IN THE CORONERS COURT **COR 2021 006035**

OF VICTORIA

AT MELBOURNE

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Tai Van Tran

Delivered On:	21 February 2024
Delivered At:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria, 3006
Hearing Dates:	15 November 2022
Findings of:	Coroner Catherine Fitzgerald
Counsel Assisting the Coroner:	Mr Lindsay Spence
	Ms Jess Syrjanen

Appearing for Ambulance Victoria:	Ms Samantha Downes, Lander & Rogers Lawyers
Appearing for the Emergency Services Telecommunications Authority:	Ms Karen Liu, K&L Gates
Appearing for the Chief Commissioner of Victoria Police:	Ms Megan Patashnyk, Victorian Government Solicitor's Office

Keywords: Mandatory inquest, police custody, unascertained, ESTA, delay

THE CORONIAL INVESTIGATION

1. On 10 November 2021, Mr Tai Van Tran died at Sunshine Police Station. At the time of his death, Mr Tran was remanded in police custody, having been arrested on 9 November 2021. His death was reported to the coroner as it fell within the definition of a "reportable death" pursuant to section 4 of the *Coroners Act 2008* (**the Act**). The death occurred in Victoria, and it was the death of a person who immediately before death was a "person placed in custody or care".[1] An inquest into Mr Tran's death was therefore mandatory under the Act.[2]

2. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

3. 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.

4. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Tran's death. The Coroner's Investigator conducted inquiries on the coroner's behalf and submitted a coronial brief. Further investigations were also directed following receipt of the coronial brief. The relevant information obtained during the coronial investigation was compiled into the inquest brief.

5. This finding draws on the totality of the coronial investigation into the death of Tai Van Tran. Whilst I have reviewed all the material, I will only refer to that which is directly

[1] Sections (2)(c), 3(1) and 4(1) *Coroners Act 2008* (Vic).
[2] Section 52(2)(b) *Coroners Act 2008* (Vic).

relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

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

Circumstances in which the death occurred

6. On 24 September 2020, two bench warrants were issued for Mr Tran by the Sunshine Magistrates' Court in respect of:

    a) Failing to appear on bail for the offences of sexual exposure in a public place and possess a controlled weapon without excuse (two counts).[4]

    b) Failing to appear on summons for the offence of contravening a community corrections order.[5]

7. On 9 November 2021, a group of police officers including Sergeant (**Sgt**) Terrence Hill, Senior Constable (**SC**) Abraham Saldana, First Constable (**FC**) Michael Hudson, and Constables Riley Keir and David Harrison were targeting outstanding warrants in their work unit. At about 11.50am, they attended Mr Tran's parents' address in Sunshine North, enquiring about Mr Tran's whereabouts to execute the bench warrants.[6]

8. Police located Mr Tran within a bungalow at the rear of the property.[7] Police found drug paraphernalia and a zip lock bag containing a white rock substance, believed to be heroin, within the bungalow. Mr Tran was arrested pursuant to the two bench warrants, and for possession of heroin.[8] According to FC Hudson, Mr Tran "*appeared lucid and engaged*

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[3] 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 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.

[4] Coronial Brief (**CB**), 277 - Warrant to Arrest.

[5] CB, 278 - Warrant to Arrest.

[6] CB, 42 - Statement of First Constable (**FC**) Michael Hudson.

[7] Ibid.

[8] Ibid.

well with the police" at the time of his arrest.[9] Sgt Hill stated that "*During my time with TRAN, he was complaint (sic), no force was used, no injuries identified on TRAN"*.[10]

9. Mr Tran was handcuffed, placed in the rear of a police van, and was transported directly to Sunshine Police Station. Upon arrival, just before 12.30pm, Constable Harrison and FC Hudson escorted Mr Tran to the custody counter where he was entered into custody by Supervising Police Custody Officer (**SPCO**) Lorana Foster.[11]

10. SPCO Foster conducted an 'Initial Supervisor Welfare Check' with Mr Tran and made the following observations of him,

> *[W]hen conversing with Mr Tran he was coherent and was able to answer the welfare questions without any concern. He understood why he was at Sunshine Station and stated he did not have any injuries/illnesses or mental health issues…I asked Mr Tran if he had taken any drugs or alcohol to which he stated he had smoked a small amount of marijuana an hour earlier. I asked if he was feeling OK to which he replied 'yes'*.[12]

11. Mr Tran's interaction with SPCO Foster was observed by Police Custody Officer (**PCO**) Carlos Ardon, who was responsible for completing the required details on the 'Attendance' system. This is a computer program used to record attendances of detainees at police stations, including the answers given in response to the 'Initial Supervisor Welfare Check'. PCO Ardon recalled that Mr Tran's "*appearance and speech throughout this time looked to be normal"*.[13] PCO Ardon also noted that "*when Mr Tran was asked about drugs or alcohol, he stated he had consumed cannabis an hour ago but did not state how much cannabis he had consumed"*.[14]

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[9] CB, 42 – Statement of FC Hudson.
[10] CB, 41 - Statement of Sergeant (**Sgt**) Terrence Hill.
[11] CB, 45 - Statement of Constable David Harrison; CB, 48 - Statement of Supervising Policy Custody Officer (**SPCO**) Lorana Forster.
[12] CB, 48 - Statement of SPCO Foster.
[13] CB, 51 - Statement of Police Custody Officer (**PCO**) Carlos Ardon.
[14] Ibid.

