IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2017 6528**

FINDING INTO DEATH WITH INQUEST

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

Inquest into the death of ERICA HUBAI

Delivered on:	9 MARCH 2022
Hearing date:	9 MARCH 2022
Date of birth:	22 AUGUST 1966
Delivered at:	THE CORONERS COURT OF VICTORIA 65 KAVANAGH STREET, SOUTHBANK, VICTORIA
Findings of:	CORONER PHILLIP BYRNE
Date of death:	23 DECEMBER 2017
Counsel Assisting the Coroner:	MS RACHEL QUINN, CORONER'S SOLICITOR

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

I, PHILLIP BYRNE, Coroner having investigated the death of ERICA HUBAI

AND having held an inquest in relation to this death on 9 March 2022 at Southbank, in the State of Victoria:

find that the identity of the deceased was ERICA HUBAI

born on 22 August 1966

and the death occurred on 23 December 2017

at Footscray Hospital, Western Health, 160 Gordon Street Footscray, Victoria, 3011

from:

1 (a) ASPIRATION PNEUMONIA

Pursuant to section 67(1) of the **Coroners Act 2008** I make findings with respect to **the following circumstances**:

BACKGROUND

1. Erica Hubai, 51 years old at the time of her death, resided at 6 Weeroona Terrace Altona Meadows which was a Department of Health and Human Services **(DHHS)**, now Department of Families, Fairness and Housing **(DFFH) (the department)** residential accommodation service.

CIRCUMSTANCE OF THE DEATH

2. On 14 December 2017, Ms Hubai attended her General Practitioner (GP) regarding an ongoing cough. The GP, after assessing Ms Hubai, cleared her to return home. The next day Ms Hubai presented to Footscray Hospital with the same symptoms and was subsequently admitted. Despite treatment, Ms Hubai's condition deteriorated to the point where she passed away on 23 December 2017.

REPORT TO CORONER

3. Ms Hubai's death was appropriately reported to the Coroner. Having regard to the circumstances and having conferred with a Forensic Pathologist, I directed an external only examination and ancillary tests. The external examination was performed by Forensic Pathologist Dr Malcolm Dodd of the Victorian Institute of Forensic Medicine. Dr Dodd opined the immediate cause of Ms Hubai's death was:

   1 (a) Aspiration pneumonia

4. Dr Dodd commented as follows:

   "*The deceased had been diagnosed with Sturge-Webber syndrome.*"

   "*This syndrome involves a congenital vascular malformation (port wine naevus) involving one side of the head and this usually corresponds to an ipsilateral leptomeningeal vascular malformation.*"

   "*The deceased also had a poor swallowing ability and as a subsequence of this, has appeared to have developed aspiration pneumonia and subsequently died.*"

   "*The lung fields showed bilateral changes which would be consistent with aspiration pneumonia.*"

   "*There are no apparent suspicious circumstances.*"

FURTHER INVESTIGATION

5. On 24 January 2018, enquiries conducted with the department confirmed that at the time of her death, Ms Hubai was the recipient of disability services from the department. Therefore, and for the purposes of my coronial investigation, Ms Hubai, "*was a person placed in custody or care*"[1] under the *Coroners Act 2008* **(the Act)** an inquest is mandated.[2]

6. Section 7 of the Act contains a provision whereby coroners should liaise with other investigative authorities so as to avoid unnecessary duplication of inquiries and investigations.

7. Given that I was aware the Disability Services Commissioners (DSC) office was conducting its own investigation into the death of Ms Hubai and given the need to avoid duplication of inquiries and investigations as set out in section 7 of the Act, I held my coronial investigation in abeyance pending the outcome of the DSC investigation.

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[1] Section 4 (2)(c) *Coroners Court Act 2008*
[2] Section 52(2)(c) *Coroners Court Act 2008*

8. On 5 April 2018, I asked that my registrar notify Ms Illona Hubai, mother of Erica and Senior Next of Kin, that I had decided to await the outcome of the DSC investigation before determining how to proceed with the coronial investigation.

9. On 8 October 2019 I was provided with a copy of the DSC investigation report dated 4 October 2019. My primary focus was in relation to matters that immediately preceded Ms Hubai's admission to hospital and could reasonably be seen as causal or contributing factors in her death. I therefore noted with interest what I will refer to as the choking incident of 15 December 2017, the day of her admission to Footscray Hospital.

