IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 1790

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: LING GONG TANG

Delivered On:	9 December 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank, Melbourne 3006
Hearing Dates:	11, 12, 14, 15, 18, 19, 20, 21 and 22 November 2013
Findings of:	IAIN WEST, DEPUTY STATE CORONER
Representation:	Mr Dyson Hore-Lacy SC with Dr Kylie Weston-Scheuber instructed by Adviceline Lawyers on behalf of relatives of the deceased Dr Ian Freckelton SC with Mr Paul Lawrie instructed by Victorian Government Solicitors for the Chief Commissioner of Police, John Ballas, Bret Heisy and David Odwazny Mr Gregory Lyon QC instructed by Lander & Rogers for Sharnie Huth, Allie Goff and John Thomson. Mr Scott Johns instructed by Tony Hargreaves Partners for

	Fiona Jones
	Mr Michael Cahill instructed by Tony Hargreaves Partners for Kate Jackson
	Mr Anthony Trood instructed by Tony Hargreaves Partners for Meghan Whitehead
	Ms J Condon instructed by Tony Hargreaves Partners for Kay Price and Kate Griffiths
Counsel Assisting the Coroner	Ms Rachel Ellyard instructed by the Coroners Court In-House Solicitors Service

I, Iain West, Deputy State Coroner having investigated the death of LING GONG TANG

AND having held an inquest in relation to this death on 11, 12, 14, 15, 18, 19, 20, 21 and 22 November 2013

at Melbourne

find that the identity of the deceased was LING GONG TANG

born on 2 May 1957

and the death occurred on 13 May 2010

at the Dandenong Hospital, 135 David Street, Dandenong 3175

from:

1 (a) DECOMPENSATED ALCOHOLIC LIVER DISEASE IN THE SETTING OF GASTRO-INTESTINAL HAEMORRHAGE

in the following circumstances:

1. Mr Ling Gong Tang, born 2 May 1957, was 53 years of age at the time of his death. He was born in China and migrated to Australia in the early 1990's. He was married to Ms Hai Troung but they were separated at the time of his death. Mr Tang was also the father of one daughter, Ellen.

2. Mr Tang suffered from a form of chronic liver disease referred to as Child-Pugh C, which is the most advanced category of liver disease.

3. Mr Tang was lodged in the Dandenong Police cells at about 3.20 pm on 12 May 2010, having been arrested for drunk in a public place, following being discovered at his wife's home in breach of an intervention order. He was released from custody at 7.54 pm and subsequently taken to the Dandenong Hospital where he died on 13 May 2010 shortly after 11.00 am.

Medical Examination

4. A post-mortem examination was conducted on 17 May 2010 by Dr Paul Bedford, Forensic Pathologist of the Victorian Institute of Forensic Medicine, who determined the cause of death to be

    1 (a) '*Decompensated Alcohol Liver Disease in the setting of Gastrointestinal Haemorrhage*'.

Purposes of the Coronial Investigation

5. The primary purpose of the coronial investigation of a reportable death[1] is to ascertain, if possible, the identity of the deceased person, the cause of death (interpreted as the medical cause of death) and the circumstances in which the death occurred.[2] An investigation is conducted pursuant to the *Coroners Act 2008* (the Act). The practice is to refer to the medical cause of death incorporating, where appropriate, the mode or mechanism of death, and to limit investigation to circumstances sufficiently proximate and causally relevant to the death.

6. Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory authority or entity on any matter *connected with the death*, including recommendations relating to public health and safety or the administration of justice.[3] This is generally referred to as the prevention role of the coroner.

THE EVIDENCE

7. This finding is based on the entirety of the investigation material comprising of the coronial brief of evidence[4] compiled by Detective Senior Sergeant Wayne Cheesman including material obtained after the provision of the brief, the statements and testimony of those witnesses who gave evidence at the inquest and any documents tendered through them, other documents tendered through Counsel (including Counsel assisting), written submissions of Counsel and their replies following the conclusion of the inquest. All this material, together with the inquest transcript, will remain on the coronial file and comprises my investigation into Mr Tang's death. I do not purport to summarise all the material/evidence in this finding, but will refer to it only in such detail as is warranted by its forensic significance and where otherwise appropriate.

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[1] Section 4 of the Act requires certain deaths to be reported to the coroner for investigation.
[2] Section 67 of the Act.
[3] Sections 72(1), 72(2) and 67(3) of the Act regarding reports, recommendations and comments respectively.

[4] Which included photos, CCTV footage and audio material. A concern was raised regarding whether any CCTV footage was missing from the evidence. I was satisfied on the basis of a statement of Senior Sergeant Philip Hulley that the cameras at the time were set to motion detection and all available footage was obtained for the purpose of my investigation.

8. In particular I note that I received, and was assisted by, the written submissions from Counsel Assisting and Counsel for the family of the deceased, the Chief Commissioner of Police (CCP), Leading Senior Constable[5] Fiona Jones, Ms Kate Jackson, LSC Meghan Whitehead, Senior Sergeant[6] Sharnie Huth, SC Allie Goff, Constable John Thomson, LSC Kaye Price and Senior Constable[7] Kate Griffiths. I note that reply submissions were also received from Counsel for LSC Jones, Mr Jackson, LSC Whitehead, LSC Price and SC Griffiths.

9. The following witnesses gave evidence at the inquest:

- Sergeant John Ballas
- Senior Constable Bret Heisey
- Senior Constable David Odwazny
- Senior Sergeant Leigh Thorn
- SS Sharnie Huth
- Ms Yu Shu Lipski
- Mr Gary Braude
- SC Allie Goff
- Dr Yvonne Kearley (concurrent)
- Dr Paul Bedford (concurrent)
- Dr Sally Bell (concurrent)
- Professor Mar Fitzgerald (concurrent)
- Dr Byron Collins (concurrent)
- Deputy Commissioner Timothy Cartwright
- Detective Wayne Cheesman (Coroner's Investigator)

Section 57 Applications – exclusion of witnesses

[5] LSC

[6] SS

[7] SC

10. LSC Jones, Ms Jackson, LSC Whitehead, LSC Price and SC Griffiths sought to be excused from giving evidence at the inquest under section 57 of the Act on the basis of self incrimination. I was advised that all members except Ms Jackson faced disciplinary offences under the *Police Regulation Act* 1958 in relation to their actions. They further indicated that they were not willing to give evidence with the benefit of a certificate under section 57(5). After considering submissions (both oral and written), I determined that the interests of justice did not require me to compel each to give evidence, even though I noted that it would be desirable (and of assistance) to hear from them.