12. The 'Attendance Summary' document records that at the 'Arrival check' there was "*Injuries – nil, Mental impairment or incapacity – nil apparent*", and at the 'Initial Supervisor Welfare Check' it was noted "*No visible signs of injury, No complaints*". Mr Tran was recorded as being affected by alcohol/drugs at the time of the offence, with the drug type being "*CANNABIS*" and the degree affected being "*Mildly*".[15]

13. At 12.37pm Mr Tran was transferred to Interview Room 1, and between 1.05pm and 1.12pm he was interviewed by FC Hudson and Constable Harrison, during which he gave a 'no comment' interview.[16]

14. The video recording of this interview shows Mr Tran to be coherent, lucid, and able to respond appropriately to questions. In respect of his physical appearance, there was nothing of immediate concern, and no obvious medical issues apparent. Mr Tran does not raise any concerns about his health.[17]

15. Following interview, Mr Tran was fingerprinted by Constable Harrison, the charge sheets were given to the Custody Sergeant, and Mr Tran was remanded to appear before a Magistrate in relation to the charges. He was then searched in the search room at 1.45pm by FC Hudson and Constable Harrison and handed over to PCOs Peter Cabban and Tarun Manipur who took him into the cells.[18] Whilst transferring him to a custody cell, PCO Manipur stated, "*I found Mr Tran to be showing symptoms of withdrawal and not talking very much".*[19]

16. Upon transfer to a custody cell, a 'Detainee Risk Assessment' (**DRA**) was completed at 1.57pm, with Mr Tran providing the following responses:

    a) negative responses were recorded as being given by Mr Tran in response to enquiries made of him about the following topics - '*suffering any physical*

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[15] CB, 224-225 - Attendance Summary.
[16] CB, 46 - Statement of Const Harrison.
[17] CB, Media Files, Record of Interview – Tai Van Tran, 9 November 2021.
[18] CB, 47 - Statement of Const Harrison.
[19] CB, 58 - Statement of PCO Tarun Manipur.

injury/illness', '*visible injuries'*, '*have you seen a doctor or been to hospital for treatment recently*', '*medication*' and '*mental health issues*';

b) with respect to '*drug use*' an affirmative response was recorded as being given by Mr Tran, noting daily heroin use with his last use that morning; and

c) negative responses as to whether he was on Methadone or Buprenorphine (Suboxone).[20]

17. At 2.01pm, the DRA was emailed to staff at the Custodial Health Service (**CHS**) and it was reviewed by Registered Nurse (**RN)** Rebecca Cotton, who noted,

> *Mr Tran disclosed that he is a daily user of heroin and that he had last used heroin that morning. From this information, I determined that Mr Tran would need to see the Custodial Medical Officer as he was likely to experience opiate withdrawal in the next 24 hours as he was not on any Opiate Replacement Therapy. I marked the box on the Health e-database that would identify him as requiring a Doctor review the following day.*[21]

18. Afternoon tea was provided to Mr Tran and others in the male cells at about 3.30pm. It is unknown whether Mr Tran had anything to eat or drink at that time. At about 3.52pm, Mr Tran was escorted from the male cells to a holding cell for the purpose of conducting a private legal call with his solicitor and was then returned to the male cells.[22] At about 5.45pm, Mr Tran was again moved to a holding cell for another call to his solicitor and then returned to the male cells shortly thereafter.[23]

19. At about 5.58pm, dinner was provided to Mr Tran.[24] This was followed by supper at 8.15pm. It is uncertain whether Mr Tran had anything to eat or drink at these times.[25] At

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[20] CB, 295-298 - Detainee Risk Assessment (**DRA**).
[21] CB, 78 - Statement of Registered Nurse (**RN**) Rebecca Cotton.
[22] CB, 323 - Custody Overview
[23] CB, 323 - Custody Overview.
[24] CB, 323 - Custody Module.
[25] CB, 57 - Statement of PCO Ian Wallace; CB, 58 – Statement of PCO Manipur.

the 9.30pm nightshift handover from Custody Sergeant (**CS**) Mark Allen to CS Chris McCran, nothing of concern was reported in respect of Mr Tran.

20. The next morning, at the 5.30am morning shift handover from CS McCran to CS John Harris, nothing of concern was reported in respect of Mr Tran, but it was noted that he was possibly withdrawing from heroin. At 6.45am, a routine cell clean and search was conducted, and all the male prisoners were moved between the cells. At this time, CS Harris had no concerns in respect of Mr Tran.[26]

21. At 6.45am breakfast was provided to the male cells.[27] It is not known whether Mr Tran had anything to eat or drink at that time.

22. At 7.58am, CS Harris was notified that Mr Tran had vomited in the cells.[28] Mr Tran was moved and placed into isolation in female cell number two. PCO Ardon stated, "*during this escort Mr Tran stated he was withdrawing from heroin and I observed him to look pale and clammy. Mr Tran was unsteady on his feet and at times I was required to assist him in walking*".[29] PCO Rachel Dawood stated, "*I observed Mr Tran to lose his balance when he got up. He looked pale and clammy. SPCO Foster helped him up and kept a hold of him while we escorted him to the F2*".[30]

23. PCO Tamara Plotzza telephoned the Custodial Health Advice Line (**CHAL**) at 8.09am in relation to Mr Tran's medical condition and spoke with the Deputy Director of Nursing, Natalie Angliss. PCO Plotzza said that Mr Tran was experiencing nausea and vomiting, and that he was clammy, sweaty, and mildly unsteady on his feet. She further advised "*Mr Tran stated he thought he was in withdrawal and the detainee was seeking a withdrawal pack (opiate withdrawal pack which is a common service provided by CHS*)".[31] PCO Plotzza handed the call over to PCO Ardon who informed Ms Angliss that Mr Tran *"was talking in full sentences, responding appropriately to questions, mobilising around*

