IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 003011

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

Deceased:	Hau Bui Nguyen
Delivered on:	10 April 2025
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	10 April 2025
Findings of:	Coroner Sarah Gebert
Counsel assisting the coroner:	James Whyman, Coroner's Solicitor
Key words:	Footscray Hospital; Western Health; In-care Death; Aspiration Pneumonia; Acquired Brain Injury

INTRODUCTION

1. On 3 June 2022, Hau Bui Nguyen was 46 years old when he died at the Footscray Hospital following a recent health decline.

2. At the time, Hau lived in specialist disability accommodation at Romawi House operated by Yooralla Disability Services in Altona.

INVESTIGATION AND SOURCES OF EVIDENCE

3. This finding draws on the totality of the coronial investigation into the death of Hau Bui Nguyen including evidence contained in the coronial brief as prepared by Coroner's Investigator, First Constable Bradley Smith, the inspection report from the Victorian Institute of Forensic Medicine, statements obtained by the Court on my direction, and advice received from the Coroner's Prevention Unit.

4. All of this material, together with the inquest transcript, will remain on the coronial file.[1] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

5. The purpose of a coronial investigation of a *"reportable death"*[2] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3]

6. Hau's death was reported to the coroner as it fell within the definition of a reportable death under section 4(2)(a) of the Coroners Act 2008 (**the Act**) because his death appeared to have

[1] From the commencement of the *Coroners Act 2008*, that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

[2] The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

[3] Section 67(1).

been unexpected, unnatural or violent, or to have resulted directly or indirectly from accident or injury.

7. The 'cause' of death refers to the 'medical' cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the 'circumstances' in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[4]

8. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the 'prevention' role.[5]

9. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[6] These are effectively the vehicles by which the coroner's prevention role can be advanced.[7]

10. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[8]

Inquest

11. Pursuant to section 52(2)(b) of the Act, a coroner must hold an inquest into a death if the deceased was, immediately before death, a person placed in custody or care, and their death was not due to natural causes.[9]

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[4] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[5] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[6] See sections 72(1), 67(3) and 72(2) regarding reports, comments, and recommendations respectively.

[7] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[8] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

[9] Section 52(3A) of the Act states that an inquest into the death of a person who was, immediately before death, a person placed in custody or care is not mandatory if the coroner considers that the death was due to natural causes.

12. The definition of a person placed in custody or care in section 3(1) of the Act includes 'a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health'. However, funding for disability services shifted from the Department of Families Fairness and Housing (**DFFH**) to the NDIS in 2019. This meant that deaths such as Hau's which occurred in residential disability care facilities after 2019 were no longer captured by the Act as 'in care' deaths for coronial purposes.

13. After Hau's death, on 11 October 2022, this lacuna in the legislation was rectified when amendments to the *Coroners Regulations 2019* came into effect. Sub-regulation 7(1)(d) provides that a person placed in custody or care now includes 'a person in Victoria who is an SDA resident residing in an SDA enrolled dwelling.[10] Hau would now meet the new definition of a person placed in custody or care.

14. For this reason, and to advance the legislative intention of section 52(2)(b) of the Act, I considered it appropriate that an inquest be held into Hau's death. A summary inquest was held on 10 April 2025 and no witnesses were called to give evidence.

BACKGROUND

15. Hau was born in 1976 and lived without health issues throughout his childhood and into his twenties at which time he worked as a carpenter. When he was around 27 years old, Hau lived with his mother, Nhe Nguyen, in St Albans while he was building his own home in Braybrook.

16. In 2007, Hau had a tragic accident whereby he fell off the roof of his still under construction Braybrook home. He was discovered unconscious and suffered severe head injuries including large left front parietal epidural haematoma, large intra-cranial haemorrhage, contra-coup injury and left temporal infarct. Hau nearly died and as a result the injuries he suffered a permanent acquired brain injury (**ABI**) complicated by epilepsy and paraplegia. After the accident he was also non-verbal.

17. Hau endured a protracted recovery period at the Gardenview Rehabilitation Centre. After around six months, Hau regained some movement in his eyes and hands which enabled him to communicate.

[10] 'SDA resident' has the same meaning as in the *Residential Tenancies Act 1997* (Vic) and captures a person who is an SDA recipient. 'SDA enrolled dwelling' also has the same meaning as in the *Residential Tenancies Act 1997* (Vic).