10. After reviewing and considering the content of the DSC report, the sole focus of my investigation related to Ms Hubai's meal management plan in place at the time of the choking incident of 15 December 2017, and whether it was followed on that occasion. I am restricted to investigating matters that could reasonably be seen as causal or contributing factors in Ms Hubai's death, that is whether there was any act which did not reach a standard, or an omission in breach of a recognised duty.

11. The DSC investigation was of a much wider scope looking at provision of disability services to Ms Hubai more broadly.

12. For the purposes of my coronial investigation, there were two issues identified from the DSC investigation that were pertinent to my investigation:

    a) the failure by the department to manage Ms Hubai's risk of choking and pneumonia; and

    b) inconsistent instructions provided to department by Scope on Ms Hubai's mealtime texture requirements.

13. On 31 October 2019, I asked my solicitor to contact department and seek a response to the DSC findings and specifically to the following matters:

    a) The Mealtime Management Plan formulated for Ms Hubai;

    b) The alleged failure of staff to follow the Plan on 15 December 2017; and

    c) The choking/aspiration that it is claimed occurred as a result of the alleged failure.

14. On 14 January 2020, the court received a response from department under the hand of Ms Carley Northcott, Director, NDIS Service Delivery, Disability and NDIS Branch of the department.

15. The department responded to each of the three matters where I sought a response. I will deal with each in turn:

a. The Mealtime Management Plan formulated for Ms Hubai

"*The department* [the department of Health and Human Services] *acknowledges that the Disability Services Commissioner (the Commissioner) found conflicting instructions to Departmental staff on Ms Hubai's food texture requirement.*"

The department went on to say that:

"*In response to the Commissioners finding, a training session was held on 17 October 2019 to educate the Weeroona Terrace group home staff on mealtime support requirements (including texture modification and preparation requirements) for people who have swallowing difficulties. The training also incorporated aspiration pneumonia, including the signs, symptoms and risk factors*....."

b. The alleged failure of staff to follow the Plan on 15 December 2017

The department, noting the transfer of services to non-government providers stated:

"To comprehensively address all practice issues identified in the Commissioner's final report, the department will continue to work in partnership with Home@Scope. A training plan and accompanying implementation plan for group home staff at 6 Weerona Terrace will be developed with Home@Scope and the department will monitor the effective implementation of this plan."

c. The choking/aspiration that it is claimed occurred as a result of the alleged failure

In relation to what I will call the "Hubai incident" of 15 December 2017, the department advises:

"The department has implemented a number of actions in relation to the issue of choking/aspiration. The issue of choking and aspiration risks for residents in disability group homes has been raised by the Commissioner in his annual report and the Commissioner has also issued a Notice of Advice with regards to the management of aspiration and choking risks to the Secretary of the department. In response, the department is developing and supporting improvements to practice in this area.

The department has joined both the Mealtime Supports Advisory Group and its sub-group Mealtime Supports Working Group. These groups were convened and are chaired by the Commissioner and bring together service providers, Speech Pathology Australia, Dieticians Association of Australia, Deakin University and the NDIS Commission with

the aim of identifying current resources and identifying gaps in mealtime management resources/guidelines.

All staff who have transferred to non-government providers were required to have a current Level Two First Aid Certificate. Instruction on the management of choking and instruction on airway obstruction forms part of this certification.

Safer Care Victoria have recently convened an expert working group including Directors of Nursing, Allied Health Professionals, Emergency Department clinicians and food safety experts from Victorian metropolitan and regional hospitals to develop safe eating and drinking guidelines suitable for use in acute care settings. The group have reviewed existing hospital systems and processes for ensuring safe eating and drinking and identified gaps and risks. Safer Care Victoria's safer eating and drinking guidelines are expected to be finalised in early 2020. Once finalised, these guidelines where appropriate for disability support workers will be shared with the five transfer providers."

16. On 31 August 2020 at my request, my solicitor contacted the department and Home @ Scope to advise that as Ms Hubai's death was "in care" within the meaning of the *Coroners Act 2008* an inquest is mandated, but that I considered that the matter could proceed by way of a summary inquest.

