IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 002930

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Bryan Pham
Date of birth:	31 March 1996
Date of death:	2 June 2020
Cause of death:	1a : MULTIPLE INJURIES AND CHEST COMPRESSION ASPHYXIA
Place of death:	19 Larisa Road, St Albans, Victoria, 3021
Keywords:	Train incident; Mental health

INTRODUCTION

1. On 2 June 2020, Bryan Pham was 24 years old when he died in a train accident. At the time of his death, Bryan was living a transient lifestyle.

2. Bryan was born to Vietnamese-Australian parents Dung Pham and Dung Le and was a brother to Tommy Pham. Bryan was reported to be a frequent recreational drug user from his teenage years, most often involving cannabis and after finishing school, using methylamphetamine.[1] Bryan experienced short periods of employment, however was unemployed and receiving Centrelink benefits at the time of his passing.[2]

3. Bryan was diagnosed with his first episode of psychosis in May 2017 at Orygen Youth Health, which was followed by an updated diagnosis of substance use disorder and schizophrenia in August 2017.[3]

4. Bryan had a history of perpetrating family violence including perpetrated towards his family, leading to police involvement and family violence intervention orders (**FVIO**).[4] Bryan was also historically charged with offences related to drugs, theft, criminal damage and breach of FVIOs.[5]

5. Bryan had extensive contact with the mental health system to treat his schizophrenia or drug-induced psychosis. He experienced psychotic symptoms including paranoid delusions and would exhibit bizarre and violent behaviour during periods of mental ill health. Bryan historically displayed poor insight into his mental illness leading to medication non-compliance. In the three years prior to his passing, Bryan was subjected to a several assessment orders, inpatient temporary treatment orders and community treatment orders (**CTO**) and was case managed by Orygen Youth Health before being transferred to the care of Mid-West Area Mental Health Service (**MWAMHS**).

6. Bryan's final CTO was revoked on 31 July 2019 by MWAMHS psychiatrist Dr Eva Amerasinghe on which occasion he was noted to display "*reasonable insight, nil psychotic symptoms, [and be] agreeable to engage with the treating team voluntarily*".[6] After this date, Bryan became increasingly disengaged from the treating team, requiring multiple reminders

[1] *Coronial Brief,* Statement of Tommy Pham.
[2] Ibid.
[3] Orygen Youth Health records, 23 and 60.
[4] *Coronial Brief*, Exhibit 6
[5] Ibid.
[6] MWAMHS Records, document titled *S65KS00AH22110311320*, 67

to attend to receive his monthly depot injection and missing appointments. Bryan received his final dose of prescribed aripiprazole 400mg depot on 24 December 2019.

7. On 6 January 2020, MWAMHS records indicate an incident in which Bryan assaulted his family members in the context of recent methylamphetamine and cannabis use. Bryan was brought to the Footscray Hospital's emergency department[7] by police as he was displaying erratic behaviour, pressured speech, ideation to harm others and thought disorder. It does not appear that Bryan was admitted for psychiatric treatment on this occasion. He was placed on an FVIO barring his entry to the family home, and subsequently stayed with various friends. Despite persistent efforts by MWAMHS to contact Bryan directly and through his father Dung Pham[8], Bryan was unable to be located after this date and was subsequently discharged from the MWAMHS on 17 March 2020.[9]

8. From 2 April 2020 to 6 April 2020, Bryan was remanded at Melbourne Assessment Prison (**MAP**) for unlawful assault and contravention of FVIO. At his reception assessment, Bryan disclosed that he was diagnosed with schizophrenia for which he was unmedicated, endorsed daily amphetamine use and denied suicidality or self-harm ideation.[10] His suicide/self-harm and psychiatric risk were rated 'nil'.[11]

THE CORONIAL INVESTIGATION

9. Bryan'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.

10. 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.

