IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 0287

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of Mark Capovilla

Delivered On:	24 February 2021
Delivered At:	65 Kavanagh Street, Southbank
Hearing Date:	24 February 2021
Findings of:	Caitlin English, Deputy State Coroner
Police Coronial Support Unit:	Senior Constable Jeff Dart

INTRODUCTION

1. Mark Capovilla was a 39-year-old man residing in a group home managed by the Department of Health and Human Services (**DHHS**).

2. Mr Capovilla had a severe intellectual disability, and also suffered from epilepsy and gastro-oesophageal reflux. He also had Autism Spectrum Disorder.

3. Mr Capovilla died on 18 January 2018 as a result of choking on food whilst on his day program at Aurora Support Services.

4. Mr Capovilla's father stated: '*Mark choking on his food and passing away came as a huge shock this was not expected at all.*'[1]

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Mr Capovilla's death was reported to the coroner as his death appeared to be as a result of an accident and was unnatural.

6. As Mr Capovilla resided in a service managed by DHHS, he is deemed to be a person under the control or care of the Secretary to the DHHS pursuant to section 3 of the *Coroners Act 2008* (**the Act**).

7. Both the cause of his death and his status as a person 'in care' made his death reportable to the coroner pursuant to section 4 of the Act.

8. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the deceased was, immediately before death, a person placed in care.

9. The jurisdiction of the Coroners Court of Victoria is inquisitorial.

10. The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death, and the circumstances in which death occurred.

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

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[1] Coronial brief, p 19.

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

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

14. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's 'prevention' role.

15. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[2]

IDENTITY OF THE DECEASED PURSUANT TO SSECTION 67(1)(a) OF THE ACT

16. On 18 January 2018, Sarah Russell visually identified Mark Capovilla, born 14 July 1978.

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

BACKGROUND

18. Mr Capovilla was born with a severe intellectual disability. As a young child he had few words and at the age of eight years his communication dramatically reduced.

19. Mr Capovilla attended the Merriang Special School in Epping.

20. His father described him as a very fussy eater from an early age. His father cut his food into small pieces as Mr Capovilla would often jam too much food into his mouth and not chew the food sufficiently.

21. At the age of 13 years, Mr Capovilla choked on some gnocchi at home, which was eventually dislodged.

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[2] *Briginshaw v Briginshaw* (1938) 60 CLR 336.

22. When he was 18 years old, Mr Capovilla started to attend Aurora Support Services (**Aurora**) on a daily basis. His father described him as being happy there and having friends and that staff looked after him well and tailored his activities to his needs. Mr Capovilla would attend with a meal prepared at home. There was a communication book that was sent back and forth between Mr Capovilla's parents and Aurora.

23. In 2013, Mr Capovilla moved from his parents' house to a Community Residential Unit at 3 Elsie Road, Reservoir. The communication book was then completed by the staff at Elsey Road and staff at Aurora. Mr Capovilla's father described him and his wife as having less input into their son's care plans at Aurora.

24. In 2016, Mr Capovilla's health declined as he lost weight, became less mobile, and his balance was affected.

25. The weight loss continued and in late 2017 his father stated staff at Elsey Road told him he was not eating well, and that staff were chopping his food into small pieces. Mr Capovilla's father was not notified of any choking incidents.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO SECTION 67(1)(c) OF THE ACT

26. On 18 January 2018, Mr Capovilla was on his day program at Aurora. He was attending a healthy eating program where participants were cooking a pastry roll. Usually they would eat the meal they cooked prior to lunch.

27. At about 11.40 am Mr Capovilla was in room 6 for a meal. There were 11 Aurora clients and four staff members. The meal consisted of pasties, crackers, and orange juice.

28. Mr Capovilla was on the couch, which was typical for him after eating a meal.

29. His head was on its side and he was noted to be motionless. A disability support worker, Robert Covacevek, thought Mr Capovilla might have been having a seizure. Mr Russell Allen, Program Manager, who was assisting with mealtime support went to the office, which was eight metres away, to get a cardiopulmonary resuscitation (**CPR**) mask. As he did so, he heard a loudspeaker announcement calling for Riki Takahashi, also a Program Manager, to assist.