11. No inference is to be drawn against these individuals because they have exercised their privilege against self-incrimination.

12. However, I accept Counsel Assisting's submission that in the absence of their oral evidence and cross examination I may still have regard to their written statements but those statements may be regarded as carrying less weight than statements adopted on oath. Further, where they are in conflict with sworn evidence from other witnesses, or with other evidence such as CCTV footage, I may choose to prefer that other evidence.

13. In addition, where an adverse finding is open on other evidence, including the sworn evidence of other witnesses who have attended the inquest, the absence of sworn oral evidence from them will not prevent me from making an adverse finding.

Standard of proof

14. Coronial findings must be made on the basis of proof of relevant facts on the balance of probabilities.[8]

Comments permitted under section 67(3) of the Act

15. It was submitted by one of the police officers that if there was an absence *of a causal connection between the circumstances of custody and the death of the deceased it would constitute an excess of power for the Coroner to comment upon any alleged failure to follow guidelines, procedures, or afford decency and dignity to the deceased,* by the police officers involved in Mr Tang's care.[9]

[8] In determining whether a matter is proven to that standard, the coroner should give effect to the principles enunciated in *Briginshaw* v *Briginshaw* [(1938) 60 CLR 336].

[9] Submission on behalf of Fiona Jones. A number of authorities are relied upon including *Harmsworth v The State Coroner* (1989) VR 989

16. I do not accept that submission. Section 67(3) of the Act permits a coroner to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice. There is nothing in the legislation to suggest that comments must only be concerned with matters causative of the death.[10]

SECTION 67 FINDINGS

17. Prior to the commencement of the inquest, it was apparent that most of the facts about Mr Tang's death are known and were not in dispute. These include the deceased's identity, the medical cause of his death (although causative issues were in dispute) and aspects of the circumstances of his death, including its place and time.

18. A number of other matters remained to be determined at inquest.

Was Mr Tang's death a death in custody?

19. Whether Mr Tang's death was a death in custody as defined by Section 3 of the Act was a matter I set about to determine as part of the inquest, although I note that there was no controversy regarding whether an inquest should be conducted.[11]

20. Section 3 (k) of the Act defines a person in custody to include: *a person in Victoria who is dying from an injury incurred while in the custody of the State.* It remained to be determined whether an '*injury*' could include lack of first aid and delayed care, if I found that this was supported by the facts, and whether these omissions had any connection to Mr Tang's death (and if so, the extent of that connection).

21. In order to assist with the threshold issue raised by this question, I heard concurrent evidence of suitably qualified experts to consider a range of directed questions (See **Death in Custody? – Concurrent Evidence).**

Other issues explored at inquest

22. Other issues I explored at inquest included an examination of the appropriateness of:

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[10] Justice Beach in *Thales v The Coroners Court* [2011] VSC 133.

Whilst the words "connected with" are capable of describing a spectrum of relationships ranging from direct and immediate to tenuous and remote, I agree with the interpretation given to these words by Muir J in Doomadgee v Clements. In that case, Muir J had to consider s 46 of the Coroners Act 2003 (Qld), which permitted a Coroner to comment on anything "connected with a death". His Honour noted that there was no warrant for reading "connected with" as meaning only "directly connected with". His Honour went on:

> *"Something connected with a death may be as diverse as the breakdown of a video surveillance system, the reporting of the death, a police investigation into the circumstances surrounding the death, and practices at the police station or watchhouse concerned."*

[11] A mandatory inquest is required pursuant to section 52(2)(b) of the Act if a death occurs *in care or custody.*

- Mr Tang's arrest for drunk in a public place and his lodgement in the cells at the Dandenong Police Station;
- Mr Tang's care and management during his detention at the Dandenong Police Station;
- The interview with Mr Tang for the charge of breach of intervention order through the flap in the cell door;
- Mr Tang's release from custody; and
- The post release of Mr Tang.

What are the relevant obligations of custodial authorities in Victoria?

23. Subsequent to the death of Mr Tang, the Victorian Ombudsman prepared a report: *Investigation into deaths and harm in custody* (March 2014), which made the following overarching statements:

- *The State owes a duty of care to every person detained in custody to ensure their safety and wellbeing. For example, in the Victorian prison system the Secretary of the Department of Justice has a statutory duty to ensure the safe custody and welfare of prisoners and offenders in the Secretary's custody.*
- *There are a number of rights that are engaged under the Victorian Charter of Human Rights and Responsibilities Act 2006 when a person is detained in custody, including a person's right to humane treatment and the right not to be arbitrarily deprived of life.*
- *The Victorian community should have confidence in what happens behind the closed doors of custodial facilities – that detainees are managed in a fair and consistent manner; that they are treated with dignity and respect for their human rights; and that those responsible for caring for detainees are held accountable for their actions.*
- *Many people in custody are vulnerable, often with complex social, legal and medical histories. Each year a number of people die in custody, while many more experience some form of harm, injury or illness.*

24. Applicable policy, procedure and legislation at the time of Mr Tang's death included:

- *The Victoria Police Manual – Policy Rules, Persons in police care or custody* (dated 22/2/10) – referred to as '**VPM Rules**';
- *The Victoria Police Manual – Procedures and Guidelines, Taking persons into police custody* (dated 22/2/10)) – referred to as '**VPM Guidelines**';

- *Dandenong Police Station, Watch House Standing Operating Procedures*, 15 February 2010 – referred to as **SOPS**; and
- *The Charter of Human Rights and Responsibilities Act 2006*. There are a number of relevant sections including 22(1) which provides that: *All persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person.*

25. The **VPM Rules** say:

Police have a legal duty to provide for the safety, security and welfare of all persons in their care or held in their custody, including persons at police premises or in police cells who are in the care or custody of police. ...This duty, in particular, involves:...

- *Ensuring the safety and wellbeing of persons in police cells, including the provision of prompt and appropriate medical care and addressing their specific needs.*

  .....In addition, under the provisions of the Human Rights Charter, persons in custody are required to be dealt with humanely and treated in a way that is appropriate to a person who has not been convicted.

26. **VPM Rules** are mandatory and provide the minimum standards that employees must apply. It makes it clear that non-compliance with or a departure from a **VPM Rules** may be subject to management or disciplinary action. The **VPM Rules** apply to operational supervisors and watch house keepers (amongst others).