[26] CB, 60-61 - Statement of Custody Sergeant (**CS**) John Harris.
[27] CB, 60 - Statement of CS Harris; CB, 63 – Statement of PCO Rachel Dawood.
[28] CB, 61 - Statement of CS Harris.
[29] CB, 52 - Statement of PCO Ardon.
[30] CB, 64 - Statement of PCO Dawood.
[31] CB, 75 - Statement of RN Natalie Angliss.

the cell and was able to get on and off the toilet independently".[32] PCO Ardon confirmed that Mr Tran *"was at a level that they could safely manage in the cells without warranting hospitalisation".*[33] Ms Angliss confirmed that a doctor would be attending mid-morning to conduct a medical review of Mr Tran. The general view of the PCOs and Ms Angliss was that Mr Tran's presentation was a drug withdrawal issue.[34]

24. At 8.58am, PCOs Ardon and Johnson conducted a verbal welfare check during which Mr Tran stated he required heroin withdrawal medication. His appearance was consistent with his presentation earlier that morning - pale and clammy.[35] Just under an hour later, Mr Tran was offered tea and coffee, which he declined.[36]

25. At 10.57am, a CHS doctor, Edward Morgan, attended Sunshine Police Station and reviewed Mr Tran at the Custody Counter, which was observed by PCO Dawood. She described Mr Tran as being "*incoherent*" during the conversation.[37] The interaction with Dr Morgan was recorded on CCTV.

26. Dr Morgan described his interaction with Mr Tran as follows,

> *[He] initially appeared quite distracted, for example, when given a face mask he used it to wipe his face before placing it on the counter, rather than placing it on his face. Although initially distracted, [Mr] TRAN responded quickly to redirection and when I began conversing with him, he was able to participate in the consultation without any difficulty. He answered my questions appropriately and told me he had no previous health issues, but he told me he was unwell because of his heavy illicit heroin use. He exhibited signs of acute opiate withdrawal, such as sweating, goose bumps, pale appearance as well as describing nausea, physical discomfort and loose bowels.*[38]

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[32] CB, 76 - Statement of RN Angliss.
[33] Ibid.
[34] Ibid.
[35] CB, 52 - Statement of PCO Ardon.
[36] CB, 64 - Statement of PCO Dawood.
[37] Ibid.
[38] CB, 80 - Statement of Dr Edward Morgan.

27. Dr Morgan further stated,

> *This is a clinical scenario that I have recognised and managed on thousands of occasions in custodial settings. I immediately instituted symptomatic treatment (medication) as is standard for the management of opiate withdrawal in police custody. I consulted with him for several minutes and reached the conclusion his primary health issue was opiate withdrawal. There was nothing else that was discussed or observed that indicated any other medical or health concern…I informed the custody staff to monitor his wellbeing and continue the medication as per the 'opiate withdrawal pack'. I left the opiate withdrawal pack for the PCOs to continue administration and advised them to contact CHAL should they have any concerns about his ongoing health…management of opiate withdrawal in police custody is one of the most common medical interventions that CHS provides. In relation to Mr Tran and how he presented, there was nothing that alerted me to any other medical concern.*[39]

28. Mr Tran consumed the starter dose from the blister pack of medication for opiate withdrawal in the presence of the PCOs and Dr Morgan.[40]

29. At 11.17am, Mr Tran was scheduled to appear via telephone link in relation to the charges which were listed at Sunshine Magistrates' Court. However, PCO Ardon stated "*Mr Tran declined to take the phone and participate. Mr Tran was laying on his bed and advised us to let the magistrate know that he was too tired to attend court and request if he could have his hearing adjourned to another date*".[41] It was recorded in the 'Custody Overview' that the matter was adjourned as Mr Tran was "*too sick*".[42]

30. The charges were adjourned to the following day, being 11 November 2021, with Mr Tran due to appear via audio-visual link. The Remand Warrant issued by the Court recorded "*CUSTODY MANAGEMENT ISSUES: May be at risk due to the following: Withdrawal*

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[39] CB, 80-81 - Statement of Dr Morgan.
[40] CB, 67 - Statement of PCO Tamara Plotzza.
[41] CB, 52-53 - Statement of PCO Ardon.
[42] CB, 325 - Custody Overview.

from drug of addiction. Recommend all reasonable assessment treatment and supervision to ensure safe custody".[43]

31. At about 1.00pm, Mr Tran was offered lunch, which he declined.[44]

32. At 3.21pm, a CHS Nurse, RN Tarryn Argus, attended Sunshine Police Station. She attended Mr Tran's cell and observed him through the cell door hatch, due to the COVID-19 restrictions which were in force at the time. RN Argus described her interaction with Mr Tran as follows,

> *Mr Tran sat up in his cell bed. He looked alert. I could see that he had a little bit of sweating, beads of sweat just across his forehead and was speaking in sentences. I asked, 'How are you feeling'. He said that he felt better. I asked if he had had any more vomiting and he said no. He also put his thumb up to indicate that he was good or fine. He said no when I asked if he had any pain. He wasn't distressed. I saw him move his legs and arms freely on the bed. I noticed that he did look a little bit dishevelled because he had long messy hair. Also, he looked malnourished because he was very thin, which is a typical feature of most heroin addicts. There was no sign of any faecal matter or vomit in his cell at that time.*[45]

33. Throughout the afternoon of 10 November 2021, Mr Tran was observed vomiting and using the toilet at various times on the CCTV by CS Mark Allen. He also observed that Mr Tran walked around his cell and used the water fountain.[46] Other PCOs made observations during their day shift that Mr Tran appeared to be withdrawing from drugs.[47]

