IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 5932

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	Thuy Xuan Nguyen
Date of birth:	20 April 1963
Date of death:	21 November 2015
Cause of death:	Intracerebral haemorrhage
Place of death:	Parkville, Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of THUY XUAN NGUYEN without holding an inquest:

find that the identity of the deceased was THUY XUAN NGUYEN born on 20 April 1963

and that the death occurred on 21 November 2015

at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria 3050

from:

I (a) INTRACEREBRAL HAEMORRHAGE

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr Nguyen was a 52-year-old man who was held in custody on remand awaiting trial at Port Phillip Prison [PPP] in Truganina after being charged with cultivating a commercial quantity of a narcotic plant. He was taken into custody on 12 March 2015, and transferred to PPP on 23 March 2015.

2. On 16 March 2015, Mr Nguyen underwent a medical examination. He did not report any past medical history, and advised that he was not taking any medications. On physical examination, Mr Nguyen was found to have a mildly elevated blood pressure reading of 163/100, but no other abnormalities or areas of concern were noted.

3. On 1 June 2015, Mr Nguyen presented to the PPP Nurse Clinic for a sore throat. Upon examination, his blood pressure was recorded as 160/106. Arrangements were made for a follow-up check on 4 June 2015, at which time Mr Nguyen's blood pressure was at a similar level. He was diagnosed with mild to moderate hypertension.

4. On 5 June 2015, a medical officer reviewed Mr Nguyen's hypertension and ordered blood tests, including glucose, lipids, and biochemistry. The medical officer also recommended that Mr Nguyen attend the Nurse Clinic twice-weekly for reviews of his blood pressure.

5. On both 9 and 11 June 2015, Mr Nguyen's blood pressure had improved, and was 140/100. On 12 June 2015, Mr Nguyen was commenced on Ramipril, an antihypertensive medication, to be taken daily. A plan was made to continue monitoring his blood pressure three times a week.

6. Mr Nguyen's blood pressure was checked in the Nurse Clinic on 15 and 17 June 2015, but he failed to attend checks on 18 and 19 June 2015.

7. On 19 June 2015, Mr Nguyen was seen for review, and stated that he was feeling good. His blood pressure was recorded as 110/70, which was within the normal range.

8. On 23 June 2015, Mr Nguyen's pathology results were reviewed by a medical officer. It was noted that his fasting blood glucose and triglycerides were mildly elevated. An appointment was made on 7 July 2015 for Mr Nguyen to be reviewed by the medical officer with an interpreter, but this review did not occur, for reasons unknown.

9. From 1 to 14 August 2015, it was noted that Mr Nguyen had not been taking his Ramipril as prescribed. He was noted to be non-compliant, and was booked in for a Non-Compliance Clinic to discuss his treatment on 22 August 2015. He did not attend this appointment.

10. On 1 September 2015, Mr Nguyen returned to the Nurse Clinic complaining of a sore throat. His blood pressure was recorded at 157/102. He was recommended to resume taking Ramipril daily, and was booked in for weekly blood pressure reviews.

11. On 9 September 2015, Mr Nguyen's blood pressure was recorded at 132/93. On 15 September 2015, it was 110/80 well within the normal range.

12. From 17 September 2015, Mr Nguyen again became non-compliant with taking his Ramipril. On this occasion, he was not booked in for a Non-Compliance Clinic. He did not resume taking Ramipril at any time after this date.

13. On 17 November 2015 at 7.35pm, nursing staff responded to a call requesting urgent medical assistance made by correctional staff for Mr Nguyen, who was experiencing left-sided weakness and slurred speech. Mr Nguyen's roommate advised that Mr Nguyen had been feeling unwell, and had sat on his bed and drank some water, some of which had dribbled out of his mouth. Nursing staff observed that, while Mr Nguyen was alert, cooperative and smiling, he had a left-sided facial droop. He was also noted to have left-sided weakness, and although he was able to move both his left arm and leg, he lacked coordination. His blood pressure was 186/90. Due to the left-sided weakness, Mr Nguyen was suspected of having suffered a stroke, and an ambulance was called. He was transported to Sunshine Hospital at approximately 8.45pm.