27. **VPM Rules** provide that a risk assessment must be conducted for each person in custody to *ensure that an assessment has been made against the Medical Checklist and that appropriate action has been taken as detailed in* the **VPM Guidelines**. The police assessment is dependent on a detainee's best verbal response to questions. The **VPM Rules** provide that the watch house keeper must ensure that the assessment is conducted on a *continuous* basis. Intoxicated or drug affected person must be checked every half hour. Where a person in a cell appears ill or injured medical assistance must be obtained.

28. The **VPM Guidelines** contain a Medical Checklist which has a sliding scale, referred to as the Coma Scale, to determine what medical action is required for a detainee. The Medical Checklist must be applied for all persons in the care or control of police '*at all times*'. The Coma Scale has 1 to 5 levels, with 5 requiring no medical action and 1 requiring urgent

medical action. It further notes that: *If the person is INTOXICATED, the best verbal response should be assessed at least HALF HOURLY.'*

29. The **SOPS** provide further detail regarding the obligations of police members, in particular,

- *All persons brought into the Watch-House arrested for drunk or drunk and disorderly must be given special attention.*
- *The drunken person is...monitored each half hour and noted on the TTBL Custody System/General Observations. If the person is asleep they are to be woken and a verbal response obtained.*
- [Intoxicated] *persons released from custody must be assisted with transport arrangements to depart the police station precincts.*

30. The obligation of police members with respect to intoxicated detainees is readily discernable from this documentation, although it was clearly not ideal to have these obligations in various places.[12]

31. Based on these documents the following was required in relation to Mr Tang at the very minimum:

- For lodgement into police custody/cells, an assessment of Mr Tang against the applicable Medical Checklist on the basis of the best verbal response;
- Checks of Mr Tang to be conducted every half hour against the applicable Medical Checklist on the basis of the best verbal response (and those checks to be recorded); and
- Upon release Mr Tang was to be assisted with transport arrangements from the police station.

32. In relation to interviewing a detainee, the following was applicable at the time of Mr Tang's detention:

- *The Victoria Police Manual – Procedures and Guidelines, Interviews and Statements* (dated 22/2/10);
- *The Victoria Police Manual – Policy Rules, Interviews and Statements* (dated 22/2/10); and

[12] I note that the Victoria Police *Operational Incident Review* recommended that consideration be given to consolidating all VPM instructions into the one set of instructions to provide clear and comprehensive guidance (and that this recommendation has been implemented).

- *The Victoria Police Manual – Procedures and Guidelines, Interviewing specific categories of person.*

33. Relevant to Mr Tang the VPMs provide as follows:

    - Any person interviewed or providing a statement should be given appropriate support to ensure that there is fairness in the process and their human rights are respected.

34. Whilst there were broad statements regarding the humane treatment of detainees, there appeared to be very little specific guidance as to what might be required with respect to attending to a detainee's hygiene (specifically where there was significant soiling).

35. It appears that there is a common practice where people are arrested for drunk in a public place and lodged in the cells that they are detained for approximately 4 hours after which they are assessed for appropriateness to be released. A detainee could be released earlier or later, it depends on the circumstances. Alternatively, a person could be taken home (rather than arrested) and released into the custody of a friend or relative. It is clear that a certain amount of discretion exists.

36. I have considered all of the obligations and requirements set out in the above documents and applied those to the facts and evidence arising in this matter.

CIRCUMSTANCES OF MR TANG'S DEATH

Mr Tang's arrest for drunk in a public place and lodgement in the cells at the Dandenong Police Station

37. At 2.08pm, Wednesday 12 May 2010, Mr Tang's wife, Ms Hai Troung, with the help of her sister, Ms Mimi Troung called emergency services for police to attend at her residence. It appeared that Mr Tang had been staying in his wife's home at 19 Dealing Drive, Oakleigh, while she had been on an overseas holiday. She had an intervention order against Mr Tang at the time (since November 2009) and did not want him in the house. She was also unwell.

38. Ms Hai Troung said of her husband's appearance at the time (through an interpreter): *'He was....looking a bit yellow, but he was conscious, he knew where he was going. He ran away....he knew what was going on. He knew where to get his wallet, the money, and all that. The key, he knew how to – when to – to lock the door. He knew...to collect all the bottles, put them in the bag....I think nothing was wrong. He was a bit yellow, that's all.'*

39. At 2.10pm, police were despatched to attend the incident. They were: Mordialloc 302 comprising SC Griffiths and LSC Price. Their attendance was monitored by local supervisor, Acting Sergeant[13] John Ballas, who was also present and requested another unit to assist. The unit deployed was Clayton 302 comprising SC Bret Heisey and Cons David Odwazny.

40. When Mr Tang became aware that the police had been called, he left the house and was located by SC Heisy and Cons Odwazny in Dealing Drive. They arrived at approximately 2.23pm after which Mr Tang was arrested for being drunk in a public place and subsequently lodged into the police cells at the Dandenong Police Station *(the Moorabbin cells not being available)* at approximately 3.20pm. The decision to arrest and take Mr Tang to the Dandenong Police Station was made by Sgt Ballas.

41. SC Heisy noticed that Mr Tang spoke partly in English and partly in another language. As noted by counsel for the CCP:

> *He was described by police as loud, animated and boisterous, theatrical but not distressed. He fumbled in his pants for his wallet and was evidently highly intoxicated and smelt strongly of alcohol and seemed to be in a state of very poor hygiene. Senior Constable Odwazny noticed dark staining on his clothes around his groin area. Mr Tang was able to stand unaided and, while he needed assistance, handed over a medicare card with his name on it. Senior Constable Heisy was clear that the police were able to communicate with Mr Tang, even though he did not speak English to the police.*
>
> *As Senior Constable Odwazny informed the court, a proper assessment of Mr Tang was undertaken when he was first taken into custody at Dealing Drive by reference to the Medical Checklist – his general demeanour was taken into account, as was his ability to understand and comply with directions. He seemed to be oriented in terms of where he was. He had no obvious injuries (no blood was visible on him but he was noticed to have decayed teeth) and the LEAP database did not contain any warnings applicable to him. Whilst he was in the company of Senior Constables Heisy and Odwazny he gave no indication of deteriorating health. These observations led to Mr Tang being categorised at 'level 4'; Mr Tang was very drunk and for that reason extra attention needed to be paid to him.'*

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[13] AS

Mr Tang arrived at the Dandenong Police Station at approximately 15.15hrs. Senior Constables Heisy and Odwazny removed him from the divisional van. Mr Tang was awake but not well coordinated. However he was able to walk 'under his own power', 'pretty well unaided'. He stopped at a bin and spat what looked like phlegm (not blood) inside it. They guided him 'to prevent him from falling over'....