[7] Materials variably state Footscray Hospital and Sunshine Hospital, neither record in the possession of the Court. See Coronial Brief pp. 24 and MWAMHS Records, document titled *pw_MWAMHS_Bryan Pham_DOB 31031996_UR318735*, pp. 151.
[8] MWAMHS Records, document titled *pw_MWAMHS_Bryan Pham_DOB 31031996_UR318735*, pp. 151-7, 160-4.
[9] MWAMHS Records, document titled *pw_MWAMHS_Bryan Pham_DOB 31031996_UR318735*, pp. 161-4.
[10] Department of Justice IMF Section 4, pp. 23, 25.
[11] Department of Justice IMF Section 4, pp. 18.

11. 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.

12. Victoria Police assigned Senior Sergeant Andrew Paulet to be the Coronial Investigator for the investigation of Bryan's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

13. This finding draws on the totality of the coronial investigation into the death of Bryan Pham including evidence contained in the coronial brief. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[12]

14. In considering the issues associated with this finding, I have been mindful of Bryan's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

Relevant incarceration and mental health treatment prior to the fatal incident

15. On 21 May 2020, Bryan attended his family home in contravention of his FVIO, while substance affected. He was apprehended by police and charged with criminal damage and contravention of FVIO. While housed in police cells on 22 May 2020, Bryan was seen by a forensic medical officer, who found Bryan to be under the influence of amphetamines and difficult to engage. A detainee risk assessment and custodial health service assessment were conducted,[13] and Bryan was noted to be a daily user of methamphetamine and placed on observation 'Level 4 – General Observation' with an observation frequency of every 240

[12] 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.

[13] Department of Justice Medical Record, 61-70

minutes, despite being recognised as drug affected.[14] While Bryan appeared low in mood, no issues with perception or thought process were observed. Bryan denied any psychiatric history, medication use or suicidal/ self-harm ideation. Later that day, Bryan was remanded by the Sunshine Magistrates Court.

16. On 25 May 2020, Bryan was transferred from police cells to MAP. Upon presentation, Bryan underwent medical review, where he denied any past medical conditions, medication, or withdrawal from alcohol and other drugs.[15] He was subsequently seen by Forensicare Registered Psychiatric Nurse (**RPN**) Webster Mudavanhu,[16] who noted Bryan's psychiatric history as per the Client Management Interface (**CMI**).[17]

17. Upon assessment, Bryan was evasive, vague, and distractable with blunted and fatuous affect. He again denied current psychiatric issues or psychiatric medication prescription, endorsed daily cannabis and methylamphetamine use and was ambivalent regarding suicidality/ self-harm. A history of previous plan to suicide by firearm was noted. Forensicare RPN Mudavanhu opined that Bryan was likely drug affected and at increased risk due to previous self-harm, drug use, homelessness and poor support system. He was rated P2,[18] S3[19] and of moderate risk of suicide, self-harm and serious deterioration.

18. Bryan was referred for psychiatric registrar review to rule out enduring mental illness and a plan was made for RPN re-review in three days. A request for medical records was sent to Northern Health, in order to obtain collateral information regarding Bryan's psychiatric

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[14] According to the Detainee Risk Assessment medical checklist diagram, Level 3 – Intermittent observation of at least every 30 minutes "is the *minimum* acceptable level for detainees affected by alcohol or drugs". Department of Justice Medical Record, 63.

[15] Department of Justice Medical Record, 12.

[16] Department of Justice Medical Records, 10-11, 38-45

[17] Client Management Interface (CMI) and Operational Data store (ODS) is the Victorian public mental health client information management system and comprises of the CMI as the local client information system used by each public mental health service and the ODS manages select data items from each CMI and is used to allocate a unique (mental health) registration number for each client, known as the statewide unit record (UR) number. ODS shares select client-level data between Victorian public area mental health services (AMHS) to support continuity of treatment and care. The ODS meets the various reporting requirements of the Department and supports the statutory functions of the Chief Psychiatrist and the Mental Health Tribunal.

The CMI search indicated a history of drug and alcohol problem, psychotic disorder, three inpatient admissions most recently 1 December 2019, and date of last contact 4 May 2020 with MidWest Area Mental Health Service. Department of Justice Medical Records 24.

[18] Psychiatric ratings are referred to as P ratings and denote the severity of an existing psychiatric condition and required intensity of care and treatment. P1 – serious psychiatric condition requiring intensive and/or immediate care; P2 – significant psychiatric condition requiring psychiatric treatment; P3 – stable psychiatric condition requiring continued treatment or monitoring; PA – suspected psychiatric condition requiring assessment.