34. At 5.13pm, PCOs Sunu Cyriac and Ahammad Ullah attended Mr Tran's cell and provided him with his dinner time medication from the withdrawal blister pack. PCO Cyriac observed Mr Tran consume the medication and then checked his hands and mouth to ensure

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[43] CB, 304 - Remand Warrant.
[44] CB, 64 – Statement of PCO Dawood; CB, 325- Custody Module.
[45] CB, 84 - Statement of RN Tarryn Argus.
[46] CB, 73 – Statement of CS Mark Allen.
[47] CB, 57 - Statement of PCO Ian Wallace.

it had been swallowed. At 5.43pm Mr Tran was provided with dinner, which he did not eat.[48]

35. At 8.37pm, PCOs Cyriac and Ullah attended Mr Tran's cell to provide him with his bedtime medication. PCO Ullah stated, "*he was lying down on his bed and appeared very sleepy. We encouraged him to take his prescribed medicine for his own welfare. [Mr] TRAN stood for a while and consumed his medicine with a sip of water. [Mr] TRAN immediately returned to bed and I closed the cell hatch*".[49]

36. At about 8.50pm, the cell lights were turned off for the night.[50] A notation made in respect of Mr Tran in the 'Custody Overview' noted he was sighted at that time with nil issues and provided with an additional blanket as requested at that time.[51]

37. During the supervisor night shift handover at about 9.30pm, CS Allen told incoming CS Paul Egan about Mr Tran in female cell number two and *"advised that the male had been remanded the previous day and had been going through heroin withdrawal. [CS Allen] told me that the male had been seen and assessed by the CHAL (custodial health) nurse. We didn't discuss the male's medication but I understood that the male would have been prescribed Suboxone, which is routine opiate-replacement therapy for prisoners experiencing heroin withdrawal*".[52]

38. A handover also occurred for the PCOs commencing night shift. This included incoming PCOs Kuljit Singh and Mustafa Tilki. They were both made aware that Mr Tran was withdrawing from heroin and was receiving medication to manage the withdrawal.[53]

39. At approximately 10.55pm, the CCTV footage from inside Mr Tran's cell shows that he sat up in his bed and rubbed his face and head repeatedly with his blanket. About a minute later he stood up, walked over to the sink, and attempted to drink from the tap although it is unclear from the CCTV footage whether he drank any water. Mr Tran then walked over

[48] CB, 69 - Statement of PCO Ahammad Ullah.
[49] CB, 69 - 70 - Statement of PCO Ullah.
[50] CB, 73 – Statement of CS Allen.
[51] CB, 324 - Custody Overview.
[52] CB, 88 - Statement of CS Paul Egan.
[53] CB, 99- 100 – Statement of PCO Kuljit Singh; CB, 105 – Statement of PCO Mustafa Tilki.

into the corner of the cell facing the wall and stood there for approximately ten seconds, prior to collapsing backwards, with his upper back and shoulders impacting the side of the toilet bowl.

40. Mr Tran remained in that position for a period of five minutes and 50 seconds prior to PCOs Tilki and Singh attending the cell. According to PCO Tilki, he had been completing some administrative tasks within the custody office when he went to the printer and, upon his return, observed Mr Tran on the CCTV monitors, sitting on the ground leaning against the wall near the toilet. He had concerns for Mr Tran due to the way he was sitting and told PCO Singh. After dressing in required personal protective equipment (**PPE**), they both made their way to Mr Tran's cell to conduct a welfare check. Neither PCO witnessed the actual collapse of Mr Tran on the CCTV monitors.[54]

41. In accordance with "*standard procedure*" and for safety reasons, PCO Singh remained at the cell door whilst PCO Tilki entered Mr Tran's cell.[55] Upon entering, PCO Tilki stated that he called Mr Tran's name multiple times without response. He then walked closer to Mr Tran and tapped his chest and shoulder to get a response and in PCO Tilki's opinion, "*Mr Tran was conscious, he made eye contact with me and groaned multiple times*".[56] The CCTV footage shows that Mr Tran moved his right arm and his mouth whilst PCO Tilki attempted to get a response from him.

42. It was apparent to PCO Tilki that Mr Tran was unwell. He told PCO Singh that they needed to get urgent medical assistance for Mr Tran. He pressed the intercom button to alert staff in the custody office to look at the CCTV camera. PCO Singh closed the cell door, and the CCTV footage shows that both PCOs left the cell about 35 seconds after PCO Tilki first entered. PCO Tilki states that after he left the cell, he immediately used the office phone to call 000 to request an ambulance. The lights are turned on the inside the cell approximately 34 seconds after the PCOs leave.[57]

[54] CB, 105-106 – Statement of PCO Tilki; CB, 101- Statement of PCO Singh.
[55] CB, 101 – Statement of PCO Singh.
[56] CB, 106 - Statement of PCO Tilki.
[57] Ibid.

43. The CCTV footage depicts a second attendance in the cell by PCOs Singh and Tilki, approximately 12 seconds after the lights are turned on. PCO Singh is observed trying to rouse Mr Tran, but on this occasion, no obvious response from Mr Tran is discernible. PCO Tilki is seen talking on a phone whilst in the cell. Both PCOs leave the cell after 90 seconds.