30. Mr Allen returned to room 6 and saw Mr Capovilla sitting upright on the couch. Mr Russell could not detect a breath. He and Mr Takahashi lifted Mr Capovilla to the floor and commenced CPR. At this point, they did not know that Mr Capovilla had choked on food. Mr Covacevek telephoned emergency services but they misinterpreted the responder's advice regarding the number of compressions.

31. Paramedics arrived and took over resuscitation efforts.

32. Ambulance paramedic, Concetta Salamone, found Mr Capovilla in cardiac arrest and his airways contaminated with food. Clinical Support Officer, Gary Becker, assisted to insert the Laryngeal Mask Airway. Repeated attempts at suctioning were made however Mr Capovilla's airways were blocked.

33. Following a brief return of spontaneous cardiac output, Mr Capovilla remained in cardiac arrest and deteriorated. He was unable to be revived and died at 12.44 pm.

MEDICAL CAUSE OF DEATH PURSUANT TO SECTION 67(1)(b) OF THE ACT

34. On 19 January 2018, Dr Gregory Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an inspection and provided a written report, dated 22 January 2018. In that report, Dr Young concluded that a reasonable cause of death was '*Choking on a food bolus*'.

35. Dr Young noted:

> *A post mortem CT scan showed abundant material in the oropharynx and laryngopharynx. Rib fractures were seen, consistent with CPR. A remote parietal craniotomy was evident. No other significant pathology was identified.*[3]
>
> *Choking is where there is a blockage of the internal airways. In this case, the circumstances suggest this was caused by food. Death may be due to hypoxia (lack of oxygen) or a reflex cardiac arrest. The deceased had a history of epilepsy and intellectual impairment, which are both risk factors for choking.*[4]

36. I accept Dr Young's opinion as to the cause of death.

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[3] Coronial brief, p 32.
[4] Coronial brief ,p 32.

RISK MANAGEMENT

Department of Health and Human Services residence – 3 Elsie Road, Reservoir

37. Lorraine Howard was Acting House Supervisor of 3 Elsie Road Reservoir from October 2015 until March 2018. During that time there were four or five clients with the majority having intellectual disabilities living at the unit.

38. She noted that during 2017 Mr Capovilla's health declined. She stated:

> *Mark had his own specific care needs. Mark required one on one care with tasks such as administering medication, personal care and feeding. Mark enjoyed his food and we were aware that he had a tendency to try and take other client's food at times. As such mealtimes were at a dining room table with 5 clients and 2 staff to supervise.*[5]

39. Ms Howard was not aware of any choking incidents however noted Mr Capovilla had dysphagia, which made him a higher risk of choking on his food.

> *As a result staff would cut Mark's food into small bite sized pieces, we avoided food that was dry and crumbly as it would stick to his mouth, Mark would also always have some form of a drink with meals to assist with his swallowing and help the food going down for him.*
>
> *Mark was kept under close supervision so that he wasn't able to take other client[s'] food. Due to close supervision Mark was never able to put too much food in his mouth. There were no incidents of Mark choking on food whilst at the Residential Unit, which was a result of Mark's care plan being closely monitored.*
>
> *The measures put in place at the Residential Care Unit were conveyed to Aurora Support Services, so that his needs were met while he was in their care.*[6]

Aurora Support Services

40. Sarah Russell, Executive Director of Aurora Support Services, advised that every client who attends the Day Service has a Person Centred Plan. This is developed in consultation with the client, family, carers, and a key worker or line manager from Aurora.

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[5] Statement by Lorraine Howard, dated 9 October 2018.
[6] Statement by Lorraine Howard, dated 9 October 2018.

41. As well as outlining goals and strategies, the Person Centred Plan also includes information '*on what level of assistance each client requires in areas such as personal care, mealtime assistance, communication needs and behavioural considerations.*'[7]

42. Mr Capovilla's most recent Person Centred Plan was dated 6 September 2016 and was prepared in consultation with Mr Capovilla, as well as John Goumas, his key worker at Aurora as well as Lorraine and Mark from his Elsey Street residence, and his parents.

