IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 3177

FINDING INTO DEATH WITHOUT INQUEST

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

I, CAITLIN ENGLISH, Coroner having investigated the death of Van Thi Thanh Do

without holding an inquest:
find that the identity of the deceased was Van Thi Thanh Do
born on 3 July 1963
and the death occurred on 21 July 2013
at St Vincent's Hospital, Fitzroy, Victoria, 3065
from:

1 (a) METASTATIC OESOPHAGEAL CANCER

Pursuant to section 67(1) of the **Coroners Act 2008**, there is a public interest to be served in making findings with respect to **the following circumstances**:

1. Van Thi Thanh Do was 50 years of age at the time of her death. She resided at Dame Phyllis Frost Centre, which is a women's prison in Ravenhall, Victoria. She had been a prisoner there since being remanded on 16 May 2012, in relation to drug offences stemming from gambling debt. She was born in Vietnam, before travelling to Australia on 22 April 2008, on a three-month temporary visa. On 13 December 2012, Mrs Do was convicted at the County Court of Victoria, Melbourne in relation to a number of drug related charges and sentenced to 2 years and 14 days imprisonment. Her husband, Mr Do was also serving a prison term in Victoria at the time of her death. Mrs Do is survived by her two sons, Anh Tran and Vu Tran, who live in Haiphong City, Vietnam.

2. A police investigation was conducted into the circumstances of her death.

3. A brief prepared by Victoria Police for the coroner includes statements obtained from Mrs Do's niece, Ngoc Thi Bich Do, treating doctor, Dr Eleanor Flynn and the coroner's

investigator. The brief also includes a report upon the results of investigations undertaken by the Office of Correctional Services Review and Justice Health. I have drawn on all of this material as to the factual matters in this finding.

4. A coroner must hold an inquest if the deceased was, immediately before death, a person placed in custody, in accordance with section 52(2)(b) of the *Coroners Act 2008* (the Act).

5. Pursuant to section 52(3A) of the Act, I am not required to hold an inquest in these circumstances, if I consider that the death was due to natural causes.

6. In accordance with section 53(3B) of the Act, a death may be considered to be due to natural causes if the coroner has received a report from a medical investigator, in accordance with the rules, that includes an opinion that the death was due to natural causes.

7. I have received a report in this case and note there were no issues identified with Mrs Do's the health management. In these circumstances, I make findings with respect to the circumstances of Mrs Do's death and do not exercise my discretion in this instance to hold a public hearing through an inquest.

Events Proximate to Death

8. On 7 January 2013, Mrs Do was admitted to the prison ward, St Augustine's, at St Vincent's Hospital, Fitzroy, where she was diagnosed with oesophageal cancer. She received several cycles of chemotherapy before returning to Dame Phyllis Frost Centre on 1 May 2013.

9. On 16 May 2013, she was re-admitted to St Vincent's Hospital and her oesophageal cancer was found to be progressive.

10. On 29 May 2013, she had surgery for an oesophageal stent replacement, however her health continued to decline.

11. On 5 July 2013, due to her condition, she was transferred to the palliative care unit, Caritas Christie Hospice at St Vincent's Hospital.

12. On 18 July 2013, Mrs Do's health worsened and on 21 July 2013, she was pronounced deceased at approximately 6am. Mrs Do's family members were with her at the time of her death.

13. In accordance with Mrs Do's religious beliefs and wishes, a Buddhist death ceremony took place in her room with after her death.

14. On 21 October 2013, the coroners investigator Constable Wightman spoke with Mrs Do's sister, Ms Mai Do, who stated that *"My sister was ill, and the Doctors and Nurses have looked after her well"*[1]

Post Mortem Examination

15. A post mortem inspection and report was completed by Forensic Pathologist Dr Jacqueline Lee at the Victorian Institute of Forensic Medicine on 23 July 2013. Dr Lee formulated the cause of death. I accept her opinion. Dr Lee noted that;

"I am of the opinion that this death is due to natural causes."

Health and Medical Investigation Team Review

16. On 18 February 2015, The Health and Medical Investigation Team[2] (HMIT) reviewed the medical care, which Mrs Do received whilst she was in custody. The review determined that the medical care was appropriate.

Office of Correction Services and Justice Health Review

17. The Office of Correctional Services Review (OCSR) reviewed Mrs Do's management in custody and found that it *"was appropriate and demonstrated consistent consideration of her needs as a non-English speaking Vietnamese prisoner with ongoing health problems."*[3]

18. Justice Health reviewed the health care provided to Mrs Do in custody and concluded that *"a plan of care was in place to manage Mrs Do's health conditions at a quality and standard equivalent to that provided in the community through the public health system."* [4]

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[1] Coronial Brief, 11.

[2] The Health and Medical Investigation Team (HMIT) is part of the Coroners Prevention Unit, which assists in the investigation and development of recommendations surrounding deaths occurring during the provision of healthcare. HMIT also assists in identifying factors that may help improve patient safety and risk management.

[3] Death in Custody Review, OCSR, 3 March 2014, 8.

[4] Report on a Death in Custody, Justice Health, 25 October 2013, 6

Finding

I find that Van Thi Thanh Do died from metastatic oesophageal cancer.

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

Mrs Mai Do

Mr Van Tran

Ms Ngoc Thi Bich Do

Constable Caitlin Wightman

Pursuant to section 73(1B) of the **Coroners Act 2008**, I direct that a copy of this finding be published on the internet.

Signature:

CAITLIN ENGLISH
CORONER
Date: 28 April 2015