44. Within about 26 seconds, PCO Singh returns to the cell with CS Egan.[58] By that time, CS Egan had been informed that Mr Tran required an ambulance. Whilst PCO Singh thought he saw Mr Tran swallowing a few times when they went into the cell,[59] CS Egan immediately assessed that "*something was seriously wrong with the prisoner*" and he did not think that Mr Tran was breathing.[60] He placed Mr Tran on the floor, checked Mr Tran's airway was clear and then immediately commenced cardiopulmonary resuscitation (**CPR**). This occurred within about 23 seconds of CS Egan entering the cell. A defibrillator, resuscitation mask and first aid kit were brought into the cell by PCO Singh within 30 seconds of CPR commencing. The defibrillator pads were applied but no shockable rhythm was indicated. CPR recommenced and continued until paramedics arrived.[61]

45. The first call made to 000 by PCO Tilki was at 11.07.14pm. His call requesting an ambulance was presented to the Emergency Services Telecommunications Authority (**ESTA**) ambulance call queue by Telstra. After one minute and 59 seconds on hold with Telstra, his call was not answered by an ESTA ambulance call-taker and the call was terminated by PCO Tilki, who was frustrated by the delay. The Telstra operator remained on the line for a total period of four minutes and ten seconds and attempted to transfer the call to ESTA on four occasions, but the call was not answered by an ESTA ambulance call-taker on any of those attempts.

46. At 11.09.40pm, PCO Tilki phoned 000 for a second time, and the call was again presented to the ESTA ambulance call queue by Telstra. After two minutes and 44 seconds on hold with Telstra, the call was not answered by an ESTA ambulance call-taker and terminated by PCO Tilki. The Telstra operator remained on the line for a total of four minutes and 20

[58] CB, 101 – Statement of PCO Singh; CB, 106 – Statement of PCO Tilki.
[59] CB, 101 – Statement of PCO Singh.
[60] CB, 90 – Statement of CS Egan.
[61] CB, 90-92 - Statement of CS Egan.

seconds and attempted to transfer the call on four occasions during that time, but the call was not answered by an ESTA ambulance call-taker.[62] As PCO Tilki was unable to request an ambulance via 000, he attended the watch house at Sunshine Police Station to ask for assistance.[63]

47. At 11.11pm, a police radio D24 broadcast was made requesting urgent Ambulance Victoria (**AV**) attendance for a male patient that was unconscious and not breathing.[64] At 11.12pm, an event was created for urgent ambulance assistance - Priority 0.[65] Mobile Intensive Care Ambulance (**MICA**) 3, MICA 9 and AV Albion Advanced Life Support (**ALS**) units were immediately dispatched. AV MICA 3 arrived on scene at Sunshine Police Station at 11.13.27pm, closely followed by AV Albion ALS at 11.15.10pm.[66]

48. By the time paramedics arrived, Mr Tran had been moved by police members into the area outside the cell to allow more space for CPR. AV MICA Paramedic Catherine Cristofaro commenced treating Mr Tran at 11.16pm and ascertained that he had no pulse and pulseless electrical activity (**PEA**) rhythm.[67] At 11.23pm, AV MICA 9 Paramedic Peter Dowling arrived on scene to assist the paramedics already in attendance and a range of resuscitative measures were employed.[68] Despite the efforts of the paramedics, Mr Tran remained in PEA cardiac arrest without change. He was declared deceased at 11.47pm.[69]

49. A critical incident investigation was immediately commenced, led by the Victoria Police Homicide Squad, and overseen by the Professional Standards Command.[70] The scene was processed by the Victoria Police Major Crime Scene Unit.[71] Homicide Squad Detective

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[62] CB, 371 – Ambulance Victoria (**AV**) Patient Safety Incident Management Review Report.
[63] CB, 106 – Statement of PCO Tilki.
[64] CB, 177 - Statement of Ruben Naiker, Emergency Services Telecommunications Authority (**ESTA**).
[65] CB, 372 - AV Patient Safety Incident Management Review Report.
[66] CB, 365 – AV Electronic Patient Care Record.
[67] CB, 119 - Statement of AV Mobile Intensive Care Ambulance (**MICA**) Paramedic Catherine Cristofaro.
[68] CB, 124 - Statement of AV MICA Paramedic Peter Dowling.
[69] CB, 121 - Statement of AV MICA Paramedic Cristofaro.
[70] CB, 180 - Statement of Detective Sergeant (**Det Sgt**) Luke Farrell.
[71] CB, 136 - 141 - Statements of Leading Senior Constable (**LSC**) Carolyn Davis, SC Hai-Tieng Lim, and Sgt Tracy Starr.

Sergeant Luke Farrell was appointed as the Coroner's Investigator, and submitted a coronial brief regarding the death.[72]

Identity of the deceased

50. On 15 November 2021, Deputy State Coroner Caitlin English (as she then was) made a formal determination identifying the deceased as Tai Van Tran, born 15 April 1978, based on a fingerprint report, the police report of death, the preliminary examination form and the Victorian Institute of Forensic Medicine admission photograph and identification report.

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

Medical cause of death

52. Forensic Pathologist Dr Hans de Boer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 12 November 2021 and provided a written report of his findings dated 6 April 2022.

53. The post-mortem examination revealed a perforated gastric ulcer with cavitation. Based on the macroscopical and histological appearance, this ulcer was chronic. The ulcer would have affected Mr Tran's general health status, but the extent to which it did is unknown. Testing for inflammatory markers (C-reactive protein and procalcitonin) was not possible due to unavailability of suitable specimens, and this further hampered the interpretation of the effects of the gastric ulcer. However, given the chronicity and localised appearance, it was not deemed likely by Dr de Boer that the effects of the ulcer alone were sufficient to cause death. These effects could, however, have contributed to metabolic/physiological derangement.[73]

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[72] CB, 180 - Statement of Det Sgt Farrell.
[73] CB, 150 - Medical Examiner's Report (**MER**).