Mr Tang showed no signs of distress, he did not communicate that he was unwell and he did not complain. ...He followed all directions given by police in relation to movement. He was very drunk but not paralytically so. He understood communications made to him, he was able to undertake basic manoeuvres and there were no particular warning signs about his condition save that he was significantly intoxicated to a point where he had lost control of his bladder and bowels. The situation was undignified but unremarkable. There was nothing at that stage that suggested Mr Tang required medical assistance.'

42. I note that Mr Tang was not handcuffed whilst being transported in the divisional van. The camera in the divisional van was on which enabled Mr Tang to be observed throughout the journey. The arresting officers were able to observe Mr Tang for a period of around 1 hour and 1 accept that they were in an ideal position to make assessments with respect to Mr Tang's presentation (from approximately 2.23 pm to 3.20 pm). A LEAP check was undertaken and there was no flag with respect to Mr Tang noted.

43. Meanwhile, SC Griffiths and LSC Price interviewed Mr Tang's ex wife and sister in law in relation to the incident, and intended to interview Mr Tang, once he was ready for release, regarding breach of an intervention order. Each indicate that they told the officers that Mr Tang was unwell, the officers deny being advised of this information.

44. The police officers on duty at the Dandenong Police Station (relevant to Mr Tang's lodgement) were: SC Jones, who was the watch house keeper; Ms Jackson (a constable at the time), who was the assistant watch-house keeper and AS Whitehead (her rank at the time), who was the supervisor for the shift. AS Whitehead was responsible for supervising all persons in custody and the reception office/front counter. SC Jones was responsible for the physical well being of prisoners in her charge.

45. All these officers were present when Mr Tang arrived at the Dandenong Police Station. Ultimately however, AS Whitehead was responsible for Mr Tang's lodgement in the cells according to the relevant SOP. At 15:20, Mr Tang's injuries were noted on the Thin Blue

Line Register (TTBL) Attendance Module as '*Cut to inside of mouth*' as well as no mental impairment. These notes were entered by AS Whitehead.

46. The CCTV images show AS Whitehead physically present upon Mr Tang's arrival at the Sally Port where it appears she is making her own observations regarding his presentation, including his interactions with others. In addition there is evidence that she made her own inquiries of the arresting officers.

47. As already noted, the arresting officers had observed Mr Tang for a considerable period of time; had a good opportunity to observe his demeanour and condition throughout that period; make the appropriate assessments and provide important information to the officers who would take over his care. They gave him a Coma scale recording of 4 (because he was very intoxicated) which requires: *Consider obtaining medical opinion. Monitor regularly for signs of deterioration.*

48. The arresting officers did however expect appropriate assessments to be made of Mr Tang once he was in the care of those at the Dandenong Police Station and that his welfare would be continuously monitored in the event of deterioration.

49. It is clear that AS Whitehead was required to make an independent assessment of Mr Tang upon his arrival at the Dandenong Police Station and that this would ordinarily take place at the charge counter. After considering all the evidence however, I accept that had this occurred (at lodgement or shortly thereafter) any assessment made by AS Whitehead would have been the same as that of the arresting officers.

50. There are however two aspects regarding Mr Tang's lodgement that are troubling and worthy of comment. Firstly, the question arises at to why he was lodged (and remained) in such a soiled state and whether this was appropriate both for his dignity and welfare. Clearly, his odour was offensive as evidence by the pinching of their noses by various officers present (See **Mr Tang and his soiled condition**).

51. Secondly, where a detainee does not speak English, I have formed the view that there is still some clarity required regarding how the Medical Checklist is applied in those circumstances (See **Comments**).

Mr Tang's Care and Management during his detention at the Dandenong Police Station

52. The TTBL records that after Mr Tang's initial assessment, checks via a CCTV monitor occurred at 4.23 pm, 6.14pm and 6.39pm. SC Jones as the watch house keeper and Ms

Jackson as the assistant watch house keeper were responsible for monitoring Mr Tang whilst he was in custody.

53. The observations of Mr Tang whilst he was in custody were recorded as follows:

- 15:31 - *Type/Created by: Supervisor/Constable Jackson* – Comment: *Searched and lodged for drunk. Checked by A/Sgt Whitehead. Nil injuries. Nil complaints. ACC.*
- 16:23 - *Type/Created by*: General Observation/Constable Jackson – Comment: *Observed moving around cell. ACC.*
- 18:14 - *Type/Created by*: General Observation/Constable Jones – a/c.
- 18:39 - *Type/Created by*: General Observation/Constable Jones – a/c.

54. No physical checks were conducted by the either the watch house keeper or the assistant watch house keeper.

55. Both SC Jones and Ms Jackson disputed what constituted half hourly checks or monitoring under the applicable police processes and procedures. It was submitted that the monitoring carried out in relation to Mr Tang was consistent with the SOPS and the member's training.[14] Effectively it was put that the observation by CCTV camera met the necessary requirements.

56. Regardless of the method of monitoring or checking undertaken, it is apparent that they weren't recorded every half hour, as required.

57. As noted in paragraphs 26 and 27, the monitoring or checking requirements for a person detained for drunk are that they should be monitored or checked based on the best verbal response, which is not possible to conduct from a CCTV monitor.

58. In addition, it is clear that the requirements must be read as a whole, with the detainee's welfare as paramount and particular attention paid to intoxicated persons. The submissions suggest an overly narrow (and self serving) reading of the requirements.

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[14] *It was submitted that L/S/C Jones performed her duties on 12 May in accordance with Standard Operating Procedures and the Victoria Police Manual, as applied in practice consistent with her on-the-job training.' The evidence in this case reveals that Jones was un-trained and unsupported in the very specific role of watch-house keeper in a very busy police gaol.'*

59. I also note that the submissions are inconsistent with the evidence given by S/C Jones to Detective Cheesman. [15] SC Jones said in response to the question:

> *Is it normal practice to physically check prisoners lodged for drunk or is monitoring done via the CCTV monitors?*
>
> *We do physical checks. Kate was doing those as far as I was aware.*[16]

60. Other police officers who were working at the Dandenong Police Station on that day included SS Huth and SC Goff who both gave evidence that intoxicated detainees were checked by a verbal response (that is, attending the cell). In addition, there was no support for the restricted interpretation from the CCP.