43. The Person Centred Plan makes references to *'Supporting me'* under which it states, *'I can carry my bag and get my lunch out'* and *'Sometimes I will need my food cut up for me, so I can eat independently.'* Under *'Independent living skills'* it states, Mr Capovilla *'Can get water from the tap himself'* and *'Can get lunch box from his bag and put it in the fridge with prompts.'*[8]

44. In Mr Capovilla's Personal Information Form it states under '*Eating and Nutrition'* it states he is not an independent eater and that '*Foods need to be cut into small portion [sic].*' It also notes he does require assistance preparing meals and '*Mark eats independently yet he needs prompting to slow down at meal times.*' It is noted he does not have a swallowing impairment.[9]

45. In her statement, Ms Russell noted, '*Mark was classified as an independent eater and did not require 1:1 supervision. I am not aware of any previous episodes of Mark choking on his food at the Day Service.*'[10]

46. The only reference Ms Russell could locate in his file regarding issues eating or swallowing was an internal file note dated 21 February 2017 which stated, *'Mark struggled with chewing his snack, especially with the solid foods such as the apples and muesli.'*[11]

47. Mr Capovilla's general practitioner, Dr David Festa, provided a report. He had treated Mr Capovilla for more than 15 years prior to his death. He stated:

> *In the years that I have treated Mark I did not personally witness nor treat any episodes of choking. Mark was certainly at risk of choking given his intellectual impairment, dysarthria (inability to speak) with constant dribbling, Gastro*

[7] Coronial Brief, p 13.
[8] Folder from Aurora Support Services, Attachment 1.
[9] Folder from Aurora Support Services, Attachment 1, pages 3 to 5.
[10] Coronial Brief, p 14.
[11] Coronial Brief p 14.

Oesophageal Reflux Disease and his propensity to bolt down his food quickly as described to me by his parents and carers. Mark's Father Valentino Capovilla has told me of an episode of severe choking before I knew Mark when he was a child in which a neighbour who happened to be a Doctor was called to clear Mark's throat. Mark's carers were aware of his risk of choking and once a year Mark had a nutrition and swallowing assessment at part of his annual physical.[12]

REVIEW OF CARE BY DISABILITY SERVICES COMMISSIONER

48. Section 7 of the Act states that a coroner should liaise with other investigative authorities to avoid unnecessary duplications of inquiries and investigations. To that end I have had regard to the investigation conducted by the Disability Services Commissioner (**DSC**).

49. In February 2018, the DSC commenced an investigation into the disability services provided to Mr Capovilla by DHHS and Aurora Support Services. The investigation revealed concerns regarding the provision of disability services provided and Notices to Take Action were issued to DHHS and Aurora Support Services.

50. The issues of concern regarding DHHS were that DHHS failed to adequately manage Mr Capovilla's risk of choking. The report stated:

> *Although Mr Capovilla had an identified choking risk, he did not have a current mealtime support plan at his DHHS group home or his day program. His choking risk was recorded in NASICs undertaken in 2016 and 2018 as well as other documentation at the group home. Information concerning Mr Capovilla's choking risk was not communicated to Aurora Support Services by DHHS.*[13]

51. The issues of concern regarding Aurora Support Services were that the quality of support provided to Mr Capovilla by Aurora found insufficient mealtime support information available to staff and failure by staff to recognize the signs of choking.[14]

52. Other concerns regarding DHHS care as found by the DSC related to the unauthorised use of chemical restraint, failure to arrange adequate dental care, poor record keeping, and a failure to review and update health management plans. I note these concerns were not directly related to either Mr Capovilla's cause of death or the circumstances of his death.

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[12] Coronial Brief, p 21-22.
[13] DSC Investigation report, p 2.
[14] DSC Investigation Report, p 4.

RESPONSE TO FINDINGS OF THE DSC

53. As a result of the introduction of the National Disability Insurance Scheme and the divestment by the State Government of residential services, on 18 August 2019 Elsey Road was transferred from DHHS to a community organisation known as Aruma.