54. Toxicological analysis of post-mortem samples identified the presence of methylamphetamine and its metabolite amphetamine,[74] morphine and its metabolite codeine,[75] diazepam and its metabolites nordiazepam and temazepam,[76] metoclopramide,[77] paracetamol,[78] and scopolamine,[79] but did not identify the presence of alcohol or any other commonly encountered drugs or poisons.[80]

55. Dr de Boer explained that the interpretation of the post-mortem toxicological results is challenging due to post-mortem artefact, possible acquired tolerance, and possible interactions between the detected substances. On face value, he opined that the detected levels appeared to be insufficient to have caused the death, especially since the deceased had been incarcerated for approximately one day prior to his collapse and blood levels of drugs (and therefore their effects) reduce over time. However, contribution of these toxicological effects to the cause of death could not be entirely excluded.[81]

56. Dr de Boer also noted that the withdrawal symptoms from toxicological substances can be severe and include cardiac dysfunction and seizures. Such severe effects are deemed to be very rare, and according to the limited amount of available literature, are usually not life-threatening. Seizures and cardiac dysfunction are both functional diagnoses, without specific findings at autopsy. Dr de Boer reviewed the CCTV footage of Mr Tran in the cells and noted that he did not see any evidence of generalised tonic-clonic seizures, but that other forms of seizure activity, or a cardiac arrythmia, could not be excluded. The role of withdrawal symptoms in the cause of death therefore remains unknown.[82]

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[74] Amphetamines is a collective word to describe central nervous system (**CNS**) stimulants structurally related to dexamphetamine. One of these, methamphetamine, is often known as *speed* or *ice*. It is a strong stimulant drug that acts like the neurotransmitter noradrenaline and the hormone adrenaline.
[75] Morphine is a narcotic analgesic indicated for moderate to severe pain.
[76] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.
[77] Metoclopramide is an anti-emetic drug used for the treatment of nausea and vomiting.
[78] Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine and propoxyphene.
[79] Scopolamine (also known as hyoscine) is an antimuscarinic agent commonly used to prevent motion sickness, in treatment of irritable bowel syndrome and in pre-operative sedation.
[80] CB, 165 - VIFM Toxicology Report.
[81] CB, 150 - MER.
[82] Ibid.

57. The interpretation of post-mortem vitreous humour biochemistry is difficult due to post-mortem artefact. Dr de Boer opined that the high levels of sodium, chloride, and urea, however, are indicative of dehydration. Dehydration may result in severe physiological derangement, and this may also have contributed to death.[83]

58. Dr de Boer also noted that the deceased was underweight and that underweight individuals are more prone to metabolic and physiological derangement than people with a normal, healthy weight. Starvation may induce a specific type of metabolic derangement, namely ketoacidosis. In ketoacidosis, the blood acidifies due to the accumulation of ketone bodies. Testing for beta-hydroxybutyrate (one of the main ketone bodies) was not possible due to the unavailability of a suitable specimen. However, toxicological analysis for other substances that are ordinarily elevated in ketoacidosis was negative. This finding therefore argues against a contribution of ketoacidosis to the cause of death.[84]

59. There was no post-mortem evidence of any injuries which may have caused or contributed to the death.

60. Dr de Boer ultimately opined that it is reasonable to attribute the death of Mr Tran to metabolic/physiological derangement in the context of a suboptimal health status, dehydration, and possible toxicological (withdrawal) effects of the detected substances. The contributions of these elements, and their interactions, however, remains unascertained.[85]

61. Dr de Boer provided an opinion that the medical cause of death was "*1(a) Unascertained*".[86]

62. I accept Dr de Boer's opinion.

[83] Ibid.
[84] Ibid.
[85] Ibid.
[86] Ibid.

FURTHER INVESTIGATIONS AND REVIEW OF CARE

63. I referred this case to the Coroner's Prevention Unit (**CPU**)[87] Health and Medical Information Team (**HMIT**) for a review of the medical care provided to Mr Tran whilst in custody at Sunshine Police Station, and for specific advice on whether the delay in paramedic attendance, caused by the failed 000 calls, contributed to the death.

64. The CPU was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health, and mental health. Mr Tran's case was reviewed by an Emergency Medicine specialist.

65. My review of the medical care provided to Mr Tran also necessitated a review of the relevant Victoria Police policy documents concerning management of persons held in detention by police, as contained in the Victoria Police Manual Policy (**VPMP)** Rules '*Persons in police care or custody*' and the related Victoria Police Manual Guidelines (**VPMG**) '*Safe management of persons in police care or custody'.*

66. The VPMP are noted to be mandatory and state that "*when a person is taken into police care or custody, Victoria Police assumes a responsibility for their safety, security, health and welfare*." The VPMP is noted to "*provide the minimum standards that employees must apply*" and it instructs police members to refer to the VPMG "*to ensure best practice is applied and minimum standards are met.*" The VPMP outlines that "*The policy and its related guidelines address the accountabilities and responsibilities for persons in police care or custody and underpin Victoria Police's application of the Charter of Human Rights and Responsibilities Act*".[88]

67. By way of overview, the relevant VPMP and VPMG impose various obligations on police members in relation to the management of detainees, and address role responsibility,

[88] CB, 377- 378 – VPMP.

information management requirements, and escalation pathways in relation to medical care. Notably, the Custody Supervisor has "*overall responsibility for ensuring the appropriate management and care of persons in custody for their shift*"[89] and custody staff "*are responsible for undertaking the day to day tasks required to ensure the care and welfare of persons in detention facilities.*"[90]