61. An inspection of Mr Tang's cell (also evidenced in photographs) show blood spatter, droplets and smears in the cell including, on the floor, bed, wall adjacent to the bed and the toilet. Ms Jackson said: '*I never looked at the cell and could not see any blood on the CCTV cameras.*'

62. Clearly, evidence as to why physical checks of detainees are necessary.

63. I also note that at the time, *a custody nurse was available at all stations with 'Category A' cells during office hours but, importantly, there was access to police medical officers who were contactable 24 hours per day via the Police Communication Centre. If there was doubt at any stage about Mr Tang's condition, resort could have been had to this service or, quite obviously, to the services of Ambulance Victoria.*

64. I find that Mr Tang was not properly checked or monitored whilst he was in custody at the Dandenong Police Station.

Mr Tang's interview for the Charge of Breach of Intervention Order through the flap in the cell door

65. Mr Tang was interviewed by SC Griffiths and LSC Price at 7.26 pm with the assistance of an interpreter, Ms Yu Shu Lipski. This took place through the flap in the cell door.

66. LSC Price said: *'We had to keep in mind that TANG was soiled from defecation and not to contaminate any further areas of the police station so we decided to do the interview*

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[15] Whilst the Office of Police Integrity (OPI) identified problems with respect to the methodology of this statement (see **Comments** below), the content of Detective Cheesman's statements was not challenged.

[16] Page 229 of the Coronial Brief

through the cell door.' In addition, she said '*so that the interpreter, Senior Constable Griffiths and myself did not have to suffer his odour.*'

67. During the interview, LSC Price recalls Mr Tang saying (amongst other matters) that he was *'in a lot of pain'*, he would '*die here'* and when asked: *'What is wrong with you?'* Mr Tang replied *'I need to go to hospital today.'*

68. During the interview SC Griffiths recalls:

- *TANG lying on the floor…..making loud moaning noises* and *observed blood splatter on the cell wall and could see he had blood on his mouth. The blood appeared fresh.*
- *He started pulling at his teeth, and it appeared he was trying to pull them out. I believed this was why there was blood in his mouth.*
- *I thought he was just being difficult and trying to avoid questioning.*
- *He did say he wanted to go to the hospital and that he had abdominal pain.*
- *He was not responding to the questions being asked and continued to moan in Mandarin.*
- *I advised the interpreter to tell TANG he would be leaving the police station after we asked him the questions and if he wanted to see a doctor he could do so when he was released. The interpreter stated he advised her he wanted to go to hospital.*
- *I then formed the opinion TANG was likely to be in pain, but also motivated by wanting to be released from custody. He continued to yell and moan in Mandarin.*
- *I can't remember if I discussed taking TANG to the hospital at this stage or not. ....The Dandenong Hospital is a short distance from the Police Station, although I'm not exactly sure how far, and I remember thinking he may be able to walk there after his release.*
- *It is not uncommon for people in custody to exaggerate a medical condition for the purpose of early release or what they perceive will be sympathetic treatment by police.*

69. The interpreter, Ms Lipski said with respect to the interview:

- As she approached the holding cell, she heard Mr Tang say '*I need to go to hospital*' [in English]
- *I could see lots of blood in the corner of the cell near the bed*

- *I could see (TANG) lying on the floor rolling from side to side whilst he was on his back*
- *He was clearly distressed*
- *In between questions by Kay, Mr Tang was saying: I want to go home, I want to have a shower, I want to go to hospital, I can't do this anymore, I am going to die*
- *On no occasion was there a verbal reply given to (Tang) by any of the police.*

70. As Mr Tang hadn't been adequately monitored or checked whilst in the cells, SC Jones was unable to give an accurate assessment of Mr Tang's presentation as to fitness for interview (or otherwise) to the interviewing members. It appears that AS Whitehead was not involved in this assessment as there was a requirement for an officer independent of the investigating officer to undertake the subsequent disposal check.

71. SC Griffiths and LSC Price said they relied on the police at Dandenong as they had been with Mr Tang for more than 4 hours. Nevertheless, the information provided directly from Mr Tang including observations of him, his soiled condition, the condition of the cell and his own words and communications through Ms Lipski should have made it clear to both SC Griffiths and LSC Price that he was neither fit for an interview and required medical assistance.

72. I note the requirement that any person interviewed should be given appropriate support to *'ensure that there is fairness in the process and their human rights are respected.'*

73. I find that Mr Tang was not fit to be interviewed by police and that the manner in which the interview was conducted was not appropriate in the circumstances.

74. In addition, it should have been clear to the officers present that he required medical assistance.

Mr Tang's release from custody

75. The CCTV footage of the cells shows Mr Tang crawling out of the cell door in the presence of the SC Jones, SC Griffiths and LSC Price as well as Ms Lipski. This is captured on CCTV from two angles. Ms Lipski would later relate her observations on radio as: *'I saw him crawl on his knees and hands, like a dog.'*

76. The vision is extraordinary. No police officer offered or felt compelled to offer Mr Tang any assistance. This is confounding and deeply distressing to witness.

77. Once Mr Tang struggles to his feet, he is processed at the charge counter and physically escorted out of the station via the Sally Port (this takes more than 8 minutes). This is also captured on CCTV and shows Mr Tang struggling to stand and walk. He is eventually pushed out into the cold night, in bare feet and in a shocking state, with blood escaping from his mouth (later located in the Sally Port area). This vision is also deeply distressing to watch.

78. Ms Lipski said that as Mr Tang was being escorted out he was making a '*Terrible noise, he was in a lot of pain. He was yelling - yelling very, very loudly.....he was just yelling in pain.*'

79. Some of the officers present thought that he was still intoxicated (well over four hours in custody). Some thought an explanation for the presence of the blood was Mr Tang trying to pull his teeth out. Given at least the requirement to be vigilant in relation to intoxicated persons, these events should have on their face caused further inquires to be made by the officers.

80. AS Whitehead was responsible for Mr Tang's release and should have been provided with information relevant to his suitability for release (I note that SC Jones maintains that Ms Lipski did not tell her that Mr Tang said he was unwell).

