IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 5048

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MICHELLE HODGSON, CORONER**
Deceased:	**MICHAEL PHU TRAN**
Date of birth:	12 March 1987
Date of death:	3 October 2017
Cause of death:	1(a) ISCHAEMIC HEART DISEASE 1(b) CORONARY ARTERY ATHEROSCLEROSIS
Place of death:	Fulham Correctional Centre, 110 Hopkins Road, Fulham, Victoria

HER HONOUR:

Background

1. Michael Phu Tran was born on 12 March 1987. He was 30 years old when he died on 3 October 2017 from natural causes.

2. At the time of his death, Mr Tran was serving a term of imprisonment at Fulham Prison. This term was due to end on 19 December 2017.

3. Mr Tran's medical history included cannabis and methamphetamine use from a young age, anxiety, and asthma.

4. At the time of his death, Mr Tran was prescribed methadone, olanzapine, mirtazapine, salbutamol inhaler, and fluticasone inhaler.

5. During his imprisonment, Mr Tran reportedly regularly took himself off his prescribed medication and missed the time period in which to take his prescribed medication.

The coronial investigation

6. Mr Tran's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).

7. Mr Tran's death was reportable because he was in the care of the State immediately before the time of his death.[1] Deaths of persons in the care of the State are reportable to ensure independent scrutiny of the circumstances surrounding their deaths. If such deaths occur as a result of natural causes, a coronial investigation must take place but the holding of an inquest is not mandatory.

8. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[2]

[1] See section 4(2)(c) of the *Coroners Act* 2008 (Vic).
[2] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not

9. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

10. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

11. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

12. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Identity of the deceased

13. Mr Tran was visually identified by his case worker, Helen Peevers, on 3 October 2017. Identity was not in issue and required no further investigation.

Medical cause of death

14. On 6 October 2017, Dr Joanna Glengarry, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the body of Mr Tran and reviewed a post mortem computed tomography (CT) scan.

15. Dr Glengarry noted the autopsy revealed significant natural disease in the form of ischaemic heart disease. She explained that the coronary arteries (arteries that supply the heart with blood) were occluded by a process known as atherosclerosis. Atherosclerosis is a build-up of cholesterol in the artery wall. When the coronary arteries are narrowed in this way, less blood containing oxygen and nutrients flows to the heart muscle. When coronary artery occlusion occurs, cardiac arrhythmias and sudden death may result.

16. Risk factors for development of atherosclerosis include smoking, emphysema, diabetes, high blood pressure, obesity, ageing, and genetic factors.

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make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

17. Toxicological analysis of post mortem specimens taken from Mr Tran identified methadone and its metabolite,[3] a clonazepam metabolite,[4] olanzapine,[5] mirtazapine,[6] pregabalin,[7] and paracetamol.

18. Dr Glengarry concluded Mr Tran's death was due to natural causes.

19. After reviewing toxicology results, Dr Glengarry completed a report, dated 23 March 2018, in which she formulated the cause of death as *"1(a) Ischaemic heart disease"* and *"1(b) Coronary artery atherosclerosis"*. I accept Dr Glengarry's opinion as to the medical cause of death.

Circumstances in which the death occurred

20. According to the *Police Report of Death for the Coroner* completed by Detective Leading Senior Constable Martin Tullett, a fellow prisoner stated that in the days before his death, Mr Tran had told him he was suffering headaches and flu-like symptoms. The fellow prisoner observed Mr Tran had recently been having difficulty breathing and he sounded congested and appeared to be struggling with flu or a similar virus. However, there is no evidence in Mr Tran's medical records that he attended a medical review regarding these symptoms.

21. At approximately 7.00am on 3 October 2017, prison staff checked on Mr Tran in his cell. When they called out to him, they heard Mr Tran grunt and saw him move his arm. His television was on at the time. Neither staff member had any concerns for Mr Tran's welfare at this time. They did not notice anything out of the ordinary at the time and Mr Tran's behaviour was noted to have been his normal response.