14. Upon presentation to Sunshine Hospital Emergency Department [ED], Mr Nguyen continued to complain of headache, and left arm and leg weakness remained. He was put under hourly neurological observation, and a brain computerised tomography [CT] scan was conducted. This showed a right corona radiate intraparenchymal haemorrhage, the location of which was suggested of hypertensive intracerebral haemorrhage.

15. On 18 November 2015, Mr Nguyen's condition remained stable. His headache did not worsen, and he remained conscious and talking.

16. On 19 November 2015 at 6.00am, a medical officer was called to see Mr Nguyen. He had risen from his bed in an attempt to go to the toilet, but had urinated on the floor and then fallen onto his left side. Upon examination, he was only intermittently obeying commands, was making incoherent noises, and his pupils were unequal. A brain CT was arranged, and both the neurology and neurosurgical registrars were contacted.

17. At 7.20am, Mr Nguyen's blood pressure was noted to be high. At 7.45am, a code blue[1] was called, and the Intensive Care Unit (ICU) was notified. In the ICU, Mr Nguyen's blood pressure was taken and was 170/80. His left pupil became fixed and dilated, and a number of treatment measures were implemented.

18. At 9.37am, Mr Nguyen was transferred to the Royal Melbourne Hospital, where he was admitted to the ICU under the care of the neurosurgery unit. A brain CT showed a large intracerebral haematoma with severe brain compression. Given the extent of the bleed, clinicians concluded that a non-operative approach was warranted. Clinicians discussed Mr Nguyen's poor prognosis with his family and they supported the withdrawal of active treatment and a palliative approach.

19. Mr Nguyen received supportive management in the ICU, and died on 21 November 2015 at 12.47pm.

20. Senior forensic pathologist Dr Matthew Lynch, of the Victorian Institute of Forensic Medicine, reviewed the circumstances of the death as reported by police to the coroner, post-mortem computer assisted tomography [PMCT] scans of the whole body and performed an external examination. Among Dr Lynch's anatomical findings was a right basal ganglia haemorrhage with adjacent oedema, mass effect, and an intracranial pressure monitor.

21. Dr Lynch concluded that it was reasonable to attribute Mr Nguyen's death to intracerebral haemorrhage without the need for an autopsy. He expressed the opinion that Mr Nguyen's death was due to natural causes.

22. At the time of his death, Mr Nguyen was a 'person placed in custody or care' as defined in section 3[2] of the *Coroners Act 2008* [the Act] because he was serving a period of imprisonment and so was in the legal custody of the Secretary to the Department of Justice.

23. Mr Nguyen's designation as a 'person placed in custody or care' is significant. This is because the Act recognised that people in the control, care or custody of the state are vulnerable and therefore, irrespective of the nature of the death, requires it to be reported to

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2 See section 3 for the definition of a "person placed in custody or care" and section 4(2)(c) of the definition of "reportable death".

the Coroner and so subject to the independent scrutiny and accountability of a coronial investigation.

24. As an additional protection, until the insertion of section 52(3A) into the Act in November 2014, all deaths of people placed in custody or care required a mandatory inquest. Now, the Coroner is no longer required to hold an inquest if satisfied that the death was due to natural causes but must publish Findings made concerning natural causes deaths of people in custody or care.[3] Of course, the Act preserves a discretionary power to hold an inquest in relation to any death a coroner is investigating.[4]

25. Leading Senior Constable Nathan Warrick of Victoria Police Wyndham North commenced a coronial investigation on my behalf, later compiling the brief of evidence upon which this finding is largely based. The brief included a statement from Dr Charles Roth, Medical Director of St Vincent's Correctional Health Service at Port Phillip Prison. In addition, a report was received from the former Office of Correctional Services Review [now the Justice Assurance and Review Office], of the Department of Justice and Regulation.