81. Ultimately however, given that the release of Mr Tang was AS Whitehead's responsibility, she should have actively sought information from all those who had interacted with Mr Tang regarding his suitability for release (including the watch house keeper and the interviewing officers).

82. Mr Tang's release was recorded on the TTBL by AS Whitehead after the conduct of a disposal interview. She said: *'there was no obvious signs of illness to me'*.

- 20:00 - *Type/Entered*: Disposal interview/SC Whitehead – *Are you satisfied with the way you have been treated by the Police during this investigation? – yes via interpreter. Do you have a copy of your documents? (specify) – BTA 04/08*

83. Ms Lipski said that she was not asked to interpret the bail conditions, nor asked to explain the charges, nor whether he was happy with the treatment but when advised that the police version conflicted with hers she said it may have happened - *I'd rather believe - the officers don't lie.*

84. It is clear that Mr Tang was not in a fit state to be released and AS Whitehead should have been aware of this and sought medical assistance.

85. Mr Tang had no readily identifiable home address. His charge sheet for breaching an intervention order says *'no fixed place of abode'*. Mr Tang's undertaking of bail has no residential condition. He was clearly not permitted to attend 19 Dealing Drive, Oakleigh South as a result of the intervention order.

86. There is conflict in the evidence regarding whether any transport arrangements were made for Mr Tang and whether they occurred before or after Mr Tang collapsed outside the station. During Mr Tang's interview he was asked whether he had a place to go for the night and he said he did - but gave no address.

87. AS Whitehead says:

> *"I then had a discussion with Kaye and asked her if TANG had an address to go to given he couldn't go home. They told me TANG told them he was staying with a friend but had not supplied an address. I then said to Kaye could they obtain an address from him through the interpreter and drop him there. I told Kaye I did not want him walking around my PSA (Police Service Area) in his soiled condition aimlessly. It was inhumane and he would possibly end up being brought back here. Kaye was in agreement and went out the front to meet TANG to follow up what we had discussed."*

88. Ms Jackson says:

> *"After returning inside I zoomed the CCTV camera on him and he was lying on the ground in front of the Sally Port door ...I then informed Whitehead that TANG was lying on the ground ...Whitehead spoke to the Mordialloc members and advised them that he should be taken to the hospital...Both Mordialloc members then went out the front of the station with the interpreter and I could see them on the CCTV cameras right next to TANG."*

89. Neither SC Griffiths and LSC Price (the Mordialloc members) recall being given instructions to transport Mr Tang before he was released (or before he collapsed).

90. There is no evidence that Ms Lipski was asked to interpret any information to Mr Tang (prior to his collapse) regarding any transport arrangements that were proposed for him.

91. Instead, the CCTV footage shows Mr Tang pushed out of the Sally Port into the night and the roller door shutting behind him.

92. I have therefore concluded that appropriate transport arrangements were not made for Mr Tang upon his release.

THE POST RELEASE FROM CUSTODY OF MR TANG

93. Once outside the police station, Mr Tang continued to struggle with his walking and eventually ends up lying on his side on the ground. A short time later SC Griffiths and LSC Price and the interpreter approach Mr Tang. An ambulance is called at approximately 8.13 pm.

94. On the basis of the information provided, it would appear that Ambulance Victoria (AV) treated the attendance as a non urgent attendance (Code 3) and after two further contacts between police and AV[17], which included advice regarding Mr Tang's deterioration (eyes rolling in the back of his head), the request was upgraded to urgent (Code 1). The ambulance arrives at 8.55 pm and Mr Tang has been outside for approximately 40 minutes.

95. During this time Ms Lipski is seen to provide water to Mr Tang and shelter him with her umbrella. She also provides a spare umbrella to another police officer.

96. A police vehicle is moved to be closer to Mr Tang. SC Griffith says:

> *"I sat in the van some of the time as I was cold."*

97. The ambulance officer said:

> *"Mr Tang was drenched from head to toe with water ....He was lying unprotected out in the open and on a slope and his body has almost built up a reservoir of water around him. It was raining....and the whole area was wet."*

98. It is not clear why Mr Tang was not moved out of the elements, either to the sally port or inside the police station. Although one officer said that they didn't expect the ambulance to take so long. Moving Mr Tang would have at least allowed him to stay dry and warm whilst waiting for medical assistance in such cold and wet conditions.

Mr Tang and his soiled condition

[17] I note that the second call was from AV to Victoria Police indicating whether other arrangements could be made due to resource difficulties, which was unusual.

99. Mr Tang was placed in the cells in a soiled condition (both faeces and urine) for more than four hours. All police officers were aware of this.

100. Various responses by police members included the pinching of noses; *dry reaching; nausea; my stomach began to turn; began to gag; I cannot stand the smell of faeces; I thought I was going to throw up and he was a biological hazard.* There is evidence which suggests that his presentation was a bit of joke for some of the officers.

101. Ms Lipski said:

> *"He was ... subject of ridicule the whole night, ... as soon as walked in,..., I was told ...., it was funny that he pooed his pants, he was stinky. I thought - I thought if someone was trying to play - play a trick on - on the police. ....one officer look at him and said, "I'm going to F vomit". And one officer came and sprayed the area, and one officer pinched her nostrils not to smell of it. And so on and so forth, yeah."*

102. As I have already noted, at the time there appeared to be no clear process for police to follow when detainee's soiled themselves, despite it being described as not an unusual occurrence. The evidence of members differed. SC Odwazny said it was his experience that a soiled person would have been given a change of clothes. SS Huth said that '*if someone couldn't wear their clothes because they were heavily soiled we would offer them a jumpsuit to put on*'.

103. I heard evidence that there was no change of clothes available for Mr Tang on 12 May 2010.

104. I note that changes have been made by the CCP which responded to a recommendation in the CIMIC review:

> *The VicPol policy and practice needs to be updated to include clear guidance on the care and responsibility to look after the hygiene of prisoners.*

105. The evidence suggests that Mr Tang's soiled condition interfered with the course of ordinary police processes on 12 May 2010. For example,

- Mr Tang wasn't formally processed at the charge counter before he was lodged in the cell and no photograph was taken;
- The watch house keeper or her assistant did not physically check him in the cell;
- He was interviewed through the flap in the cell door; and
- Ms Jackson said:

I did not sign the witness area as I normally would because TANG had signed the form with what I believed was faeces on his hand and I did not want to touch the form.