[19] Suicide ratings are referred to as S ratings and denote the level of observation indicated by clinical assessment. S1 – immediate risk of suicide / self-harm; S2 – significant risk of suicide / self-harm; S3 – potential risk of suicide / self-harm; S4 – Previous history of risk of suicide / self-harm (these prisoners are not considered to be "at risk", their risks are historical only). Prisoners with an S1 rating require custodial observations every 15 minutes, an S2 rating every 30 minutes, and an S3 rating every 60 minutes.

history.[20] Bryan was informed of how to access emergency mental health support within the prison if needed.

19. Bryan was transferred to the Metropolitan Remand Centre (**MRC**) on 27 May 2020, where he remained until release to the community on 1 June 2020. Bryan was assessed upon arrival by CCA RPN Rebecca Halliday.[21] Bryan presented as lethargic with slow and slurred speech. He was fatuous and overfamiliar with Ms Halliday, giggling and demonstrating disturbance in thought content, stating "*I love you, can I hug you. You are just like my mother. Why do you hate me?*". Disturbances in perception were also noted but difficult to assess. Bryan was disoriented to time and place and only intermittently aware that he was being assessed. He denied suicide and self-harm ideation. The previously assigned risk ratings of P2, S3 were maintained, and possible drug-induced psychosis was queried. It was noted that Bryan was booked for psychiatric review and was for 'At Risk Review'[22] the following day.

20. On 28 May 2020, Bryan was re-reviewed by Correct Care Australia (**CCA**) RPN Ms Halliday.[23] Bryan presented as sedated and childlike, with slow and slurred speech, however he had been woken for assessment. Disturbances in thought content and perception were noted but unable to be thoroughly assessed due to fatigue. Bryan was observed to have impaired insight and judgement and again denied suicidal or self-harm ideation and reported his mood to be ok. Previously assigned risk ratings of P2, S3 were maintained and a plan for repeat risk review the following day was made.

21. On 29 May 2020, Bryan was again reviewed by CCA RPN Ms Halliday.[24] Bryan stated that he had not used drugs or alcohol for the past three-to-four months, which was noted to conflict with his previous account. Bryan also disclosed that his previous psychological history included diagnosis of drug-induced psychosis, but that the possibility of schizophrenia had also been questioned; and that he had not experienced any psychiatric episodes since ceasing drug use.

22. Bryan denied self-harm or suicidal ideation and reported good mood, and prison officers reported that he was doing well. Some strange thought content regarding being held against his will was noted, in the context of prison COVID-19 isolation protocols. It appears that CCA

[20] Department of Justice Medical Record, pp. 60
[21] Department of Justice Medical Record, pp. 8-9
[22] The At Risk Service cares for incarcerated people at risk of self-harm and/or suicide. CCA Policy *CS3.1 Adult Initial and Transfer Assessment* pp. 7.
[23] Department of Justice Medical Record, pp. 8
[24] Department of Justice Medical Record, pp. 6-7

RPN Ms Halliday accepted Bryan's revised account of his mental health history, concluding that in the context of improved mental state, no psychotic episodes since cessation of substance use, non-medication for one year and absence of psychotic symptoms, Bryan likely had a history of drug-induced psychosis. Bryan's suicide risk level was decreased to S4. It was noted that Bryan had appointments booked with the psychiatric registrar and psychiatric nurse practitioner.

23. On 1 June 2020, Bryan displayed bizarre and inappropriate behaviour while in cells, requesting that female staff enter his cell, exposing himself, saying strange things[25] and stating that he would hurt himself.[26] Consequently, Bryan was reviewed by registered nurse Mr Matthew Parker at 10:25 am.[27]

24. Bryan was reported to be vague and difficult to assess, presenting as agitated, distracted, disinhibited and disorganised. Bryan's thought content was fixated on stress related to his court hearing scheduled for later that day, and he was unable to explain his behaviour. Officers reported that Bryan had stated the floor of his cell was electrified, however he could not state whether he was experiencing perceptual disturbances. Regarding harm to self, Bryan reported vague suicidal ideation, expressing that he had been thinking that it would help the world if he hurt himself. Bryan was unable to provide a safety guarantee but denied plan or intent to harm himself and indicated that he was no longer thinking this way. Mr Parker formulated that Bryan's disorganised, impulsive and agitated state placed him at risk of harm through misadventure.