18. He remained at the Gardenview Rehabilitation Centre until June 2011 when he was first admitted to Romawi House where he lived until his death. Hau received 24 hour care from disability support workers at Romawi House.

19. Hau was unable to perform tasks independently and relied on disability support workers to mobilise using an electric wheelchair. A ceiling hoist and sling was used to transfer Hau in and out of bed. He also received assistance for all hygiene and personal care. Staff would check on Hau at least every half an hour, including while he slept.

20. Hau had severe dysphagia (difficulty swallowing) and required feeding and medication to be provided through a PEG[11] tube. Hau also required oral suctioning from trained staff members for the management of his oral secretions such as saliva and phlegm. Staff were aware that Hau was at constant risk of aspiration pneumonia.

21. Hau enjoyed community outings and was taken for walks by disability support workers weekly. He was passionate about soccer and enjoyed watching sports on TV. He also enjoyed regular visits from his family who would take him on day trips to meet with friends, play and watch soccer, go to the beach, and visit the Men's shed as he used to be a builder. He would also regularly stay at the family home to spend time with his extended family.

Medical History

22. Hau attended General Practitioner (**GP**) Dr Vimal Arora of 'The Clinic Altona' since 2011. His medical history included: acquired Brain Injury with post intracranial haemorrhage, severe oropharyngeal dysphagia, epilepsy, Type 2 Diabetes Mellitus, recurrent aspiration pneumonia, Hepatosteatosis and depression.

23. Dr Arora noted that Hau experienced multiple episodes of aspiration pneumonia associated with multiple hospital admissions in the four to five years prior to his death. Similarly, Hau's brother Han Nguyen said that Hau was getting more infections over the last two to three years.

24. In combination with the care he received from Dr Arora, Hau also attended with an occupational therapist, physiotherapist, podiatrist, speech pathologist, and a dietician.

[11] Percutaneous endoscopic gastrostomy (**PEG**) is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall. Most commonly inserted to provide a safer route for the long-term provision of nutrition.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

25. On 13 May 2022, Hau reported feeling unwell to his carers. His blood glucose levels and temperature were measured and both were above normal parameters. His carers noted he appeared drowsy but responsive. Nurse on call was contacted and advised that Hau should attend hospital following which an ambulance was called and he was transported and admitted to the Footscray Hospital.

26. Hau was diagnosed with a urinary tract infection and urinary sepsis. He remained in hospital overnight and was discharged the following day, being 14 May 2022, with a prescription for the antibiotic, amoxicillin.

27. The following evening at around 6.00pm, Hau's carers noted that his abdomen and legs appeared yellow, firm, and bloated. Staff again contacted nurse on call and were again advised to contact an ambulance. Paramedics arrived at approximately 8.30pm and investigations revealed an elevated heart rate and reduced oxygen saturation levels.

28. Hau was transported to the Footscray Hospital emergency department (**ED**) and presented with cholangitis complicated by aspiration pneumonia. Cholangitis is an infection of the common bile duct characterised by fever, jaundice and abdominal pain. The condition can be caused by gallstones causing a blockage in the common bile duct (choledocholithiasis).

29. He required oxygen support and antibiotics which were delivered intravenously. Hau was identified as being at risk of pressure injuries.

30. On 17 May 2022, Continuous Positive Airway Pressure (**CPAP**) therapy was trialled to support respiratory function. However, Hau was not able to tolerate a CPAP mask and oxygen was continued via high flow and nasal prongs.

31. Hau's treating clinicians aimed to stabilise him to undergo an Endoscopic Retrograde Cholangiopancreatography (**ERCP**) to treat his obstructive cholangitis. An ERCP is a surgical procedure to remove gallstones from the gallbladder. Such a procedure requires anaesthetic and Hau's respiratory status was not considered stable enough at any point during his admission to endure this procedure.

32. On 20 May 2022, multiple Medical Emergency Team (**MET**) calls were made due to a low respiratory rate. Hau was treated with high flow oxygen. A repeat chest x-ray was performed and showed worsening right basal atelectasis.

33. Over the coming days Hau remained on intravenous antibiotics and as such was continually considered unsuitable for an ERCP. Skin assessments were performed on 21, 22, and 23 May 2022 with no record of any injuries to or around the nasal area.