54. I requested information from Aruma as to how it has implemented responses to the DSC Notice to Take Action.

55. Aruma responded by providing the Notice to Take Action (NTTA) Action Plan,[15] which included an audit of records to ensure residents' documentation was up to date, and that all residents were reviewed by a speech pathologist, and residents' health alerts and risks have been updated. The Action Plan noted all mealtime support plans accurately reflect the current level of risk and have been copied from files and laminated for ready access by staff. Residents with identified choking risks have received a complete assessment by a specialist and recommendations have been implemented. In addition, supervision meetings are conducted with staff, which incorporate discussions in relation to the role and responsibilities of staff in supporting residents at risk of choking. Training has also been delivered by a speech pathologist to staff on nutrition, swallowing and mealtime support for staff, including casual staff. This includes prevention strategies and emergency responses.

56. Most importantly, an audit of documents shared with day service providers for residents was conducted and an Action Plan has been implemented to improve communication of critical client information, such as health alerts and risks, to their day service providers.

57. I also requested information from Aurora Support Services as to how they ensure communication with residential organisations such as Aruma properly identifies risk. The DSC report identified that Aurora had no knowledge of Mr Capovilla's specific risk or mealtime requirements which was a concern.

58. Aurora has advised the following practices have been introduced or revised in response to their internal investigation following Mr Capovilla's death. These include:

    (a) Service Agreements and Participant profiles are developed between participant, families, and carers specifying the roles and responsibilities of both the participant and the organisation. The Participant profile includes information such as Specific Health

[15] The Action Plan provided was last updated 29 October 2020.

Management Plans, doctor's treatment sheets, Behavior Support Plans, Therapy Assessments, Mealtime Guidelines, and Allied Health Assessments/reports;

(b) participants are issued with a Communication Diary at the commencement of placement and thereafter each January. This diary travels with the participant to and from residence and service on a daily basis. In addition, each Participant has a Person Centred Plan;

(c) an annual swallowing checklist will be conducted for each participant by staff and a 'yes' response to checklist will trigger the Manager to contact carers or family to discuss appropriate avenues of support;

(d) a six monthly survey is conducted with participants, families and carers to identify issues arising and a 1:1 discussion with a manager is available, and,

(e) communication between Aurora and residential facilities will occur via telephone, fax, and email with the expectation staff maintain file notes and diary entries as necessary.

59. Other initiatives include improved communications between Aurora and the residential facility as well as formal communication on an annual basis.

60. I am of the view that Mr Capovilla's death was preventable. There was inadequate communication between DHHS and Aurora regarding his choking risk and there was no meal time support plan provided.

61. I am satisfied that that the changes implemented by Aurora and Aruma will address the concerns identified by the DSC and there is no need for me to make recommendations.

COMMENTS

I make the following comments connected with Mr Capovilla's death under section 67(3) of the Act:

62. In June 2018 the Disability Services Commissioner published a report titled: *A review of disability service provision to people who have died 2017-2018.*

63. The report noted that people with intellectual disability are well known to be at higher risk of choking. This is due to physical factors such as difficulties with chewing and swallowing (known as dysphagia), and behavioral factors such as gorging or pica (eating non-food items.)

64. The report notes that poor management of choking and aspiration risk have been identified as common contributors to premature death in people using disability services.[16]

65. Section 3 of the Act defines people 'in care' to include a person who was under the control, care or custody of the Secretary to the DHHS. This includes people in receipt of disability accommodation services administered by DHHS under the *Disability Act 2006*. In these cases, the death must be reported to the coroner, regardless of the cause or circumstances of the death. The introduction of the NDIS and the divestment by the State Government of a number residential services to community or privately run accommodation means that the deaths of those people who no longer reside in residential accommodation administered by DHHS are no longer within the definition of being 'in care' under section 3 of the Act. This requires legislative amendment to ensure deaths within this vulnerable cohort remain reportable to the coroner.

I convey my sincere condolences to Mr Capovilla's family for their loss.

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

[16] Disability Services Commissioner, *A review of disability service provision to people who have died 2017-2018*, p 25

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

Valentino Capovilla, senior next of kin

Margaret Capovilla, senior next of kin

Aurora Support Services

Aruma

Department of Health and Human Services

Disability Services Commissioner

Secretary, Department of Justice & Community Safety

Attorney-General, The Hon. Jaclyn Symes

Signature:

Caitlin English
Deputy State Coroner

Date: 24 February 2021

NOTE: Under section 83 of the **Coroners Act 2008** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.