25. Bryan's risk levels were amended to S3, P2; risk of suicidality, self-harm and serious deterioration were rated 'moderate'; and "*some intent/ ambivalence*" regarding suicide/ self-harm was noted. A plan for housing in a modified cell was made and it was noted that Bryan was booked to be reviewed by a CCA mental health nurse practitioner the following day.

26. Bryan attended tele court as scheduled at 2PM. He was sentenced to pay a fine and be released. At 3:55 pm, Bryan was assessed by CCA RPN nurse Ms Cheryl Johnson as part of medical discharge procedures.[28] Bryan again displayed bizarre behaviour during this assessment, including overfamiliarity with CCA RPN Ms Johnson, appearing to talk to someone and laughing inappropriately. CCA RPN Ms Johnson requested review by mental health staff and

[25] Not further described
[26] Department of Justice Individual Management File Sections 1-3, pp. 3, 25
[27] Department of Justice Medical Record, pp. 5-6, Individual Management File Sections 1-3, pp. 2.
[28] Department of Justice Medical Record, pp. 5

spoke with a CCA physician 'Steven' who agreed to review Bryan.[29] CCA confirmed via statement that Bryan does not appear to have been reviewed by Steven or any other medical officer, but was unable to state why this did not occur.[30] CCA RPN Ms Johnson also made an appointment for Bryan with his regular GP the following day and informed Bryan of this.[31]

27. Bryan was next reviewed by CCA RPN psychiatric nurse Ms Helen Sholakis.[32] He was noted to be smiling and apologetic regarding his earlier behaviour, stating that he had never behaved like this before and explaining that it was due to anxiety. He denied current thoughts of harm[33] and CCA RPN Sholakis confirmed via statement that she did not believe that Bryan expressed an intention to engage in drug and alcohol use on release to the community.[34] Bryan expressed a plan to stay in crisis accommodation or with friends upon release and was advised to seek out community mental health support (GP, psychiatrist). A discharge summary detailing Bryan's contact with the prison mental health team was completed at 4:24 pm.[35] In statement to the Court, CCA RPN Sholakis indicated that she had regard to Bryan's history[36] and her assessment of Bryan on this occasion was likely brief.[37] CCA RPN Sholakis was unable to provide any further detail regarding her assessment with Bryan by way of statement, as she did not recall the review.

28. At 4:42 pm, the prison received a fax from Northern Health/ NorthWestern Mental Health indicating that they had no records of Bryan having had contact with Northern Area Mental Health Service or Northern Community Care Unit. It appears that a request for records was erroneously sent to Northern Health, rather than MWAMHS where Bryan had previously received mental health care.[38]

29. Bryan was released from custody at an unknown time on 1 June 2020. Once released, Bryan attended his parents' home and spoke with his brother, Tommy. Bryan told Tommy he wanted

[29] There are no notes in the medical record to suggest that Dr Steven reviewed Bryan.
[30] Dr Steven was identified by Mark Bulger of CCA as possibly Dr Stephen Ryan, who holds general medical registration with AHPRA with principle place of practice listed as Ravenhall (registration number MED0001159565). Dr Stephen Ryan is not a psychiatrist. Statement of Mark Bulger, Correct Care Australasia, dated 28 October 2024, pp. 2
[31] Sunshine Health Medical Centre records do not contain any account of this appointment or Bryan's failure to attend.
[32] Note timestamped 6:08PM. Department of Justice Medical Record pp. 5, 77-79
[33] It appears from Ms Sholakis' statement dated 4 November 2024 that use of the word harm encompasses suicidality.
[34] It is unclear whether Ms Sholakis engaged in explicit inquiry regarding this. Statement of Ms Sholakis, pp. 3
[35] Corresponding clinical notes completed at 6:04PM, Department of Justice Medical Record pp. 5.
[36] Including but not limited to Bryan's history of drug use, reported abstinence for the last 3-4 months, history of psychotic disorder and psychiatric inpatient admission, and queried diagnosis of schizophrenia.
[37] Statement of Ms Helen Sholakis, dated 4 November 2024, pp. 1
[38] Bryan's '*MAP Reception Interim Risk Management Plan Mental Health Professional (MHP) Prisoner Summary*' (Department of Justice Medical Record, pp. 58) notes that the Mid West Area Mental Health Service should be contacted for collateral information on Bryan. Next to this, the phone and fax numbers are written for Northern Health. There is no evidence in the medical records in possession of the Court that Bryan received heath care at Northern Health. It therefore appears that this fax was sent to the incorrect mental health service.