17. Both parties were advised of my tentative tentative view to adopt the conclusions reached by the DSC in relation to "meal time management" on the day on the final day hospital admission and enquire if it would seek to challenge/resist the conclusions reached by the DSC in relation to that discrete issue.

Response from the department

18. The court received a response from department under the hand of Ms Northcott dated 30 September 2020.

19. The department noted that my proposal to '*adopt the Disability Services Commissioner's conclusions on the issue of mealtime management on the day of the hospital admission and to proceed to summary inquest*'. The department welcomed the opportunity to respond and advised that it did not '*oppose the Coroner proceeding as proposed*'.

20. In relation to mealtime supports provided to Ms Hubai:

    The department acknowledged that the DSC's investigation report included the adverse finding that '*DHHS failed in its duty of care obligations to take reasonable steps to monitor*

and address Ms Hubai's risk of choking and pneumonia in the months prior to Ms Hubai's death'.

21. To assist me to understand actions taken since Ms Hubai's death the department confirmed that:

    "*as outlined in our last correspondence, in response to the Commissioner's Final Report and Notices to Take Action the department worked closely with Home@Scope, the new service provider at 6 Weeroona Terracem Altona Meadows to implement quality improvement actions. This included a training session that was delivered by a speech pathologist from Loqui on 17 October 2019 to educate staff on aspiration pneumonia, including the signs, symptoms, risk factors and support requirements (including texture modification and preparation requirements) for people who have swallowing difficulties*".

22. The department provided a copy of the full improvement action plan that was provided to the DSC on 2 December 2019.

System wide improvements

23. In its response the department outlined system wide improvements. The department advised that:

    "*Since 2017-2018 Victorian Government funding of $3.5 million has been provided to assist in the provision of training and the development of learning and development programs for disability support workers to enhance their capabilities and confidence as part of the transition to the NDIS. Further funding is being provided to develop specialist training in positive behaviour support planning in 2020.*

    Prior to the transition to the NDIS, Victoria worked with the Commonwealth to develop a mandatory worker orientation module 'Quality, Safety and You' to assist all NDIS workers to better support people with disability and explain the obligations of workers under the NDIS Code of Conduct. The NDIS Code of Conduct includes requirements to take all reasonable steps to prevent and respond to all instances of violence, exploitation, abuse and neglect of people with disability.

    The Victorian Government is working with the Commonwealth Government and other States and Territories to develop a national NDIS Workplace Plan which will include a focus on maintaining capability and quality of service.

The department continues to respond to system-wide recommendations coming from the Commissioner's death investigations. In 2020 this includes work on swallowing and choking risks…"

Safe mealtimes

24. The department acknowledging that "*The management of dysphagia remains a complex and significant issue for the disability sector across Victoria and nationally.*"

25. In addition to the improvements outlined by the department in its previous correspondence to the Court in January 2019, the department outlined the following further improvements for safe mealtimes.

    "To improve practice in this area, a poster has been developed by the Disability Services Commissioner with the input from the department, Scope and Speech Pathology Australia as well as other key stakeholders. The poster provides simple guidance on what to do to make mealtimes safe and enjoyable, as well as the signs to look out for that may suggest there is an issue or problem – and who to contact for further or urgent support or assistance.

    The poster will shortly be distributed to the transfer providers for display in all group homes to increase awareness of swallowing and choking risks and the importance of following a resident's mealtime management plans.

    The department has also recently engaged with a project funded by the NDIS Quality and Safeguards Commission to develop the resources for disability workers staff in safe mealtime practices. This project led by the University of Technology Sydney (UTS), comprises an 'inclusive, interdisciplinary and collaborative team who will co-create a training course for people with disability, direct support workers, family members and NDIS providers on swallowing disorders and mealtime management. The course will be designed to 'support NDIS providers to meet registration requirements in relation to the delivery of safe and enjoyable meals while also reducing the risk of choking death and increasing the nutritional benefit of the meals. Consortium organisational members include: UTS, Arima, VALID, Speech Pathology Australia and others. The project is expected to be delivered by June 30, 2021. The department is participating in an advisory group for the project to help ensure the project addresses the learning needs of Victorian disability support staff working in the group home setting.

