[34] Alecto Consulting (presented by Martina Stanley) (2010) Evaluation and Continuous Improvement Review: Community Support Services: Final Report for External Stakeholders Southern Cross Community Care (Vic), p 6.
[35] Alecto Consulting (presented by Martina Stanley) (2010) Evaluation and Continuous Improvement Review: Community Support Services: Final Report for External Stakeholders Southern Cross Community Care (Vic), p 6.

[36] Statement of Vipula, page 3.

[37] Statement of Vipula, page 3.

[38] Statement of Jonathon MORRIS, paragraph 16-18.

[39] Statement of Rose MEMET, paragraph 21.

said that some instructions were printed on the roster and these were routinely provided to CSW.[40]

51. Under the service agreement between SCC and the Council, it appears the intention was that the team leader would brief CSW on any new clients allocated to them. In their tender SCC asserted that:

- Prior to the commencement of services for a new client or where an existing client is to commence a new service type (personal care or respite care), or as directed by the Home Care Co-ordinator, Southern Cross Care (Vic) will undertake a face to face briefing between the community support worker and the team leader.
- The briefing will provide an opportunity to communicate the details of the care plan and task list, to discuss the Occupational Health and Safety checklist, to discuss the handover information and ensure the community support worker is fully informed.
- Should Southern Cross Care (Vic) be unable to undertake the briefing prior to service commencement, due to the urgency of the service request, it will, with the prior approval of the Yarra City Council Home Care Co-ordinator, provide the appropriate information relating to client care needs, circumstance, OH&S concerns and any other critical information to the community support worker over the phone and then provide the formal briefing at the next possible opportunity.[41]

52. Ms Memet stated that she had fortnightly meetings with CSWs but there was no indication from the statements in the brief that CSWs and Team Leaders met prior to commencing services with a new client.

53. It appears that the team leader may have assumed that the roster clerk would provide the HCTS with the roster to the CSW. According to the service agreement, the team leader was supposed to meet with a CSW before the CSW started with a new client and it would have been reasonable to think that the team leader would provide the HCTS to the CSW in that meeting.

54. The discrepancies in the amount of information that each person thought that the CSW was given suggests that there were systemic issues in the provision of information to the CSW. It

[40] Statement of Nicole RYAN, paragraph 18.
[41] Southern Cross Care (Vic) (2008) Yarra City Council : Contract No 969 – Home Care Services, schedule 11, p 65.

further suggested that there was no policy, or a poorly understood policy about what information should be provided to the CSW and by whom.

Support provided by CSW

55. Mr Vipula claimed that SCC management encouraged him to work with children without providing him with any training or resources to do so. Mr Vipula and Ms Memet both anticipated that Mr Vipula would talk to the client's family to determine what activities Mr Vipula and Felix would undertake.[42] The brief did not mention whether Mr Vipula and Ms Phan were provided with an interpreter. In the HCTS of approximately 7 May 2008, the CSW was supposed to provide care at Felix's home for the first session. This did not occur.

56. Mr Vipula stated that he spoke to management about the difficulties that he had with managing Felix in his first session and that management 'laughed along' and did not offer him any help or support.[43] Ms Ryan, the roster clerk, said that Mr Vipula had not mentioned anything to her. The remainder of the SCC employees were silent on whether Mr Vipula had raised issues relating to Felix to them.

57. In their tender, SCC promote that:

> ...support workers are encouraged and expected to report back to the team leader if difficulties emerge – they may be related to misunderstandings about the scope of the work to be undertaken, ways of doing tasks or may be a personality difference. As soon as the team leader has been advised of this, contact is made with the client and a solution is sought to alleviate the problem.[44]

58. On Mr Vipula's version of events this did not occur.

59. After Felix went missing, SCC sent managers to Yarra Bend Park and they provided some care and support to Mr Vipula. However, on the Monday after Felix disappeared Mr Morris attended Mr Vipula's house and asked to see all the information that Mr Vipula had been given in relation to Felix and notified Mr Vipula that he was suspended on pay. Mr Vipula said that he felt after that time that SCC were going to attempt to blame Felix's disappearance on him.

60. Again this seemed at odds with SCC's tender document which provides:

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[42] See, Statement of Rose MEMET, paragraph 21, see also Statement of Vipula, page 3.

[43] Statement of Vipula, page 5.

[44] Southern Cross Care (Vic) (2008) Yarra City Council : Contract No 969 – Home Care Services Schedule 14, p 105.

> Southern Cross Care (Vic) aside from providing personnel with support from their immediate supervisor on a day to day basis are also aware that personnel may require additional assistance at times and particularly in times of stress resulting from an incident. Southern Cross Care (Vic) has prepared guidelines (appendix 55) which provide managers with information on how to best assist their personnel during times of stress or personal trauma.[45]

61. Tress Cox Lawyers letter to the CPU of 15 June 2012 confirmed Mr Vipula's view that SCC considered him solely responsible for Felix's death. Tress Cox Lawyers on behalf of SCC states: *"...the unfortunate death of Felix Hua was a clear case of human error on the part of the Community Support worker involved."*

62. Prior to Felix's disappearance, CSWs providing respite care were not required to inform SCC of where they were taking the client and indeed no one at SCC nor Ms Phan knew where Mr Vipula regularly took Felix. This would have delayed any assistance that could have been provided if Mr Vipula was unable to contact the office in an emergency.