to go out and celebrate, Tommy knew that this meant he want to go out and get drugs.[39] Bryan left his parents' home around 9.00 pm that evening.[40]

30. It is unclear from the available evidence where Bryan spent his evening but at 1.29 pm on 2 June 2020, Byran was shown on CCTV footage to be at the Flinders Street Railway Station.[41] The CCTV footage available showed Bryan entering the train pit between platforms 1 and 2 collecting a white hat and then exiting the pit and making a praying motion on the platform.[42]

31. Police members intercepted Bryan on platform 5 at approximately 1:37 pm.[43] The police members spoke with Byran and he confirmed that he went into the train pit to collect his hat and was otherwise ok. Police members then performed checks on the LEAP system and noted that he was on bail and that there was an active FVIO in place but there was nothing to action otherwise.[44] Given that their interactions were good with Bryan at the time, they decided to let Bryan move on and take the next train.[45]

32. Byran was observed to take a train heading towards Footscray Railway Station and at 1.52 pm he got off at the Footscray Railway Station.[46] Available CCTV footage shows Bryan rushing away from the train he alighted before stopping and turning to look back at the train and walking back to it. Bryan is then observed on CCTV footage to enter the pit between carriages 3 and 4 of the train.[47] A witness nearby approached Bryan and tried to help him out of the pit but Bryan didn't respond and remained still until the train took off.[48] The train moved approximately 1-2 metres during which time, Bryan was struck and forced into the space between the carriage and the platform. The train stopped through emergency braking and emergency services were called to the scene but were unable to resuscitate Bryan and he was declared deceased on site.[49]

[39] *Coronial Brief*, Statement of Tommy Pham.
[40] Ibid.
[41] CCTV footage obtained from Flinders Street Station.
[42] Ibid.
[43] *Coronial Brief*, Statement of Senior Constable Brad Williams.
[44] Ibid.
[45] Ibid.
[46] CCTV footage obtained from Footscray Train Station
[47] Ibid.
[48] *Coronial Brief*, Statement of Liul Mekonnen
[49] *Coronial Brief*, Statements of David Palmer and paramedic Jayden Estacamento.

Identity of the deceased

33. On 4 June 2020, Bryan Pham, born 31 March 1996, was visually identified by their brother, Tommy Pham.

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

Medical cause of death

35. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 3 June 2020 and provided a written report of his findings dated 4 June 2020.

36. The post-mortem CT scans evidenced multiple right and left posterior rib fractures, left hemopneumothorax hemoperitoneum. There was also evidence of severe pelvic fractures, left lumbar transverse process fractures and perinephric haematoma.

37. Toxicological analysis of post-mortem samples identified the presence of methylamphetamine (~0.3 mg/L), amphetamine (~0.04 mg/L) and aripiprazole[50] (~0.03 mg/L).

38. Dr Beer provided an opinion that the medical cause of death was 1(a) multiple injuries and chest compression asphyxia, and I accept his opinion.

CPU REVIEW

39. In order to review the substantive mental health treatment history, I directed the independent practitioners in the Mental Health and Disability Investigation Team of the Coroners Prevention Unit (**CPU**)[51] to review the mental health care and interventions provided to Bryan in the proximate period leading to his passing.

40. At the time of Bryan's incarceration, mental health services were provided across MAP and MRC as follows:

[50] Aripiprazole is a third-generation antipsychotic drug with partial agonist activity at dopamine D2-receptors and 5-HT1A receptors and antagonist activity at 5-HT2A receptors (eMIMS, 2018)

[51] The Coroners Prevention Unit (**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.