34. On 25 May 2022, nursing staff noted the presence of a left nostril pressure area. Hau was reviewed by the medical team who recommended a transfer to a single room to facilitate oxygen through a face mask instead of nasal prongs to allow the nasal pressure injury to heal.

35. At this time, due to the Western Health COVID-19 policy, high flow oxygen via a face mask required the patient to be placed in a single room with the doors closed.

36. Unfortunately, no single rooms were available at the time and over the coming days Hau continued to receive oxygen via nasal prongs. Nursing staff applied moisturiser regularly as well as repositioned the prongs in an attempt to alleviate the nasal pressure injuries.

37. On 27 May 2022, Hau suffered a nosebleed (epistaxis) with a large blood clot noted in the left nostril. He was reviewed by the medical team and his anticoagulant, clexane[12] indicated for Deep Vein Thrombosis (**DVT**) was withheld for 48 hours.

38. He suffered a further nosebleed on 29 May 2022. He was again assessed by the medical team who recommended oxygen therapy be delivered by a face mask and not from nasal prongs. A single room was still not available and as such Hau continue to receive oxygen via nasal prongs. His treating team consulted the infectious diseases team who recommended additional padding be placed around the nasal prongs.

39. Over the following days nostril ointment was continually applied by nursing staff and Hau did not have any further episodes of nosebleeds. By 1 June 2022, Hau no longer required oxygen therapy and as such he was discharged the following day to Romawi House. An outpatient appointment with Ear, Nose and Throat (**ENT**) was arranged prior to discharge to review his nasal pressure injury.

[12] Enoxaparin sodium (Clexane) is a blood thinner.

40. Hau returned to Romawi House in the afternoon of 2 June 2022. A small amount of bleeding from his nose was observed by staff while he was being changed. The bleeding ceased when he sat upright and staff left him to rest.

41. At around 5.00pm, staff heard Hau coughing and noticed his nose had again started bleeding which stopped when his head was lowered. The bleeding returned at around 6.30pm while Hau was being fed.

42. His condition deteriorated and at about 7.00pm Hau began to cough, had laboured breathing, and complained of chest pain to his carers. His nose had again started to bleed. Staff members noted a gurgling sound as Hau breathed. Attempts were made to contact a locum GP but were unsuccessful and after around 20 minutes, staff contacted emergency services.

43. Ambulance Victoria paramedics responded to the call and arrived at approximately 7.50pm. Hau's oxygen saturation levels were measured at just 36% and he was considered hypoxic. Oxygen was administered and Hau was returned to the Footscray Hospital via ambulance arriving at around 9.10pm. On admission to the ED Hau was found to be hypoxic believed secondary to recurrence of aspiration pneumonia following a nosebleed.

44. Treatment was provided in the ED, including further antibiotics, in line with his limited goals of care[13] but Hau nonetheless continued to deteriorate. Following discussions with family, active treatment was withheld, and Hau was transferred to palliative care prioritising comfort care. In the company of his brother, Hau passed away at around 7.00pm on 3 June 2024.

Identity of the deceased

45. On 3 June 2022, Hau Bui Nguyen, born 22 May 1976, was visually identified by his brother, Han Nguyen, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

47. Forensic Pathologist Dr Gregory Young, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 6 June 2022 and provided a written report of his findings dated 7 June 2022.

[13] Hau as not for CPR, intubation or non-invasive ventilation according to his documented goals of care.

48. The post-mortem examination showed no obvious signs of injury. The bridge of the nose and external nares were unremarkable. A post-mortem computerised tomography (**CT**) scan confirmed the presence of consolidated lungs and a PEG tube. The head showed a left craniotomy with underlying encephalomalacia, but no intracranial haemorrhage.

49. Dr Young provided an opinion that the medical cause of death was 1(a) aspiration pneumonia complicating epistaxis in the setting of prolonged nasal prong use in a man with multiple co-morbidities.

50. I accept Dr Young's opinion.

CPU REVIEW

51. As part of my investigation, I obtained advice from the Coroners Prevention Unit (**CPU**) about the clinical management and care provided to Hau proximate to his death.

52. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided to the deceased by reviewing the medical records, and any particular concerns which have been raised.

53. As part of their review, the CPU were assisted by the medical records from Western Health, Yooralla, and the Altona Super Clinic and the coronial brief. The CPU were also assisted by a statement from Dr Christopher Lemoh, Head of General Internal Medicine, Western Health, dated 30 June 2023.