106. The lack of adherence to proper processes and procedures in relation to Mr Tang continued to remain unchecked by those responsible for his care throughout his detention. It appears inescapable that Mr Tang's soiled condition contributed considerably to this situation.

107. There is evidence to suggest that the Dandenong Police Station was busy and understaffed in the reception area on 12 May 2010 but no evidence that there were many others incarcerated in the cells at the same time as Mr Tang.

108. Despite there being no specific police guidelines regarding the management of detainees who were soiled, I am of the view that more competent, diligent and compassionate police officers would have made arrangements to address Mr Tang's soiled condition and preserve his welfare, dignity and hygiene.

Death in custody? - Concurrent Evidence

109. I convened a panel of experts to give concurrent evidence and answer a set of directed questions. Those experts were Dr Yvonne Kearley, Dr Paul Bedford, Dr Sally Bell, Professor Mark Fitzgerald and Dr Byron Collins.

110. The unanimous opinion of those five experts was that:

- Mr Tang died of decompensated alcoholic liver disease in the setting of gastrointestinal haemorrhage, which had been determined at autopsy by Dr Bedford;
- Mr Tang's continued alcohol consumption precipitated the multi-organ failure which caused his death;
- there were four pre-existing or underlying medical conditions which played a contributing role in his death and they were: advanced chronic liver disease (due to alcohol abuse), diabetes, a form of psychiatric diagnosis and alcohol dependency;
- there were six recently arising conditions which played a contributing role in his death and they were hypothermia, subdural haemorrhage, pneumonia, hypoglycemia, acute renal failure and hypotension;
- hypothermia was in the moderate range but close to the severe range;

- it was not possible to rank those recently arising factors, including hypothermia, in order of significance or to attribute a particular role to any one factor;
- the causes of hypothermia were identified as the presence of alcohol, a subdural haematoma, the pre-existing liver disease, environmental factors (exposure to the elements including being wet and cold) and also the presence of bleeding;
- it was not possible to say the extent to which that hypothermia was attributable to his time in and immediately after police care and custody rather than attributable to the effects of his decompensated liver disease and other conditions;
- at the time of his admission to Dandenong Hospital Mr Tang's death was inevitable;
- it was not possible to say whether admission at an earlier time could have prevented his death or whether multiple organ failure may already have been established at time he was taken into custody; and
- Mr Tang could have survived only if all factors were reversed but it was impossible to say if all factors could have been reversed.

111. In summary (as put by Counsel Assisting),

- Hypothermia played a role in Mr Tang's death;
- Mr Tang's exposure to the elements outside the police station contributed to the development of that hypothermia;
- However, the extent of the role played by hypothermia in Mr Tang's death cannot be determined; and
- the extent of the role played by his time after police custody in the development of hypothermia also cannot be determined.

112. I note Professor Fitzgerald's view that:

> '*Coincidentally at the time of his custody his death was imminent and inevitable as a consequent of his sever, end stage liver disease and continued alcohol consumption.*'

113. Having considered all the evidence, giving particular consideration to the role of hypothermia in Mr Tang's death, the possible causes of the hypothermia as well as the predominance of other factors in his death, I find that Mr Tang's death was not a *death in custody* within the meaning of the Act.

Victoria Police's response from Mr Tang's death

114. The CCP made a formal and frank apology in relation to Mr Tang's death.[18]

115. Following Mr Tang's death Victoria Police also conducted an organizational review of the handling of persons in police care or custody. In particular I note the following changes:

- the establishment of the Custodial Health Advice Line '*which ensures the physical presence of registered nurses on a daily basis at all custodial facilities in Victoria and provides a 24 hour telephone service to custody staff.*'
- a dedicated Custody Supervisor role has been created (vests the legal responsibility in a single dedicated supervisor whose sole responsibility is to ensure the safe care of persons in custody).
- the Person Warning Flag system has been upgraded with an emphasis placed upon noting known medical issues.
- clearer expression of the requirement to 'check and rouse intoxicated detainees physically every 30 minutes'.[19]
- clearer guidelines on the requirement to provide for prisoners' dignity and physical comfort and hygiene[20].

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[18] On behalf of the Chief Commissioner, and the leadership and membership of Victoria Police, I want to apologise to Mr Tang's family and friends. We have an obligation to care for every person in our custody, and we have an obligation to treat every person with respect and dignity. On what I have seen, we fell well short of the standards expected in terms of both the care we showed, and the respect and dignity we provided. We missed opportunities to get medical assistance for Mr Tang. I find his treatment deeply distressing, and can only imagine how distressing it is for his family and loved ones. We should have done much better for Ling Tang. We let him down, we let his family down and let the community down. I appreciate this seems hopelessly inadequate, but I offer my genuine apology and say we have leant from this and have done much to try and prevent it from every occurring again. Statement of Deputy Commissioner Tim Cartwright

[19] Applicable to drug affected persons (Level 3):

This is the minimum acceptable level for detainees affected by alcohol or drugs.....

- *Detainees to be physically checked and roused at least every 30 minutes;*
- *CCTV can be used in addition to physical checks*
- *The detainee is actively engaged during every physical check.*

Guidelines for conducting checks

- Detainees are to be physically checked. This means that custody staff are to go to the detention facility and observe the detainee. While CCTV enhances the monitoring of detainees, physical checks are still required. CCTV is not to be used as the sole means of monitoring a detainee's condition.
- When the observations level requires custody staff to actively enrage with the detainee, this should include speaking with them, asking questions about their health or welfare needs and obtaining a response.

Summary

116. The five primary police officers (one now retired) who were involved in the care or who had contact with Mr Tang have expressed little or no responsibility for any of the decisions made or actions taken on 12 May 2010. SC Jones says that she has had no specific training to undertake the situation she was facing, but at the same time she was an experienced watch house keeper. Ms Jackson says her role was sub-orordinate and she was the most junior officer on duty. AS Whitehead said her appointment was only recent, she relied on the experience of SC Jones and did not observed and/or was not advised of pertinent matters regarding Mr Tang. SC Griffiths and LSC Price said that they relied on the watch house keeper (and others) in whose custody Mr Tang had been in for some hours before they arrived.

117. The CCP says on the other hand that: '*The manner in which he was treated by the five police members having responsibility for his custody at the Dandenong Police Station was grossly lacking in care and compassion.....and its unacceptability is patent.*' In addition: '*A laissez-faire, disinterested attitude, inconsistent with the obligations of a serving member of the Victoria Police, attended the interactions'* on this day.