63. It appeared from the evidence in the brief that Mr Vipula was given limited support in his work.

Communication with the family

64. Ms Nhon Phan spoke some English, however, the Council considered that it was best to provide a Vietnamese speaking assessment officer. Ms Phan's daughter, Julie Hua, said that Ms Phan does not speak English.[46] Ms Phan used an interpreter to provide her statement for the Coroner. In her statement, Ms Phan says:

> *"When I agreed for my son to be part of the service I thought he'd be looked after by a Vietnamese speaking person. I thought that they would do this so I could communicate with the person who came to look after my son, However there was never a Vietnamese person who came to my house. Also when I was interviewed initially by the intake worker I told them about the concerns I had about my son running away."*[47]

65. It is not mentioned in the brief, but it appears that SCC did not provide an interpreter for Ms Phan to talk to SCC CSWs. In her statement, Ms Phan made many references to her fear of Felix running off. It may have been beneficial for Ms Phan to be able to communicate these

[45] Southern Cross Care (Vic) (2008) Yarra City Council: Contract No 969 – Home Care Services Schedule 12, p 89.

[46] Statement of Julie HUA, page 2.

[47] Statement of Nhon PHAN, page 2.

fears to SCC's CSWs. It was unclear whether the Council or SCC told Ms Phan that the CSW would not speak Vietnamese. In their tender documents, SCC mentioned that they would use interpreters and recruit bi-lingual staff or staff that have knowledge of other cultures.[48]

Improvements

66. The CPU requested information from SCC about the improvements to the service provision that SCC have made since the death of Felix. The SCC noted the following:

- greater diligence in assessing whether a client is suitable for care by SCC after receiving information from the Council[49]
- new process of holding a follow-up meeting between team leader and CSW after first or second shift
- six weeks after care commences, SCC send out a client survey
- recruitment of two capable team leaders[50]
- a number of casual roster clerk positions replaced with permanent part time positions[51]
- new Clinical Governance Manager and Business Analyst Manager
- relocation to a more suitable office.

67. SCC also provided the Coroners Court with a copy of a report from Alecto Consulting P/L who conducted an external review of SCC's business. That report was a version that was edited for public release. The report noted improvement projects that SCC was continuing to work on. These are contained in Table 2.

[48] Southern Cross Care (Vic) (2008) Yarra City Council: Contract No 969 – Home Care Services, p 43.

[49] Letter to CPU from TressCox Lawyers (15 June 2012) p 2, attachment 9.

[50] Alecto Consulting (presented by Martina Stanley) (2010) Evaluation and Continuous Improvement Review: Community Support Services: Final Report for External Stakeholders Southern Cross Community Care (Vic), p 6.

[51] Alecto Consulting (presented by Martina Stanley) (2010) Evaluation and Continuous Improvement Review: Community Support Services: Final Report for External Stakeholders Southern Cross Community Care (Vic), p 6.

Table 2: Improvement projects undertaken by SCC[52]

Quality Improvement Initiatives	Status
Improvements to People Management	
Improved handover systems with CoY staff	Implemented
New process for handover of new clients to CSWs (initial and subsequent briefings)	Partially implemented
Development of a formula for staff requirements for CSS	Completed
Training in recruitment and induction for team leaders	Completed
Identification of skill requirements for care tasks	In progress
Mandatory training sessions for all CSWs (Manual Handling, First Aid, etc.)	Ongoing
Performance management program for all CSWs	In progress
Recruitment drive to increase number of CSWs with qualifications in disability	In progress
Agreement of new EBA including provisions and guidelines for briefing sessions	Completed
Various initiatives to ensure that all CSWs have Certificate III as minimum qualification	Implemented
Recruitment for new admin support position	Commenced
Increased number of part-time permanent CSWs to replace casual staff	Ongoing
Improvements to Management of Information	
Development of skills matching functions	In progress
Development and 'roll out' of documentation standards for client files	In progress
Recording of all qualifications for CSWs at CoY	Completed
Improved recording of WWCC information	Ongoing
Collaborative effort with Council staff to update client files with incomplete or dated information	In progress
Identification and documentation of 'conditions' for all clients < 64 years	Almost completed
Improved management of training register	In progress
Improvements to Processes and Protocols	
Minimum referral guidelines for intake	In progress
Documentation standards for users of the Client Management System	In progress
Agreement of KPIs and quarterly reporting to Council staff	Implemented
Discharge of clients who are no longer receiving services	In progress
Improved monitoring of OH&S reports	Implemented

68. Alecto Consulting made additional recommendations for further improvements.

Some of these were:

- develop more structured group training sessions for CSWs which provide ongoing training in key professional development topic areas including:
  - active service model
  - working with children safely
  - preventing elder abuse
  - develop sub-teams for geographic districts to improve efficiency of CSW travel time and costs

[52] Alecto Consulting (presented by Martina Stanley) (2010) Evaluation and Continuous Improvement Review: Community Support Services: Final Report for External Stakeholders Southern Cross Community Care (Vic), p 7.

- use sub-team structure to create a stronger link between roster clerks and individual CSWs.