Table 1: Mental health service provision across Melbourne Assessment Prison (MAP) and Metropolitan Remand Centre (MRC)

	MAP			MRC		
Health Service Provider	Primary Healthcare Services	Primary Mental Health	Secondary Mental Health	Primary Healthcare Services	Primary Mental Health	Secondary Mental Health
Correct Care Australasia	✓			✓	✓	
Forensicare		✓	✓			✓

41. Bryan was referred for a psychiatric registrar review on 25 May 2020, while incarcerated at MAP, after it was determined that he required further assessment to rule out an enduring mental illness. On 27 May 2020, Bryan was transferred to MRC.

42. In his statement to the Court, Mr Mark Bulger of Correct Care Australasia (**CCA**) indicated that the referral for psychiatry assessment made on 25 May 2020 represented an internal referral within Forensicare and that CCA did not provide psychiatric consultant or registrar services at MRC.[52]

43. In her statement to the Court, Forensicare psychiatrist Dr Elena Bhattacharya confirmed that when incarcerated persons are transferred to another location, all existing referrals and appointments are systematically cancelled. Upon the transferring prisoner's arrival at the receiving prison, the responsible Health Service (in this case CCA), have responsibility for reviewing all bookings, including future appointments, cancelled due to the transfer process and to re-refer to the appropriate service to re-book appointments where required. Any need for psychiatric registrar review would then need to be re-established upon interprison transfer assessment[53] and any required referrals made at the receiving location.[54] Dr Bhattacharya further confirmed that Bryan was not referred for Forensicare mental health services during his period of incarceration at MRC.

44. Bryan's medical record indicates in several case note entries that he was believed by CCA staff to be scheduled for review by Forensicare mental health practitioners.[55] These entries

[52] Statement of Mr Mark Bulger, Correct Care Australasia, 2
[53] The initial assessment of an incarcerated person upon arrival at the new location.
[54] Statement of Dr Elena Bhattacharya, Consultant Forensic Psychiatrist, Forensicare, 3
[55] Bryan's medical record variably states that he was booked for "psych review" (recorded 27 May 2020), booked with the psychiatric registrar (29 May 2020) and booked with the psychiatric nurse practitioner (29 May 2020 and 1 June 2020). Department of Justice Medical Record pp. 6, 7, 8.

included the date that an appointment with a mental health nurse practitioner was scheduled.[56] CCA should have known as part of their inter-prison transfer assessment responsibility with the DJCS' Justice Health, that when a prison transfer occurs, all existing appointments get automatically cancelled. It is the responsibility of the receiving prison's health service provider, in this case CCA, to review all health bookings cancelled, including future appointments, and re-refer to Forensicare to re-book appointments where required. It appears that CCA nursing staff were either not aware that Bryan's original Forensicare psychiatry registrar appointment had been cancelled upon transfer to MRC, or incorrectly believed that a new referral had been made.

45. The precise reason for CCA staff believing that Bryan had a scheduled appointment for psychiatry review is unclear. This may have theoretically reflected a lack of understanding that Forensicare appointments are cancelled upon transfer, an error in appointment booking, an absence of relevant detail regarding cancellation in the forensic appointment management system, a misinterpretation of appointment information, communication breakdown or some other factor. It is noted that CCA policies[57] provided to the Court regarding the assessment of incarcerated people at reception do not state that existing appointments are cancelled upon transfer. They do, however, state that appropriate referrals should be made following the initial reception assessment[58] and that patients may be referred when presenting with a "*complex set of symptoms or behaviours that may relate to the onset of mental illness*"[59] (as was observed in Bryan's case).

46. Based on Bryan's bizarre presentation during the inter-prison assessment by a CCA RPN on transfer to MRC, diagnostic queries regarding the possibility of an underlying psychotic disorder, it would have been reasonable for Bryan to referred to Forensicare or reviewed by a psychiatry medical practitioner.