22. Mr Tran's cell door was then closed.

23. At approximately 9.20am, prison staff entered Mr Tran's cell and found him unresponsive and lying in bed face up with blood around his nose. Mr Tran had no vital signs and rigor mortis had already set in. Cardiopulmonary resuscitation was therefore not attempted.

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[3] Methadone is used for the treatment of opioid dependency or for the treatment of severe pain.
[4] Clonazepam is a benzodiazepine and possesses sedative and anticonvulsant properties.
[5] Olanzapine is used in the treatment of schizophrenia and related psychoses. It can also be used for mood stabilisation and as an anti-manic drug.
[6] Mirtazapine is used in the treatment of depression.
[7] Pregabalin is used as an analgesic, anticonvulsant, and anxiolytic agent.

24. There were no signs of external trauma, drug use, or other signs indicating the cause of death.

Justice Health review of Mr Tran's medical treatment while in custody

25. Justice Health is responsible for the delivery of health and alcohol and other drug services for prisoners across Victoria's prison system. I received a report dated 3 December 2017, which reviewed the medical care Mr Tran received in prison.

26. While at Fulham Correctional Centre, Mr Tran consulted health, mental health, and allied health staff, including dental, for various health matters on a regular basis. This included reviews to manage his anxiety.

27. Chronic healthcare plans were in place to monitor Mr Tran's general health, including his asthma and mental health needs. However, Mr Tran often failed to attend these reviews.

28. Occasionally, Mr Tran was cautioned about his frequent use of his salbutamol inhaler to ensure that it remained effective. Mr Tran later reported that he was using non-prescribed buprenorphine to assist sleeping and requested Valium to assist withdrawal. He was cautioned about using buprenorphine and was prescribed short-term melatonin to assist with sleep.

29. Whilst in custody, Mr Tran was diagnosed with hepatitis C. He was counselled and medical staff monitored his liver function. A course of hepatitis B vaccinations was also completed.

30. In August 2017, Mr Tran reported he was hearing voices and was subsequently prescribed a low dose of olanzapine.

31. Justice Health noted there was no evidence that health staff attempted to engage Mr Tran in his healthcare in addition to the scheduled health promotion appointments to ensure he remained compliant with his healthcare plan and monitoring. The report noted that GEO Group[8] will be required to submit an action plan to facilitate active engagement with prisoners to achieve optimal health outcomes. Progress to the action plan will be monitored through clinical governance meetings with Justice Health.

[8] GEO Group Australia provides outsourced correctional services.

32. Justice Health concluded Mr Tran's chronic healthcare follow-up could have been more closely monitored. However, the failure to closely monitor Mr Tran's chronic healthcare did not directly contribute to his death. I accept this conclusion.

Justice Assurance Review Office review

33. The Justice Assurance Review Office (**JARO**) provided a detailed report, dated 6 July 2018, which reviewed whether Mr Tran's custodial management was appropriate. There is no need for me to repeat the contents of that report in this finding as none of the issues identified were directly linked to Mr Tran's cause of death.

34. In summary, JARO acknowledged Mr Tran's drug history, drug-related offending, and drug incidents in custody. These issues were important considerations in his individual case management. Despite the dynamic security measures and wide-ranging strategies to reduce drug offending implemented by Corrections Victoria and Fulham Correctional Centre, Mr Tran engaged in drug-taking behaviour for a significant period of his term of imprisonment.

35. JARO concluded that the overall individual custodial management of Mr Tran throughout his time in custody met the standards prescribed by Corrections Victoria. I accept this conclusion.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was Michael Phu Tran, born 12 March 1987;

(b) Mr Tran died on 3 October 2017 at Fulham Correctional Centre, 110 Hopkins Road, Fulham, Victoria, from ischaemic heart disease and coronary artery atherosclerosis;

(c) his death was due to natural causes; and

(d) the death occurred in the circumstances described above.

Publication

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

I convey my sincere condolences to Mr Trans's family.

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

Ngoc Nguyen, Senior Next of Kin

Trung Tran, Senior Next of Kin

Justice Assurance and Review Office, Department of Justice and Regulation

Justice Health, Department of Justice and Regulation

Signature:

MICHELLE HODGSON
CORONER
Date: 23 November 2018.