



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 004118

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of: Coroner Leveasque Peterson

Deceased: Si Ro Vo

Date of birth: 25 November 1963

Date of death: 16 July 2025

Cause of death: 1a : METASTATIC LUNG CANCER
(PALLIATED)

Place of death: Port Phillip Prison
451 Dohertys Road
Truganina Victoria 3029

Keywords: Death in custody, natural causes

INTRODUCTION

1. On 16 July 2025, Si Ro Vo was 61 years old when he was found deceased whilst a patient at St John's Inpatient Unit at Port Phillip Prison. At the time of his death Mr Vo had been serving a sentence of imprisonment since April 2025.
2. Mr Vo had a medical history that included non-small lung cell carcinoma, with bony and cranial metastasis, Type 2 diabetes, chronic kidney disease, hypertension, asthma, benign prostatic hypertrophy, gout, dyslipidaemia and Gastro-oesophageal Reflux disease.
3. Mr Vo also had an Acute Resuscitation Plan (ARP) in place which stated that in the event of a cardiac arrest Mr Vo was not to receive CPR rather he was to be given comfort care. The ARP was reviewed in April 2025, with no changes made, and again in May 2025, at which time the plan was amended to note that in the event of an acute clinical deterioration Mr Vo was to be provided with comfort care rather than clinical escalation.

THE CORONIAL INVESTIGATION

4. Mr Vo's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.
5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding 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.
6. 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.

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

Circumstances in which the death occurred

7. Mr Vo had been in palliative care for a number of months as his cancer had metastasised to the brain. His condition was terminal and clinicians and other staff were providing comfort care as a pathway to death.
8. In the week prior to his death, Mr Vo had become increasingly unresponsive. On 16 July 2025 staff reported that Mr Vo was checked at approximately 10.30 pm and he was breathing and calm but otherwise unresponsive. When staff checked in on him again some twenty minutes later, Mr Vo was deceased. In the context of his treatment plan no efforts were undertaken to resuscitate Mr Vo.

Identity of the deceased

9. On 21 July 2025, Si Ro Vo, born 25 November 1963, was visually identified by his child, Tinaa Thu Hang Vo.
10. Identity is not in dispute and requires no further investigation.

Medical cause of death

11. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 18 July 2025 and provided a written report of her findings dated 25 July 2025.
12. The post-mortem examination was consistent with the clinical history.
13. Dr Zhou provided an opinion that the medical cause of death was 1(a) METASTATIC LUNG CANCER (PALLIATED).
14. I accept Dr Zhou's opinion.

FINDINGS AND CONCLUSION

15. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Si Ro Vo, born 25 November 1963;

- b) the death occurred on 16 July 2025 at Port Phillip Prison 451 Dohertys Road Truganina Victoria 3029, from 1(a) METASTATIC LUNG CANCER (PALLIATED), and
- c) the death occurred in the circumstances described above.

I extend my sincere condolences to Mr Vo's family for their loss.

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:

Tinaa Vo, Senior Next of Kin

First Constable Matthew Cheng, Coronial Investigator

Signature:



Coroner Leveasque Peterson

Date: 06 January 2026

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.