- continue to review the process for conducting subsequent briefings for CSWs. In addition to recent improvements this could be focussed on:
  - relationship building with CSWs
  - reporting to Council on complex clients
  - opportunity for coaching of CSWs
- develop written guidelines for specific tasks and processes undertaken by roster clerks. Include key principles that allow the staff to make appropriate decisions for situations that cannot be anticipated
- provide the written protocols to new roster clerks as part of their job readiness training
- develop systems to ensure that feedback from carers is documented and that a record of the time and date of that transfer is recorded
- continue to improve the processes for initial briefing of carers and ensure that carers provide written confirmation that they have been supplied with specific information about clients. Ideally, a copy of the information provided to the carer should be attached so that there is a record of information that has been provided
- continue developing new processes in consultation with council staff to ensure that respite clients are managed differently to other client groups. This includes ensuring that adequate information is available with regards to the support needs of the care recipient (rather than the respite recipient or carer)
- consider the development of a new referral tool, which is specifically designed to capture the needs of children receiving respite.

<u>The delivery of services to young people under the HACC program</u>

69. The Home and Community Care program encompasses various services including assisting older people with home maintenance, cleaning, shopping and personal care and providing respite care to younger disabled people. The majority of HACC clients are elderly - only 2.9% of all HACC clients were under 20 years old in 2009-10. Child HACC clients

generally require more specialised care than older HACC clients.[53] A review of HACC assessment procedures also found that the assessment of children is problematic.[54]

Council's and SCC's provision of HACC to younger people

70. The vast majority of the Council's HACC clients were over 18 years old (approximately 99%). The Council engaged SCC to provide HACC services presumably based on its wealth of experience in providing care to the aged.

71. SCC was primarily an aged care provider.[55] Their 2010 - 2015 Strategic Direction Plan demonstrated their commitment to aged care. That plan sets their aspiration as 'Older people, living well, loving life and participating within a just and inclusive community. And their purpose as 'Southern Cross Care (Vic), within a Christian ethos, is committed to serving and supporting older people and their families'.[56] In his statement for the Coronial brief, Mr Jonathon Morris, SCC Regional Manager, stated that SCC had some issues with developing processes for children with disabilities.[57]

72. The CPU wrote to SCC and requested information about whether SCC had policies in relation to caring for younger people. SCC (through their lawyers) replied:

> *"As at the time of the death of Felix Hua, Southern Cross Care (Vic) [SCC (Vic)] had no policies in place specific to children with disabilities and it's the view of SCC that no such policies are required. ... no policies can be written that will apply to every individual. ...the policies that were in place at the time of the death of Felix Hua should have been adequate to ensure care was delivered appropriately. Unfortunately, it is the case, that human error cannot be eradicated entirely no matter what policies are in place. ...the unfortunate death of Felix Hua was a clear case of human error on the part of the community support worker involved."*[58]

[53] Howe, A. & Warren, D., (2005) Strategic Directions in Assessment: Victorian Home and Community Care Program – Final Report.

[54] Howe, A. & Warren, D., (2005) Strategic Directions in Assessment: Victorian Home and Community Care Program – Final Report, p 55.

[55] Alecto Consulting (presented by Martina Stanley) (2010) Evaluation and Continuous Improvement Review: Community Support Services: Final Report for External Stakeholders Southern Cross Community Care (Vic), p 3.

[56] Southern Cross Care (Vic). Strategic Plan 2010 – 2015 accessed on 17 August 2012 from http://www.southern-cross.org.au/strategic_direction.

[57] Statement of Jonathon Morris, paragraph 13.

[58] Tress Cox Letter 15 June 2012, attachment 9.

73. Given that SCC agreed to provide respite care to children as part of their service contract with the Council, it seemed anomalous that they would not have any policies about how to care for these clients.

74. SCC had not elaborated on how the community support worker erred or what provisions they had in place to limit the potential for Mr Vipula to make a mistake.

Inquest

75. On 6 December 2012, an initial Directions Hearing proceeded before me and I sought details of any concessions from the parties together with any improvements that had been implemented since Felix's death. A second hearing proceeded in May 2013.

76. On 17 June 2013, there was a further Directions Hearing. The following issues were highlighted:

- Mr Vipula Mudianselage was unqualified for the task of providing respite care to Felix.
- As well as a lack of relevant qualifications, Mr Vipula had no previous experience in working with children or with children with disabilities.
- Despite being aware of this, SCC employed Mr Vipula, and in doing so, ignored their own policies and procedures.
- At the time, SCC appeared to be working discordantly, with communication difficulties between staff and the accessible recording of relevant and vital information.
- Despite Mr Vipula's claim to have complained about the difficulties in managing Felix, SCC had no record of this.
- SCC had no policies specifically in relation to the care of children or children with disabilities (SCC agreed to provide respite care to children as part of their contract with COY).
- Changes had been implemented, as documented in the *Statement of Agreed Facts,* but the issue was how their effectiveness measured
- Many of the changes since Felix's death involved new policies and procedures but the monitoring mechanisms to ensure compliance were unclear

- The Certificate III in HACC was still a basic qualification required by CSWs although the relevance of such in regard to the respite care of children and children with disabilities was unclear.
- Due to Ms Phan's limited English skills, there was an inability for her to communicate effectively – Ms Phan's expectation had been that a Vietnamese speaker would be caring for Felix.
- Ms Phan was the person who could provide the most accurate, helpful and current information about Felix and his needs.