    The department further noted that it is:

    "...committed to addressing the systematic recommendations of the Commissioner to ensure that we effectively address the identified system-wide issues prior to the transition to the

NDIS. In addition, the Victorian Government continues to provide monitoring of the transferred services to ensure quality and safe services and accountability to government.''

Response from Home@Scope

26. On 1 October 2020, the Court received a response from Home@Scope under the hand of Catherine Sharples, Group Manager Quality and Safeguarding at Scope (Aust) Ltd.

27. Ms Sharples confirmed that 6 Weeroona Terrace, Altona Meadows is now managed by Home@Scope, a subsidiary of scope, as a result of the transfer of stated funded houses to the private sector, which occurred following Ms Hubai's death. Ms Sharples further advised that whilst living the department managed home, Ms Hubai attended a day program run by Scope (not Home@Scope).

28. Ms Sharples advised that:

"*The Scope side of the business who managed the day service participated in the DSC investigation and as such received a copy of the DSC investigation report; however, all sections related to Weerona Terrace and the services provided to Ms Hubai, by the DHHS are heavily redacted....As such, Home@Scope will refrain from providing comment as to the conclusions and findings.*

Nevertheless, Home@Scope wish to advise that the DHHS formulated an action plan in relation to the DSC's findings...Home@Scope worked with DHHS to address the relevant actions which were completed by 30 October 2019".

29. A copy of the formulated action plan was provided to the Court.

30. At my instruction on 16 March 2021, my solicitor wrote to Scope seeking to enquire whether Scope accepted the conclusion by the DSC's investigation report of 4 October 2019 "*...that Scope provided conflicting instructions to DHHS staff on Ms Hubai's food texture requirements.*"

31. To assist Scope with its response, an excerpt of the department's letter dated 14 January 2020 was provided to Scope advising that:

"*The department acknowledges that the Disability Services Commissioner (the Commissioner) found conflicting instructions to department staff on Ms Hubai's food texture requirements.*"

"*In response to the Commissioner's finding, a training session was held on 17 October 2019 to educate Weeroona Terrace group home staff on mealtime support requirements (including texture modification and preparation requirements) for people who have*

swallowing difficulties. The training was delivered by a Speech Pathologist-a certified member of Speech Pathology Australia from Loqui Speech Pathology".

32. I note that on 17 March 2021 Ms Sharples clarified that "*The home where Ms Hubai resided was operated by DHHS who were issued with a separate NNTA*" and confirmed that the Court's letter references, "*the findings DSC made against Scope*".

33. On 5 October 2021, Ms Sharples responded to the Court's letter dated 16 March 2021 on behalf of Scope. She stated that:

    "*Scope agreed with the ODSC* [DSC] *that we indicated 'smooth puree food' in a plan and then in verbal and email communication indicated the need for 'mince moist food'. We disagreed to the extent to which this impacted outcomes given the responsibility for ensuring staff are trained on individual support needs sat with DHHS.*

    We agreed to ensure we improve our language and in fact since that time having moved to the NDIS there are revised procedures for Meal time management".

Conclusion

34. My reading of the department's reply indicates to me that although no direct concession is made, that the department does not oppose the finding made by DSC as to sub-optimal management on the occasion in question.

35. Although no direction concession is made by Scope in relation to the finding reached by the DSC, it was acknowledged by Scope that it indicated the need for '*smooth puree food*' in a plan and then in verbal and email communication indicated the need for '*mince moist food*'.

36. I am satisfied that the actions taken by the department and other linked agencies address the issues identified by DSC that relate to my coronial investigation. These actions negate the need for me to make any formal recommendations in relation to these matters.

FINDING

37. I formally find Erica Hubai died on 23 December 2017 at Footscray Hospital, 160 Gordon Street Footscray as a result of aspiration pneumonia.

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

Distribution of Finding

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

    - Ms Illona Hubai, Senior Next of Kin;

- Disability Services Commission;
- Department of Families, Fairness and Housing;
- Scope; and
- First Constable Melanie Hunter, Coroner's Investigator, Victoria Police.

Signature:

PHILLIP BYRNE
CORONER
Date: 9-8-22