118. The statements of the members and the CCP stand in stark contrast. Despite this, the CCP assured me that no cultural issues played a role in this matter.

119. I make the comment that, whilst incarcerating citizens may become routine for police officers, there is no such thing as a minor deprivation of liberty – particularly for the offence of drunk in a public place.[21]

120. In my view there was no particular expertise required to have provided for the proper care and management of Mr Tang.

121. There were many failings at the Dandenong Police Station in relation to Mr Tang's incarceration on 12 May 2010 which I have outlined above.

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[20] Subject to risk assessment, detainees should be allowed to shower, wash, to shave as required....the decision to give detainees access to these facilitates and items should balance the potential risk against the health and dignity of the detainee.
To support the general welfare and hygiene of detainees, Station Commanders are to ensure: Replacement clothing is available for detainees for when clothing is taken from them for evidentiary, safety or hygiene purposes.

[21] There have been many calls in the past for removing this offence altogether, with sobering up centres proposed as an alternative.

122. In addition, I find that Mr Tang, as a person deprived of his liberty, was not treated with humanity and with respect for the inherent dignity of a human person as required by the *Charter of Human Rights and Responsibilities*.

FINDINGS

123. Having considered all the evidence, I find that Mr Ling Gong Tang born on 2 May 1957 died on 13 May 2010 of decompensated alcoholic liver disease in the setting of gastro-intestinal haemorrhage in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

Disciplinary Offences against police officers involved in a death

124. Four of the currently serving police members were charged with disciplinary offences under the *Police Regulation Act* 1958 **after** the completion of the inquest evidence (I understand that these matters have either been finalised or are about to be finalised). It is not clear to me why it was necessary to wait for this to occur. In fact, the completion of the disciplinary matters may have allowed me to hear evidence from these key witnesses which would have enhanced my investigation. I consider that Victoria Police should as soon as possible consider whether any disciplinary action should be taken in relation to the actions of police and that it is not appropriate that those issues be postponed pending the coronial process. The CCP and not the Coroners Court is primarily responsible for the actions of its members and for its own policies and procedures. In my view, it is appropriate that it considers the adequacy of both as soon as possible after a critical incident.

Language difficulties and the application of the Medical Checklist

125. It is my view that some further clarification should be provided to police members regarding when an interpreter is required in relation to the current detainee risk and welfare assessment. I note the following exchange between Dr Westin-Scheuber of counsel and Assistant Commissioner Cartwright:

> *So to clarify, the questions that are referred to at 5.2 of the new VPM Guidelines, I'll just read from that. "The following questions should be asked to assist with the assessment. Do you have any illnesses or injuries? Have you seen a doctor or been to a hospital for these issues? Are you taking or supposed to be taking any*

medication?" and so on, those are the questions that you've referred to in your evidence?---Yes, they are.

Is it your view that in order to be able to administer these questions to a person – a detainee who does not speak English, that would require the services of an interpreter?---Yes, they would.

But you're not aware of any guidelines currently in place or under way to mandate the use of an interpreter for the asking of those questions?---That's correct.

126. In contrast, the submission of the CCP said:

> *'If the detainee's lack of English interfered in any significant way with [the] ability to discharge ...functions, or if the person's lack of facility with English introduced a concern or a doubt in their minds about the detainee's condition, it was their responsibility to obtain the services of an interpreter.'*

127. The latter explanation is more subtle, and given the importance of the assessment, further clarification may be prudent to assist officers with their obligations.

RECOMMENDATIONS

Pursuant to Section 72 (2) of the **Coroners Act 2008**, I make the following recommendation connected with the death:

Manner in which evidence is taken from police witnesses in police contact deaths

128. The death of Mr Tang was investigated by the Victoria Police Homicide Squad and overseen by Professional Standards Command (PSC). In addition, the OPI conducted a review of both the inquest brief produced by the Homicide Squad and the oversight conducted by PSC.

129. I note that the OPI indentified an inconsistent manner in which the police officers involved in the care of Mr Tang were interviewed for my investigation.

> *Specifically the circumstances surrounding the arrangements to conduct 'statements of interview' with subject members and the failure to electronically record any discussion or negotiation whilst eliciting their assistance.*
>
> *The apparent failure to corroborate or electronically record statements allegedly made by the subject members during 'statement of interview' process risked undermining public confidence in the transparency and integrity of the investigation.*

The inclusion of such material would provide robust support to the Victoria Police brief.

130. I note the OPI suggested the following as an appropriate approach in the *Review of the investigative process following a death associated with police contact* (June 2011):

> *In the absence of any suspicion as to possible criminal conduct and where practicable investigators should:*
>
> - *audio and visually record a 'free narrative' account of what happened by police involved in any incident involving a death associated with police contact as soon as possible after the incident has occurred.*

131. This Court has made a number of recommendations with respect to improving the manner in which evidence is gathered from relevant police members, consistent with the OPI suggestion, to improvement transparency and confidence in the investigations. I understand that these are presently under consideration by the appropriate authorities.

132. I endorse this approach and make the following recommendations:

Recommendation 1

In the absence of any suspicion as to possible criminal conduct and where practicable investigators should:

> audio and visually record a 'free narrative' account of what happened by police involved in any incident involving a death associated with police contact as soon as possible after the incident has occurred.

Recommendation 2

To allay perceptions regarding collusion and bias, without compromising the coherence of the account given by Victoria Police members following a police contact related death, I recommend that the Secretary to the Victorian Department of Justice provide an institutionally independent, legally trained person to observe the interview process with Victoria Police members involved in the incident.

Pursuant to Section 73 (1) of the **Coroners Act 2008**, I order that this finding be published on the internet.

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

- Ms Hai Troung, Senior Next of Kin
- Adviceline Lawyers on behalf of relatives of Mr Tang
- Victorian Government Solicitors on behalf of the Chief Commissioner of Police
- Tony Hargreaves Partners on behalf of Fiona Jones, Kate Jackson, Meghan Whitehead, Kaye Price and Kate Griffiths
- Lander & Rogers on behalf of Sharnie Huth, Allie Goff and John Thomson
- Detective Leading Senior Constable Wayne Cheesman, Investigating Member

Signature:

IAIN WEST
DEPUTY STATE CORONER
Date: 9 December 2014