77. An Agreed Statement of Facts dated 5 June 2013,[59] from Southern Cross Care and Council was tendered.

78. On 24 June 2013, the inquest commenced.

79. At the outset of the inquest both Mr Cash and Ms Hinchey made open apologies to the family and while both acknowledged deficiencies in the policies and the care that was provided,[60] SCC stated in part:

> *"Southern Cross Care (Vic) is deeply sorry Felix died while in its care. Felix should not have been allowed to wander off with such tragic consequences while he was supposed to have been under the watchful eye of a Community Support Worker employed by SCC (Vic).*
>
> *SCC (Vic) does not seek to make excuses but does maintain that it provided the Community Support Worker concerned with information about Felix and his condition which, had it been actioned properly, would have avoided Felix's death."*

80. Several witnesses gave evidence at inquest including:

Ms Nhon Phan, was the mother of Felix. She required the assistance of an interpreter and it was apparent that she had little recollection of some events and a poor understanding of English; she described herself as illiterate and she relied on the assistance of her daughter with any written document.

Ms Phan told the inquest about caring for Felix when he was out,

[59] Inquest Brief and Exhibit 'A"

[60] Transcript pages 4-6

"I always make sure that he is within my reach and I put a leash on him or hold his hand tightly"[61]

81. Ms Phan explained this when she met a Vietnamese speaking Council Worker. She had also told the worker that her son could not swim but he "*loved water*".[62] Ms Phan was expecting and hoping that her son would be cared for by someone who spoke Vietnamese. When asked how she communicated with the carer she told the inquest that "there wasn't much communication within me and the man who looked after my son".[63] Ms Phan was asked about the home care task sheet which was unsure about, but she did recall two people attending her home:

> *"When they came Felix was home but they did not speak to Felix but they did keep an eye on him. They look at him and assessed him and in the mean time Felix was playing and minding his own business being in his own world....I gave them many instructions. One of them , very important to me I told them my son if – when not – he loves to run about and run away from them and I asked them to keep an eye on him and to make sure to keep him by their side"*[64] *during later questioning Ms Phan stated "I told many things to the people from Council and I expect them to relay those instructions to the person, um, who looks after my son. It goes without explaining."*[65]
>
> However, she also stated that it was obvious that Felix had to be kept within reach because of his tendency to run off.[66]

82. Ms Phan was taken to aspects of the statement from the carer, Mr Vipula but disagreed with his version of her reaction to the difficulties he faced on his first outing with Felix. She told the inquest

> *"...I do not agree with that at all because how could I laugh at something I did not understand. It's as if he – he talked to me in a totally different language. I did not understand what he was trying to say."*[67]

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[61] Transcript page 12

[62] Transcript page 12

[63] Transcript page 14

[64] Transcript page 17

[65] Transcript page 28

[66] Transcript page 28

83. When Ms Phan was asked whether Mr Vipula explained to her the difficulties on their second outing she said:

> *"He might have attempted to do so sir but as I already said before the court that I have very very limited English so it was like talking to someone else."*[68]

84. She thought Mr Vipula understood the need to keep an eye on Felix:

> *"The fact that he had taken Felix out for many outings and brought him home safe and sound made me believe he was doing his job all right."*[69]

85. Later Ms Phan was asked:

> *"Did he ever tell you about an occasion when Felix ran off?.....He might have but I don't remember".*[70]

86. Ms Phan was not aware of being told about any other occasion when the police were called whilst Felix was in the care of Mr Vipula.[71]

87. Although Ms Phan had initially provided a harness to Mr Vipula she ceased doing so because Felix did not like it and Mr Vipula said there was no need.[72]

88. Ms Phan[73] was recalled as a witness towards the end of the inquest to look at photos of Felix on Mr Vipula's phone but could not recall having seen them before.

89. Mr Clyde Dearing was Felix's teacher. He mourned the loss of Felix who was a valued member of the school community. He referred to the excursions with Felix such as going to a park mid week and noted

> *"..that might be the only case where we might be able to have given Felix a little bit of room to move.. if he moved more than say 10 metres from the group then we would respond and either call on him to stop or move to bring him back with us."*[74]

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[67] Transcript page 20

[68] Transcript page 22

[69] Transcript page 23

[70] Transcript page 26

[71] Transcript page 26

[72] Transcript page 31

[73] Transcript page 384

[74] Transcript page 44

He expected that any carer would need training and an understanding of '*autism*' in caring for Felix.[75]

90. Mr Jonathon Morris was employed by SCC when Felix died. He told the inquest in part:

> *"...I think there was almost an assumption that younger people with disabilities could be looked after with the same procedures and protocols as for older people, and I think this was entirely wrong. So I think we – we um, because it was such a small proportion of our clients, we didn't really seem to have systems in place at that time recognising the specific needs of children, and I think we really didn't – I don't think we handled that well, at that stage."*[76]

> *"Is it the case then that a roster clerk, for example, could have theoretically been allocating respite care for a child to an employee without any specific training or knowledge about children or children with disabilities? ---Certainly could be."*[77]

91. Mr Morris told the inquest about the difficulties encountered and associated problems when SCC took over from the previous provider. He said:

> *"...I wasn't involved in the project, so I'm just – and that was the difficulty, but when you're transferring, I think it was about 600 clients at one hit, the difficulty of going through that transfer, and I think that it wasn't – that level of detail I think got lost in the – what I think was a chaotic situation with a new computer system that was taking – that wasn't working well at all, it was causing a lot of problems. People hadn't been trained properly in it, everything was going wrong, and I think that – I suspect that that was part of the problem of what was happening in terms of actually conveying that information across. I don't believe that happened, although I'm saying that not actually – not being part of that process at the time. But I think there was from my understanding a very difficult situation, and I think that unlike what happened, once it was established there was a - what was called a handover process, so there was a meeting in which individual clients – there was a process of explaining what the needs of the clients were. Handing over any information, making sure that all of that information would then be conveyed to the relevant carers. There was process in place for new clients, but I think dealing with what I*

[75] Transcript page 45

[76] Transcript page 79

[77] Transcript page 81

think was for about 600 clients at one hit, I think there was a problem in the way that that was handled looking at – after the event. And I think that was something that probably, in retrospect, probably wasn't handled as well as it could've been."[78]

92. There was a lot of evidence and questioning about the different procedures that were expected to be completed and performed by the caseworker (including the client task sheets, time sheets/rosters). Mr Morris maintained that his memory of matters including his meeting after the event and conversations with Mr Vipula was correct.[79]

93. Mr Morris told the inquest that the death proved to be a catalyst for change at SCC and a continuous improvement plan was put in place;

"So we put in place systems for making sure that we had better tracking of qualifications, better tracking um, of what we do, making sure that staff were better informed of their requirements."[80]

94. He provided very limited hearsay evidence about another occasion when police were apparently called to attend when Felix was in the care of Mr Vipula, which was first raised by SCC after the inquest had commenced.[81]

95. When asked about 'mistakes' that may have been made Mr Morris stated:

"I think the recognition, as I said - I think the most important one really is to do with how we would ensure that clients, and in particular people with complex disabilities, were being supported and really to work through the appropriate training that was required and how we would, m'mm, provide appropriate supplement, I think that was probably – that was certainly a major."

So knowing what you know now where you've talked about allocating children to people who have had maybe some experience or some – so would one of those things be if this – sorry, the inference being that Mr Vipula would never have been allocated to Felix post these changes?

"---I – I would believe that that's – yes, that given what we know now that would be the case, yeah."[82]

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[78] Transcript pages 87 & 88

[79] Transcript page 125

[80] Transcript page 102

[81] Transcript page 117

96. Mr Vipula Mudiyanselage (referred to throughout the inquest with Mr Mudiyanselage's consent as Mr Vipula) was the carer allocated for Felix. He gave lengthy evidence under protection of a certificate pursuant to S57 of the Act. He was previously employed by Calvary Silver Circle as a carer for the elderly and told the inquest that he held a Masters of Law and Accounting. These were impressive qualifications but of limited assistance to the training required as a carer for a disabled child. Mr Vipula had a strong accent (arriving in Australia 2007) however, there was little doubt that he was a literate man capable of understanding English albeit not his first language.[83]

97. Mr Vipula told the inquest that he was allocated a child, Felix via a time sheet/roster system and went to his home.[84] He spoke to Ms Phan using some English words and sign language; she expected Mr Vipula to take Felix out to parks, supermarket, Victoria Gardens and the beach.[85] They had visited St Kilda beach twice and he produced a photo of Felix there, which he maintained had been shown to Ms Phan. He was unfamiliar with the term '*autistic*' but had read some books. He apparently had no difficulties with Felix being near water when he took him to the beach. He told the court about the difficulties he experienced with Felix when he first took him out and claimed that when he later raised issues with his managers they assured him he would be all right.[86] According to Mr Vipula there were communication problems with the managers.[87]

98. In regard to another occasion when the police were called, Mr Vipula claimed that the police accepted it was a misunderstanding and that he had told Ms Phan but was uncertain that she understood. He claimed that he didn't mention it to management because of the past difficulties and the fact he feared he might lose his job.[88]

99. In regard to the differences between his evidence and that of Mr Morris he claimed there had been a misunderstanding.[89] He could not identify an unsigned document that was allegedly

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[82] Transcript page 133

[83] Transcript pages 117 & 230-231

[84] Transcript page 155

[85] Transcript page 162

[86] Transcript page 212

[87] Transcript page 164

[88] Transcript pages 168 & 201

[89] Transcript page 170

produced following a meeting with SCC lawyers, which he said was just a conversation.[90] He conceded that when he signed his contract of employment and was interviewed he did receive some items in a bag including a 'book' (the Community Support Workers handbook) which he denied ignoring but did not read.[91] He claimed that he had not been shown the DVD related to Felix's behaviour. Towards the end of his testimony he was asked:

> Ms Wilson: Mr Vipula you were shown the community support worker's handbook and I believe your evidence was that you did receive a handbook? Or something that looked like this?---*Yeah, it looked like that lady's – yeah.* But that you didn't read it?---*I didn't read it.* Were you ever told about the book by anybody at Southern Cross?---*No, nobody told me anything about it.* Were you ever told or directed to read that document?---*No.* Were you ever told what its purpose was?---*No.*[92]

100. Mr Vipula found Felix's family very nice but was not confident that they understood what he was saying when he tried to explain what had occurred when he took Felix out.[93]

101. Mr Vipula repeatedly denied challenges about his recollection of events, meetings with supervisors, processes and verbal and telephone communications with SCC. Mr Vipula was accused of false denials but maintained he had not received the home care tasks sheet.[94] Finally it was put to him:

> You know that you were aware that Southern Cross Care expected you to keep an eye on him at all times, don't you?---*Yeah, I was – I mean it's not that – they told me to go and look after – there, I don't know whether they expect anything or – I had to get my own experience to do it and I just (indistinct) I don't know anything about it.* And you didn't need to be told by anyone to keep your eyes on him because common sense explained to you from your experience that he would run off?---*No, for two hours when he was playing there, he never – with my own experience, he never ran away or is run away.*[95]

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[90] Transcript page 180

[91] Transcript pages 184 & 211

[92] Transcript page 256

[93] Transcript page 234

[94] Transcript page 255

[95] Transcript page 256

102. Ms Janice Horsnell told the inquest that she was the CEO at SCC and commenced her evidence by reading a fulsome apology. She was aware of the transfer of staff from the previous provider and told of her dismay about discovering Mr Vipula's lack of qualifications including the absence of any working with children check.[96] She had difficulty understanding Mr Vipula's lack of knowledge of the term 'autistic'.[97] She stated:

> *"I think autism is broadly known throughout our community and I would have expected, even if he hadn't received thorough education at Southern Cross Care at the time, that he would have asked a question after so many visits about Felix's behaviour or his inability to communicate properly and his behaviours which were not consistent with a boy of 14."*[98]
>
> *"Without putting a name to it, he had to – how does that sit with you?---That doesn't sit with me. I did see his task sheet at the time of the incident. Even if he didn't have a name to it, being autism, it was really clear that Felix, as with a lot of most other young people with a disability and particularly an intellectual disability, need a very clear level of supervision and support. Now, I'll give an example. Without any training at all, if you had a baby with your or a two year old. I think any of us would know, even if we didn't have a baby of our own and had no training with small children, that you had to keep a close watch on them. You wouldn't leave a baby or a small child somewhere else for any reason. You would take that baby or small child with you. As with somebody with an intellectual disability, whether they be a child or an adult with an intellectual disability, they are vulnerable and not able to take responsibility for their own safety and I think that is a responsibility that most adults with any level of intellectual capacity would know without training, so I find that difficult."*[99]

103. In regard to the obligations of SCC under the contract with Council to provide or arrange for training for workers, it was put to her that it did not occur here and she said:

> "But that's not what happened in this case?---*Well, I understand not. However, I cannot I guess testify whether he was given a briefing or not. You know, the*

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[96] Transcript page 262

[97] Transcript page 263

[98] Transcript page 263

[99] Transcript page 264

supervisors say that he was given information, he said he wasn't and I can't tell you which is right and which is wrong."[100]

104. Ms Horsnell was asked about the sufficiency of employing someone inexperienced in working with children or children with disabilities. She had some doubts about his lack of experience but noted in part:

> *"...I think that is an area which we certainly have improved about thorough assessment, thorough retraining and not assuming that somebody who has transferred from another program has already had that training."*[101]

105. Ms Horsnell was asked about the circumstances in which she was informed about the prior incident involving police attendance during a period of respite care. Apparently an unknown police officer had told her, *"I recognise this boy and I recognise the name of the carer... because on a previous occasion I was called by a woman – I was on duty and I was called to the oval because there was a young boy with a disability wandering aimlessly, seemingly by himself.. I was talking with the woman who had the boy and at that time a young man jumped out of the car and said it's all okay, he's with me...so there was no report then taken..."*[102]

106. Ms Horsnell was unable to provide me with the name or further details of the police officer concerned and my further enquiries of the investigating member were to no avail.

107. Ms Horsnell told the inquest about the thorough review that occurred and the implementation of every recommendation.[103] She conceded that even if Mr Vipula had read the CSW Handbook (which he had not), it contained nothing about caring for children or children with disabilities.[104]

108. Later Ms Horsnell told the inquest that it should not have been difficult for an adult to keep Felix safe and stated:

> *"...if you knew that he had a tendency to run off, you would not leave his side...you wouldn't have let him go – if it was true that he went to get a biscuit, you would not*

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[100] Transcript page 265

[101] Transcript page 265

[102] Transcript page 269

[103] Transcript page 272

[104] Transcript page 272

have left him, as you would not a two year old. You would take a two year old or somebody that couldn't keep themselves safe with you....he had been with him 31 times They had a good enough relationship that, as he did with his school teachers who were women, that you would be – you would take his hand and you would take him with you. You would not leave him and turn your back on him."[105]

109. Mr Adrian Murphy is the Manager of Aged and Disability Services at Council. He provided information about assessments and a background to the contractual arrangements with SCC. The services were ultimately provided by the Council were contracted to SCC. He agreed it was their responsibility to monitor and supervise the contract. He noted that despite a specific requirement within the contract requiring carers to be trained, Mr Vipula was not specifically qualified to look after Felix. Mr Murphy agreed that *"..we have a responsibility to monitor and supervise the contract and yes, to that extent we have responsibility for overseeing and making reasonable enquiries to ensure that Southern Cross are complying with the contract."*[106]

110. He gave evidence about the hand over meetings that regularly occur and the provision under the contract to inform the Council if necessary services are unable to be provided so that council can source them elsewhere. Council now have two specialty providers for children with disabilities and cultural communities.[107]

111. Mr Murphy tendered the 'Incident Report' prepared for Department of Human Services (DHS) and sought to clarify an aspect of Mr Morris' evidence stating:

"...Felix wasn't part of the transition from Contractor A to Contractor B; Felix's handover occurred after the contract started with Southern Cross. A specific handover occurred. (Still, only within days of the contract commencing)"[108]

112. Finally, Mr Murphy confirmed his belief that Council had handed over to SCC pursuant to the 29 May request for respite services for Felix's meeting, the updated Care Plan, Behaviour Support Plan and DVD.[109]

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[105] Transcript page 288

[106] Transcript page 318

[107] Transcript page 335

[108] Transcript pages 346

[109] Transcript page 349

113. Ms Therese Desmond an Executive Manager Community Services SCC reassured the inquest that given the systems now in place no-one could be employed as Mr Vipula was without appropriate training or qualifications. Ms Desmond highlighted several improvements and changes to their process that had occurred together with how they are monitored.