68. The "*Medical Checklist*" in the VPMG is noted to apply at all times to all persons in the care or custody of police. It contains required escalation in medical care and requests for medical advice, depending upon the medical condition of the detainee. By way of summary, where a detainee appears to be ill or injured, custody staff should obtain medical advice or assistance from the CHAL, and where the detainee has an impaired conscious state, their condition should be assessed using the "*Medical Checklist*", which directs the appropriate response.[91]

69. It is a requirement that an assessment be made about whether it is suitable to lodge a person in detention facilities.[92] The VPMP also imposes specific obligations on members to obtain information about the medical condition of detainees from the moment they are taken into police care or custody, and to make an assessment of the person using the "*Medical Checklist*".[93] All persons in detention facilities must be entered into the 'Attendance module' and a DRA must be completed and emailed to the CHS for all persons detained more than four hours.[94]

70. The VPMG *Safe management of persons in police care or custody,* also outlines the requirements for observation and ongoing welfare checks for all persons in police cells. The DRA is used to determine the level of observation and frequency of welfare checks that are required for a detainee, and which are recorded within the 'Custody Module'.[95] The level of observation is determined by reference to several factors in the DRA, including

[89] CB, 382 – VPMP.
[90] CB, 384 - VPMP
[91] CB, 392 - 393, 412 – VPMG.
[92] CB, 399 - VPMG
[93] CB, 390 - 391 – VPMG.
[94] CB, 381 – VPMP.
[95] CB, 401 - 402 - VPMG.

use of the medical checklist, the risk of self-harm, risk of harming others and any security risks.[96]

71. I have had specific regard to both the CPU advice, and the relevant VPMP and VPMG, to determine whether the care provided to Mr Tran in custody was appropriate.

Perforated gastric ulcer with cavitation

72. The post-mortem examination found Mr Tran to be suffering from a perforated gastric ulcer with cavitation. There is no evidence before me to indicate that Mr Tran was aware he was suffering from a gastric ulcer or that he had sought any medical assistance in relation to it prior to his arrest by police. I note that the DRA recorded negative responses from Mr Tran to '*suffering any physical injury or illness*' and '*have you seen a doctor or been to hospital for treatment recently*'. Similarly, SPCO Foster (who conducted the 'Initial Supervisor Welfare Check') stated "*when conversing with Mr Tran he was coherent and was able to answer the welfare questions without any concern. He understood why he was at Sunshine Station and stated he did not have any injuries/illnesses or mental health issues*".[97]

73. Mr Tran's brother Hung (Vince) Tran has stated that it was only after his brother's passing that he became aware that Mr Tran had been experiencing stomach pain. After his brother's death, Vince Tran was informed by his mother that Mr Tran had been having stomach pain, lost his appetite and had been vomiting after eating food. Vince Tran indicated that his mother became aware of this about a week prior to his son's death when she saw him holding his stomach in pain.

74. Having regard to the available evidence, I am satisfied that Victoria Police were not aware, and could not have been aware, of Mr Tran's medical condition relating to the gastric ulcer. I also note that it is unclear what specific contribution this medical condition made to his death.

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[96] CB, 401 - VPMG

[97] CB, 48 - Statement of SPCO Foster.

Drug withdrawal

75. When he was first taken into custody, Mr Tran denied use of illicit drugs other than recent cannabis use. However, during the DRA, Mr Tran disclosed to police that he was a daily user of heroin, and his use was recorded as "*Last Used: today morning*".[98] He was noted by police to be experiencing withdrawal symptoms and it was determined that he would need a medical review as he was likely to experience opiate withdrawal whilst in custody.

76. In accordance with the obligations of police members in the VPMP and VPMG, the information in the DRA was emailed to the CHS and it was reviewed. Mr Tran was then scheduled for an in person medical review within 24 hours.

77. It appears that Mr Tran experienced an escalation in withdrawal symptoms the following day, 10 November 2021, with vomiting shortly before 8.00am. He received withdrawal pack medication just before 11.00am, at 5.13pm and at 8.37pm. Mr Tran was assessed that day by both Dr Morgan in the morning and RN Argus in the afternoon, with no significant concerns identified, noting that he had been commenced on a standard withdrawal pack. I also note that Mr Tran regarded his own symptoms as consistent with drug withdrawal, and that there does not appear to have been any significant deterioration in his medical condition prior to his collapse, just before 11.00pm.

78. It is apparent that there were no concerns held for Mr Tran's welfare in custody, other than the issue of management of opiate withdrawal. The CHS and the CHAL were appropriately contacted in that regard, and Mr Tran was reviewed by both a doctor and a registered nurse, neither of whom raised any concerns about his medical condition or his welfare in the cells.

79. The CPU HMIT review provided an opinion that Mr Tran "*was treated appropriately for opiate use disorder*".[99] I accept this opinion. The review by CPU HMIT did not take any issue with the medical assessment by those involved with Mr Tran, but did note that it would have been preferable that his vital signs were recorded when he was assessed, and that making an assessment without entering the cell is undesirable from a medical

[98] CB, 31 - Detainee Risk Assessment.
[99] CB, 475 - Coroner's Prevention Unit (**CPU**) – Health and Medical Investigation Team (**HMIT**) Memorandum.

perspective.[100] However, as Mr Tran was conscious and communicating throughout the day, it does not appear that either of these deficiencies caused or contributed to his death. I also note that it is unclear what specific contribution drug withdrawal played in his death.