47. Forensicare Registered Psychiatric Nurse (**RPN**) Mudavanhu appropriately planned to obtain collateral report from MWAMHS regarding Bryan's psychiatric history on 25 May 2020. It appears that the fax attempting to gain this information was mistakenly directed to Northern Health. This represents a missed opportunity to obtain collateral information from MWAMHS regarding Bryan's extensive psychiatric history that may have led to further investigation into

[56] It was recorded on 29 May 2020 and 1 June 2020 that Bryan had an upcoming appointment with a mental health nurse practitioner scheduled for 2 June 2020. Department of Justice Medical Record pp. 6, 7

[57] Policies titled *CS3.1 Initial and Transfer Assessment*, *CS3.2A General Nurses Assessment of Mental Wellbeing on Transfer Factsheet*, *CS3.1 Adult Initial and Transfer Assessment* and *CS14.2 Mental Health Assessment and Treatment*.

[58] CCA Policy *CS3.1 Adult Initial and Transfer Assessment*, pp. 7.

[59] CCA Policy *CS14.2 Mental Health Assessment and Treatment*, pp. 14.

Bryan's current mental health status and an escalation in his clinical care whilst incarcerated and appropriate referrals for supports in the community upon his release.

48. Forensicare have since the fatal incident confirmed further notes that since 2022, it has strengthened the processes for collateral information requests following Mental Health Reception Assessments. For example, out of 1,095 collateral requests for information since between January and Aug 2025, more than 99% requests for collateral were followed up. Forensicare administration support now follow-up collateral requests made following reception including when that person moves to another location to ensure it is reviewed and uploaded to JCare.[60]

Review at the time of release

49. Bryan was released from MRC on 1 June 2020. Earlier this day, Bryan had presented with disturbances in behaviour, thought content and process consistent with behaviour previously displayed while incarcerated and indicative of a possible underlying psychotic process. Bryan also endorsed suicidal ideation and was identified to be at risk of harm through misadventure. Following his court hearing, Bryan continued to display unusual behaviour consistent with psychosis, leading to a request for review by health practitioner called 'Steven'.[61]

50. Bryan was not further reviewed by 'Steven', although I cannot now determine why. He was, however, reviewed by CCA RPN Sholakis immediately prior to discharge. CCA RPN Sholakis stated that this review was likely brief. The depth of this review does not appear proportionate to the 'red flags' of Bryan's recent bizarre behaviour and statements of suicidality.

51. CCA RPN Sholakis' note regarding risk of suicide is superficial and non-specific, referring broadly to Bryan denying current thoughts of harm but not specifying what kind of harm this refers to (i.e. deliberate self-harm, suicide, harm to others) or any formulation regarding the complexities of suicide risk (e.g. identifying any dynamic factors that may increase risk in Bryan's case such as substance use, psychotic process or acute stressors).

52. The available evidence confirms that CCA RPN Sholakis made some enquiry into the reason behind Bryan's behaviour that morning. On face value, this conversation appears to have

[60] Landers & Rogers correspondence sent to the Court on behalf of Forensicare dated 18 September 2025.
[61] It is theoretically conceivable that the decision to review Bryan was impacted by an increased demand on healthcare professionals during COVID-19. However, the reason that Bryan was not reviewed is unclear. Department of Justice Medical Record, 5

concentrated upon Bryan exposing himself to a prison officer, with Bryan apologising, acknowledging the disrespectful nature of his behaviour, stating that he had never done this before and explaining that this was due to anxiety. These notes do not offer a plausible explanation for Bryan's other strange behaviour that day (i.e. stating that the floor of his cell was electrified, appearing to talk to someone), and it is unclear if this was explored. Only scant notes regarding Bryan's mental status were made, and no notes regarding key targets for the assessment of psychosis (i.e. alterations in speech, thought form, thought content and perception).

53. Bryan was advised to attend his GP for an arranged appointment and seek psychiatry review upon discharge. This advice was of limited utility to an individual in circumstances such as Bryan, who does not have a fixed address, has a known history of substance use and psychosis and has recently displayed bizarre behaviour. The likelihood that he would engage in these services without support (e.g. case management, assistance from loved ones) is low.