114. Sergeant Loveridge gave evidence regarding his largely unsuccessful enquiries[110] made to identify the police officer with whom Ms Horsnell spoke at the search scene

Comments and Conclusions

115. The review of the *Community Support Worker's Handbook*[111] does not provide Community Support Workers (CSW) with any specific information regarding the complexities and differences of providing respite to a child with a disability as opposed to an elderly person requiring home or personal care services. This grouping of policies and work instructions to apply across two different cohorts of clients, namely the elderly and a child with a disability is apparent throughout the work undertaken by the Council and SCC. This is reflective of the Home and Community Care program (HACC) which encompasses various services including assisting older people and providing respite care to younger disabled people. The majority of HACC clients are elderly - only 2.9% of all HACC clients were under 20 years old in 2009-10. Child HACC clients generally require more specialised care than older HACC clients.[112] A review of HACC assessment procedures also found that the assessment of children is problematic.[113]

116. Given the acknowledged difficulties of working with this group, it is reasonable to expect there is information specific to working with a child with a disability readily available to CSWs.

Staff training

117. There is no doubt SCC did employ Mr Vipula outside of their policies. The changes made to the policies of SCC are appropriate and should reduce the chance of reoccurrence however,

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[110] Transcript page 389

[111] Provided in hardcopy to the court.

[112] Howe, A. & Warren, D., (2005) Strategic Directions in Assessment: Victorian Home and Community Care Program – Final Report.

[113] Howe, A. & Warren, D., (2005) Strategic Directions in Assessment: Victorian Home and Community Care Program – Final Report, p 55.

it remains that an employee of SCC was employed outside of the organisation's existing policies. This suggests a human resource governance structure that does not have established checking mechanisms and which do not appear to be included in the work undertaken by SCC.

Staff competency

118. In addition to the minimum qualifications required to be a CSW for SCC, there are many situations when a client presents a complex set of challenges and which the minimum qualifications alone do not ensure a CSW has the specialist skills required. This is common with younger persons with a disability. The 2011 Department of Health *Strengthening assessment and care planning. A guide for HACC assessment services*[114] document states:

> HACC target group, but they generally have high and complex needs. Many people in this group are clients of both HACC and Disability Services, indicating the complexity of their care needs and the likely involvement of multiple agencies in supporting them and their families or carers.

119. The change made by SCC that now requires a minimum qualification for CSWs working with a child with a disability to include a Certificate III in HACC and Certificate IV in HACC with disability units of competence or a one-day working with people with disabilities course, is appropriate. It increases SCC's compliance with the *Department of Health 2010 HACC Community Care Worker Training and Qualifications* advice supplement and goes a long way to ensuring a CSW is qualified to look after a child with a disability. The regular supervision and support activities and increased training are all activities undertaken by SCC to increase the capacity of CSW to implement a Home Care Task Sheet (HCTS) safely. However, as stated in the CEO Ms Jan Hornsnell's apology to the court, Felix was a vulnerable child with very individual behaviours and needs and there is reason to expect SCC take greater care in ensuring a CSW is also competent in providing an appropriate level of care.

120. In addition, the capacity of Ms Phan and Mr Vipula to communicate any risks or changes regarding Felix was less than ideal, and SCC's position that the non-occurrence of self-reported dissatisfaction by a CSW or family in the context of language barriers as an

[114] Victorian Government, Department of Health 2011. Strengthening assessment and care planning. A guide for HACC assessment services. Accessed 18 November 2013 at: http://www.health.vic.gov.au/hacc/assessment.htm#download

indicator of satisfaction is not contemporaneous. It is reasonable to expect SCC be regularly and proactively seeking satisfaction of service from families.

121. The SCC 2009 Client Survey[115] identified dissatisfaction specific to respite services, with two of the areas related to the impact of language barriers on the family's experience of care. The Council Instructions Manual, *Client Reviews Work Instruction*[116], includes regular review by the Council Assessment Officer, of which a frequency is not stated. In addition, the reviews by SCC are only completed when the CSW highlights significant changes or when a family thinks the service no longer meets their needs, notwithstanding any language barriers. In the case of a child with a disability and the predictable developmental changes, for example, increase in size, weight and strength, change in behaviours when influenced by pubescence, it is reasonable to expect a SCC initiated review is completed regularly.