54. Upon Hau's discharge, Dr Lemoh advised that he had recovered from his cholangitis but was at a high risk of reoccurrence since definitive management via an ERCP was not possible. In relation to his overall clinical picture at the time of discharge, Dr Lemoh stated:

Although not fully recovered to baseline level of function, Mr Nguyen had largely recovered from his presenting illness, shown overall clinical improvement, and appeared physiologically stable. He required care and treatments able to be adequately delivered in his usual place of accommodation. He thus appeared to be fit for discharge with ongoing ambulatory care by his general practitioner and private dietitian, with planned outpatient ENT follow up of his nasal bleeding.

55. The CPU noted that Hau was a man with multiple, significant medical co-morbidities prior to his presentation to the Footscray Hospital in May 2022 with a serious acute episode of cholangitis.

56. His final admission was complicated by aspiration pneumonia that required an extended period of high flow nasal oxygen. Due to his severe dysphagia, the CPU noted that Hau was at significant risk of aspiration and he had multiple previous hospital admissions for aspiration pneumonia. In his statement, Dr Lemoh similarly accepted Hau was an ongoing risk of aspiration pneumonia due to unsafe swallowing and long-term PEG feeding.

57. The CPU accepted that Hau's nasal pressure injury developed as a result of the nasal oxygen therapy he received at hospital. The need to transfer Hau to a single room to allow oxygen through a face mask instead of nasal prongs was recognised by his treating team on 25 May 2022 however it was not a feasible option due to COVID-19 restrictions in place at the time and limited resources.

58. The CPU advised that nasal pressure injuries experienced by Hau are an uncommon but recognised complication of high flow nasal prong usage. Despite the development of the injuries, the CPU advised it was clinically necessary to continue oxygen therapy via nasal prongs in the absence of any preferable alternative options.

59. Hau had only two nosebleed episodes at the Footscray Hospital which the CPU considered were mild with only a small amount of bleeding documented on each occasion. Further, both episodes resolved relatively quickly.

60. At the time of Hau's discharge on 2 June 2022, he had not required oxygen therapy or experienced any further nosebleeds for two days. A review with the ENT team was planned for after his discharge.

61. The CPU opined that Hau's nosebleed which occurred at Romawi House after his hospital discharge on 2 June 2022, and subsequent aspiration pneumonia and clinical deterioration, could not have been reasonably predicted prior to discharge from the Footscray Hospital.

62. The CPU agreed with Dr Lemoh and considered that Hau appeared clinically stable at the time of his discharge. It follows that the CPU considered the discharge itself was reasonable and appropriate.

63. Moreover, the CPU considered the broader clinical management and care Hau received at the Footscray Hospital was reasonable and appropriate. The nasal pressure injury was quickly identified, strategies available to his treating team were implemented to minimise the risk of deterioration, and a post-discharge follow up plan was in place.

64. I accept the CPU's advice in relation to the care provided to Hau proximate to his death.

FINDINGS AND CONCLUSION

65. Pursuant to section 67(1) of the Act I make the following findings:

    a. the identity of the deceased was Hau Bui Nguyen, born 22 May 1976;

    b. the death occurred on 3 June 2022 at Footscray Hospital, 160 Gordon Street, Footscray, Victoria, 3011, from aspiration pneumonia complicating epistaxis in the setting of prolonged nasal prong use in a man with multiple co-morbidities; and

    c. the death occurred in the circumstances described above.

66. I am satisfied that Hau's nasal pressure injuries which developed at the Footscray Hospital in late May 2022 were appropriately identified and managed by clinical staff who were limited in their ability to escalate Hau's care and transfer him to a single room to facilitate oxygen via a face mask due to COVID-19 restrictions and limited hospital resources. Despite reasonable efforts in the circumstances, Hau's condition nonetheless deteriorated.

67. There is no evidence to suggest that the clinical management or care on the part of clinicians at Footscray Hospital or Hau's carers at Romawi House was anything other than reasonable and appropriate.

I convey my sincere condolences to Hau's family for the loss of their much loved family member.

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

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

Han Nguyen, Senior Next of Kin

Western Health

Yooralla Disability Services C/- Lander & Rogers

First Constable Bradley Smith, Victoria Police, Coronial Investigator

Signature:

Date: 10 April 2025

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 investigation. 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.