54. Given Bryan's recent presentation and concerns raised by multiple other prison and healthcare staff on the day of his release, it would have been expected for CCA RPN Sholakis to have carried out a thorough assessment of Bryan's mental status targeting the possibility of psychosis and risks of suicide and harm due to misadventure and arrange supports commensurate to Bryan's assessed needs. This review fell short of reasonable expectations.

55. The lack of review by any CCA health practitioner called 'Steven' and lack of thorough and targeted review by CCA RPN Sholakis both represent missed opportunities to further assess and treat Bryan. These reviews may have led to the identification of psychosis or suicide risk and led to the initiation of treatment potentially impacting the fatal outcome. However, it is not possible to state with certainty how these reviews would have unfolded if conducted, and as such, these issues do not represent a concrete opportunity for the prevention of Bryan's passing.

FINDINGS AND CONCLUSION

56. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[62] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

57. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Bryan Pham, born 31 March 1996;

    b) the death occurred on 2 June 2020 at 19 Larisa Road, St Albans, Victoria, 3021, from 1(a) multiple injuries and chest compression asphyxia; and

    c) the death occurred in the circumstances described above.

58. Having considered all of the circumstances, I am satisfied that Bryan intentionally took his own life.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

59. Continuity of mental health care for those exiting prison is a significant bridge for individuals with serious mental health needs to receive appropriate referrals for supports in the community. Researchers have noted that, "*the prison-to-community transition period is one of high risk and need, particularly for those with mental illness. Some individuals cycle in and out of prison for short periods with little opportunity for mental health stabilization or service planning either in prison or the community*."[63]

[62] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

[63] Browne CC, Korobanova D, Chemjong P, Harris AWF, Glozier N, Basson J, Spencer SJ, Dean K, 'Continuity of mental health care during the transition from prison to the community following brief periods of imprisonment' (2022) 20;13:934837 *Front Psychiatry*.

60. In this case, I find that there were missed opportunities for Bryan to be reviewed by mental health care professionals during his incarceration, particularly during his discharge. I find that the review conducted by CCA RPN Sholakis at discharge fell short of reasonable expectations of clinical quality of care and represents one such missed opportunity to further assess, diagnose and treat Bryan.

61. Despite the critical importance of continuity of care for those with serious mental illness, discharge planning for those transitioning from prison to the community is often inadequate. I note that the Office of the Chief Psychiatrist (**OCP**) now has an expanded role under the *Mental Health and Wellbeing Act 2022,* and this is an opportunity for quality improvement within prison mental health services. Part of the enhancements include responsibilities of oversight in custodial settings where forensic mental health and wellbeing services are provided.[64]

62. Although this was not the case when Bryan passed, I note that the OCP is now formally responsible for promoting the highest standard of clinical practices and care in these settings, with powers to investigate incidents, review reportable deaths, and assess the use of restrictive interventions.[65] By supporting services to identify and address systemic issues and embed standards, guidelines and practice directions for the provision of mental health and wellbeing services, the OCP's expanded remit offers a meaningful opportunity to improve the standard and consistency of mental health care available to people in custody and hopefully prevent future like deaths from occurring.

I convey my sincere condolences to Bryan's family for their loss.

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

[64] Reform activities and news involving the Office of the Chief Psychiatrist, available online at: https://www.health.vic.gov.au/chief-psychiatrist/reform-activities-and-news-involving-the-office-of-the-chief-psychiatrist

[65] Ibid.

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

Dung Thi Bach Le & Dung Anh Pham, Senior Next of Kin

Kellie Dell'Oro, Meridian Lawyers

Sven Edquist, Head of Legal, Forensicare

Correct Care Australasia

Forensicare

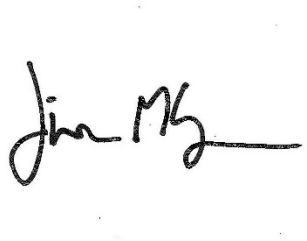
Fiona Karmouche, Lander & Rogers

Associate Professor Sophie Adams, Office of the Chief Psychiatrist

Marius Smith, CEO, Victorian Association for the Care and Resettlement of Offenders.

Senior Sergeant Andrew Paulet, Coronial Investigator

Signature:



Date: 24 September 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.