26. In addition to these materials, I requested a further statement from Dr Roth to clarify what, if any, actions had been taken to manage Mr Nguyen's non-compliance with his anti-hypertensive medication. Dr Roth advised:

    a. Pharmacy technicians employed at PPP are responsible for the daily dispensing of medication to patients, and would be the first health staff to become aware that Mr Nguyen was non-compliant with his antihypertensive medication. If a pharmacy technician becomes aware that a patient has missed three or more consecutive doses of medication, the technicians are responsible for booking the patient into the appropriate Non-Compliance Clinic.

    b. Between June and November 2015, Mr Nguyen had two periods of non-compliance where he missed three or more consecutive doses of Ramipril. The first was from 31 July to 12 August 2015, and a second period of non-compliance commenced 17 September 2015.

    c. After the first period of non-compliance in July 2015, Mr Nguyen was referred to the Non-Compliance Clinic, and an appointment was scheduled for 22 August 2015. Mr Nguyen did not attend that appointment. The nurse conducting the Non-Compliance Clinic noted that an appointment would be booked with a medical

[3] Section 73(1B).
[4] Section 52(1) provides that a coroner may hold an inquest into any death that the coroner is investigating.

officer regarding Mr Nguyen's non-compliance, but it is unclear from medical records whether this occurred.

d. There is no record in the bookings schedule in Mr Nguyen's medical records indicating that he was booked into the Non-Compliance Clinic following his second period of non-compliance, beginning in September 2015. However, given the mild nature of his hypertension, it is unlikely that Mr Nguyen would have been considered to have been at risk of imminent complications as a result of this condition.

e. Records were not able to definitively conclude whether Mr Nguyen refused to follow medical advice. It is standard practice by medical staff at PPP to discuss treatment options with a patient. If the patient refuses treatment, they are asked to sign a refusal form. There is no signed Refusal of Treatment Certificate in Mr Nguyen's medical records, or notation to suggest that he refused treatment with antihypertensive medication.

f. Mr Nguyen suffered from mild hypertension that was well controlled on the smallest dose of Ramipril [when taken correctly]. There is no record of the risks associated with untreated hypertension being discussed with Mr Nguyen, but this is not unexpected, as he was compliant at the times he was seen by a medical officer. In addition, his hypertension was of a mild nature, which would not raise concerns of imminent complications. Medical practitioners generally do not discuss or document the severe consequences of a mild condition with a patient.

27. On the evidence available to me, I am satisfied that Mr Nguyen was diagnosed with moderate hypertension while in custody at PPP, and commenced on Ramipril with good effect. Further, there were two separate periods of time where Mr Nguyen failed to take his medication, without any explanation provided as to why. He ultimately succumbed to an intracerebral haemorrhage as a result of his moderate hypertension.

28. As outlined by Dr Roth, there is a system in place at PPP to identify and address prisoner non-compliance with medication. However, medical records obtained reveal an absence of any clearly documented actions to address Mr Nguyen's non-compliance beginning 16 September 2015. This is not in line with the policies and procedures at PPP. However, I am satisfied that Mr Nguyen exercised his personal autonomy not to take his medication as prescribed, although the reasons behind this are not clear.

29. I find that Mr Nguyen, late of Port Phillip Prison in Truganina, died at Royal Melbourne Hospital in Parkville on 21 November 2015 of intracerebral haemorrhage. In accordance with the advice provided by Dr Lynch, I am satisfied that Mr Nguyen's death was due to natural causes.

30. I further find that Mr Nguyen's access to medical treatment while in custody was reasonable and appropriate in all the circumstances.

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

Suan Hoang, Senior Next of Kin

Senior Constable Nathan Warrick

Emma Catford, Justice Assurance and Review Office

Synnove Frydenlund, Western Health

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 1 December 2017