Assessment of risk and the HCTS

122. Acknowledging SCC has increased the detail and specificity of the HCTS since the death of Felix Hua, combined with the greater level of communication, and ongoing support put in place by SCC, the safety of a child with a disability receiving respite care from SCC has increased. The *Community Support Worker's Handbook* does not provide the CSW with guidance on what to look for in assessing the environment for an out of home respite session. It is unreasonable to expect a CSW, especially Mr Vipula, who was not trained, to have a framework for assessing an outdoor or other area for environmental risks specific to the child in their care. The reference to not going near water could refer to anything from a birdbath to the ocean. This lack of clarification relies on an untested assumption that Mr Vipula was capable of using his commonsense to assess the risk of Felix running away versus the time it took him to return from his car, versus his decision to park the car in an area where his line of sight of Felix was obscured. The reliance on the CSW's common sense as the framework for assessing the safety of public areas for visiting during respite sessions requires review. The inclusion of agreed sites between the SCC Coordinator, family and CSW for out of home respite sessions should be included in the development of the HCTS for a child with a disability.

[115] Annexure Volume 2, Section 41, page 62.
[116] Annexure Volume 2, Section 44, Tab 7.

The evidence

123. There were some inconsistencies between the evidence of Mr Vipula and others but in so far as Ms Phan was concerned, I was satisfied that it could have resulted from the obvious language barrier. In so far as other instances were concerned, it was apparent that when Mr Vipula commenced his carer role, it was during a period of upheaval or '*chaos*' as described by one witness[117] so it is not surprising that in such a situation there may have been the capacity for some misunderstanding and communication breakdown.

124. As a professional carer, Mr Vipula should have read the CSW Handbook but his failure to do so could not be said to have put him at any disadvantage as the evidence revealed it would have been of little if any assistance given it was devoid of any information about caring for children or children with disabilities.

125. The evidence tended to reveal SCC as an organisation that may not have taken the full opportunity to reflect upon the incident to the point of appreciation of the impact of the failure of governance and the ability to learn from that.

Response to the death of Felix and Submissions

126. The investigation and inquest did highlight several areas of concern however it was apparent from the evidence, the statement of agreed facts, the new processes and the submissions, that the work undertaken by SCC and the Council has been substantial and aims to address the gaps identified in their internal reviews regarding the death of Felix.

Findings

I find that Felix unfortunately died from drowning. In the course of their opening, apology and evidence SCC sought to shift some responsibility for the death of Felix onto the carer however, I could not conclude that he should be blamed for this unnecessary and preventable death.

I found there to be a disparity between policy, procedure and actions by SCC and the Council leading up to the death of Felix Hua. The improvements that have occurred around the services provided by SCC and the Council whilst considerable, only establish the expected standard so I find that there remains the capacity for further enhancement and my recommendations are so directed.

[117] Evidence at inquest of Mr Morris

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

The impact of the National Disability Insurance Scheme (NDIS) is that after July 2015, HACC services to people under 65 will be wholly funded and managed by the Victorian government, until the NDIS becomes fully operational across Victoria in 2019-20. For people aged 65 and over (50 and over for Aboriginal and Torres Strait Islander people), all community care and residential care services will be funded, regulated and managed by the Commonwealth Government.

The Australian Government Department of Health and Ageing released the *Community Care Common Standards*[118] in March 2011. The Victorian Government Department of Health has appointed the Victoria Australian Healthcare Associates (AHA) to conduct, on the department's behalf, the Community Care Common Standards (CCCS) Quality Reviews of HACC funded organisations in Victoria. The timeframe for Quality Reviews is 1 July 2011 until 30 June 2014 and is a three-year cycle.

The Council and the SCC have undertaken many changes and improvements all aimed at increasing the safety and appropriateness of the care provided to children with a disability and their families. This includes increased evaluation of services client/carer surveys and an audit schedule. The predicted changes by the *Community Care Common Standards* quality review, the transition to NDIS and the release of the updated HACC Program Manual[119] should include the evaluation of the changes made since the death of Felix Hua.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

To ensure SCC staff are qualified to complete their role and responsibilities, the organisation review the existing system of governance for human resource procedures and establish checking mechanisms to monitor compliance.

To improve a CSW capability to provide respite care to a child with a disability, SCC implement and document an education session in the child's home with the child, their family, the CSW, the

[118] Australian Government Department of Health and Ageing. 2010. Community Care Common Standards. http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-commcare-qualrep-standards.htm

[119] http://www.health.vic.gov.au/hacc/prog_manual/index.htm

SCC Care Coordinator to review the capacity and competency of the CSW to provide safe care according to the HCTS, prior to sole caring sessions commencement.

To increase the safety of a child with a disability from a Culturally and Linguistically Diverse (CALD) background where the family does not speak English as their first language, the education session in the child's home should also include access to an interpreter service to enable discussion of the HCTS by all parties.

To increase the safety of a child with a disability from a CALD background where the family does not speak English as their first language, SCC should establish a regular and documented review with the family and the CSW, including access to an interpreter service to assess ongoing appropriateness, satisfaction of care and identification of risks.

To improve the safety of a child with a disability receiving respite care from SCC, the Council should review the Instructions Manual, *Client Reviews Work Instruction* to include the requirement for a contracted service to initiate a regular review of the care with the family of a child with a disability at least every three months.

To increase the safety of a child with a disability with out of home respite sessions as part of the HCTS, the HCTS should include listed sites for visiting that are agreed to by the family, client, SCC Coordinator, CSW and are based on the needs of the child and safety and appropriateness of the environment.

I direct that a copy of this finding be provided to the following:
The Family of Felix Hua
Sergeant Anthony Loveridge, Investigating Member of Victoria Police

Signature:

HEATHER SPOONER
CORONER
Date: 28 November 2013