Response to the medical emergency

80. Mr Tran was classified at the lowest level of observation – 'Level 4 – General Observation'. This required him to be physically checked every four hours.[101] The DRA for Mr Tran recorded a coma scale assessment upon entering custody as 'five' (being the highest rating) and an observation level of four (the minimum observation requirement), requiring four-hourly observations.[102] Mr Tran was subsequently reviewed by Dr Morgan and RN Argus, with no changes suggested to Mr Tran's classification or observation level.

81. Almost six minutes elapsed between Mr Tran collapsing and PCOs attending his cell for an initial welfare check. However, it is apparent from the level of observation he was under that he was not under constant observation. Mr Tran's collapse only became evident to the PCOs upon a periodic observation of the CCTV live feed, and there is no evidence which suggests the collapse should have come to their attention at an earlier point in time.

82. Upon the initial attendance in the cell, PCO Tilki assessed that Mr Tran was still conscious and responsive, albeit requiring immediate medical assistance. This is corroborated by the CCTV footage. No CPR was necessary at that time. When PCO Singh entered the cell on the second occasion with PCI Tilki, there is no obvious response discernible from Mr Tran on the CCTV footage, but it is not possible to determine from the CCTV footage whether he had ceased breathing and/or had a pulse at that time. The first time Mr Tran was noted as not breathing was when CS Egan entered the cell, and he immediately commenced CPR, which was the appropriate response.

83. The CPU HMIT review opined that it is difficult to comment on whether the outcome would have differed if CPR had been commenced sooner. It was noted that out of hospital

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[100] Ibid.
[101] CB, 411 - VPMG – Safe management of persons in police care or custody.
[102] CB, 297 - Detainee Risk Assessment.

cardiac arrests have a very poor prognosis, especially when unwitnessed, as was the case for Mr Tran.[103] I accept this advice.

84. Based on the available evidence, I am unable to determine the exact moment when Mr Tran ceased breathing, but I am satisfied that it was at a point in time after he was initially assessed by PCO Tilki, who correctly assessed that an ambulance was required and appropriately contacted 000 immediately. CPR was commenced as soon as it was assessed by CS Egan that Mr Tran was not breathing, and a defibrillator was applied. In that regard, the police response to the medical emergency was also appropriate.

Delay connecting to ESTA ambulance call-taker

85. PCO Tilki called 000 at 11.07.14pm and 11.09.40pm, with both calls being presented to the ESTA ambulance call queue but unanswered. PCO Tilki terminated the first call after one minute and 59 seconds and called back, then hung up the second call after two minutes and 44 seconds. PCO Tilki instead sought the assistance of police members within the station to broadcast the request for an ambulance directly over D24 police radio.

86. The total time delay between the first 000 call commencing, and the D24 broadcast requesting AV assistance, was approximately four minutes. AV MICA Paramedics arrived on scene one minute and 24 seconds after the Ambulance Case Priority Zero was created. Both calls to 000 were abandoned by the PCO, with the Telstra operator making four attempts on each occasion to connect the call through to an ESTA ambulance call-taker. Both calls were unanswered by ESTA.

87. ESTA's performance benchmark during this period required calls to be answered by an ESTA ambulance call-taker within five seconds, a performance benchmark that was clearly not met in this case.

88. The question of whether this delay in any way caused or contributed to the death of Mr Tran was referred to the CPU HMIT for medical advice. The CPU reviewer opined that "*in this instance, the slight delay in getting through to AV did not contribute to death as Mr Tran*

[103] CB, 476 - CPU HMIT Memorandum.

was already in cardiac arrest with CPR ongoing. The prognosis of asystolic cardiac arrest in the community is very poor". Having regard to this evidence, the delay occasioned in the dispatch of AV paramedics by virtue of two calls to 000 remaining unanswered within the ESTA ambulance call queue, did not cause or contribute to Mr Tran's death.

89. In September 2022 the Inspector-General for Emergency Management (**IGEM**) released a publicly available report '*Review of Victoria's emergency ambulance call answer performance – COVID-19 pandemic related 000 demand surge'* (**'IGEM Report'**). Finding 4 of that report was that ESTA did not meet the primary ambulance emergency call answer speed benchmark in any month from December 2020 to June 2022. The IGEM Report identified that there was a fundamental shift in ESTA's operating environment arising from the COVID-19 pandemic and surge related demands in respect of emergency ambulance calls. It also found that increases in emergency ambulance call activity received by ESTA strongly correlated with COVID-19 infections in the Victorian community.

90. The unanswered 000 calls which occurred in relation to Mr Tran fell within the time period investigated by IGEM. ESTA's inability to meet ambulance call answer benchmarks during this time is now a matter of public knowledge. Having regard to the existing public awareness of this issue, and the fact that the delay in this case did not cause or contribute to the death of Mr Tran, no further comment or finding regarding this issue is necessary.

FINDINGS AND CONCLUSION

91. Having investigated the death of Tai Van Tran, and having held an inquest in relation to this death, I make the following findings pursuant to section 67(1) of the Act:

    a) the identity of the deceased was Tai Van Tran, born on 15 April 1978;

    b) the death occurred on 10 November 2021 at the Sunshine Police Station, 497 Ballarat Rd, Sunshine, Victoria, 3020; and

    c) the death occurred in the circumstances described above.

92. I am satisfied that Mr Tran received appropriate medical care whilst in police custody.

I convey my sincere condolences to Mr Tran'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 Victora website in accordance with the rules.

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

Hung (Vince) Tran, Senior Next of Kin

Ambulance Victoria (C/- Lander & Rogers Lawyers)

Emergency Services Telecommunications Authority (C/- K&L Gates)

Victoria Police (C/- Victorian Government Solicitor's Office)

Detective Sergeant Luke Farrell (VP33917), Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

Date: 21 February 2024

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.