IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 668

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Deceased:	**THI QUI TRAN**
Delivered on:	25 November 2020
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	**25 November 2020**
Findings of:	**SARAH GEBERT, CORONER**
Counsel assisting the Coroner:	**Ms Eleanor Downie, Coroner's Solicitor, Coroners Court of Victoria**
Representation	**Ms Jan Moffatt, DTCH Lawyers on behalf of North Western Mental Health Services**

HER HONOUR:

BACKGROUND

1. Thi Qui Tran (known as Qui) was born on 14 January 1965 and was 53 years old at the time of her death. Ms Tran was born in Vietnam and is one of eight children (being the sixth oldest). Ms Tran ordinarily resided in Braybrook with her partner, Minh and her dog, Lucky.

2. At the time of her death she was an involuntary inpatient at the NorthWestern Mental Health (**NWMH**) Adult Mental Health Rehabilitation Unit (**AMHRU**) on an inpatient treatment order which was due to expire on 19 March 2018.

3. Ms Tran had a diagnosis of schizophrenia from 1989 and had been treated by public mental health services since that time. She had a history of non-adherence to pharmacological treatments resulting in frequent relapses and a reluctance to engage with services. Ms Tran was usually subject to the *Mental Health Act 2014* (Vic) (**MHA**) and treated as a compulsory patient with inpatient and community based treatment orders. She had type 2 diabetes, was obese, had raised prolactin levels from the antipsychotic medications,[1] and experienced recurrent urinary tract infections. Ms Tran also spoke limited English.

4. Ms Tran's medical records reveal that she was very social, that she loved to travel (and did so frequently), she enjoyed food and was generous with her fellow patients (sharing her meals and sometimes money).

5. Ms Tran was located shortly before 4.00pm on Wednesday, 7 February 2018 in an unconscious state on the footpath outside 82 Marshall Street, St Albans whilst on approved leave and died on 9 February 2018 at the Sunshine Hospital of *heatstroke*.

THE CORONIAL INVESTIGATION

6. Ms Tran's death was reported to the coroner as it appeared to fall within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). She was also *'in care'* as defined by the Act as she was subject to an Inpatient Temporary Treatment Order ('**ITTO**') under the MHA.

7. A coroner independently investigates 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

---

[1] Prolactin is a hormone that is important for male and female reproductive health. Some medications can result in elevated prolactin levels.

coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[2]

8. 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.

9. Victoria Police assigned Senior Constable Timothy Farrant (**SC Farrant**) to be the Coroner's Investigator for the investigation into Ms Tran's death. SC Farrant conducted inquiries on my behalf,[3] including taking statements from witnesses and compiling a coronial brief of evidence. The brief comprises statements from Ms Tran's brother, health professionals who had treated Ms Tran, the forensic pathologist who performed the autopsy, investigating officers as well as other relevant documentation.

10. As part of the coronial investigation, advice was sought from the Coroners Prevention Unit (**CPU**) regarding the care provided to Ms Tran proximate to her death. The CPU is staffed by healthcare professionals, including practicing physicians and nurses, who are not associated with the health professionals and institutions under consideration and are therefore able to give independent advice to coroners.

11. When a person dies *'in care'* an inquest into the death is mandatory. After reviewing all the material, I determined that the circumstances of her death were adequately revealed by the coronial brief, the health service had detailed their decision making around the granting of leave to Ms Tran and appropriate health procedures and alerts were already in place (following previous coronial investigations), which meant that the investigation could be concluded.

12. This finding is based on the totality of the material obtained during my coronial investigation, including the inquest. Whilst I have considered all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Background

13. On 12 May 2017, Ms Tran was admitted to the AMHRU for rehabilitation with the goal of re-establishing her independence and enabling her return to live in her public housing unit in

[2] This is 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.

[3] The carriage of the investigation was transferred from Deputy State Coroner English.

Braybrook. Together with Ms Tran, her family and partner, Minh, care and treatment plans and goals where developed and until her death there was evidence towards achieving this. Her program included swimming, tai chi, music classes, group meals at local restaurants, coffee club, shopping, walking group and public transport use.

14. Ms Tran made good progress in the AMHRU with 24-hour nursing support and in particular, the regular administration of psychoactive medications, which she had not been taking reliably for many years.

15. The medical records document a team-based approach to Ms Tran's recovery, including a sensitivity to her capacity to use and understand English. There is evidence of shared decision making with Ms Tran, family involvement, referrals to specialists, multidisciplinary and clinical reviews, regular medical, psychiatric registrar and consultant psychiatrist reviews and care planning. In addition, the AMHRU and Ms Tran's community case manager had frequent contact with the external services including her GP, the Department of Housing and State Trustees.

16. The clinical risk assessment and management process (**CRAAM**) was completed regularly and Ms Tran was rated as medium risk on admission and until 16 November 2017 when she was rated as low risk. She remained at low risk with escalation to medium only for short periods and associated with her being absent without leave (**AWOL**), requiring a review by a psychiatrist prior to further leave being given.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

17. Ms Tran left the AMHRU at about 10.00am on 7 February 2018 for her morning 30-minute approved leave to the kiosk on hospital grounds. The expected daytime temperature was 37 degrees Celsius. According to Nurse Jacqueline Mtetwa who was driving along Furlong Road, she saw Ms Tran at approximately 11.45am[4] board a bus. She informed the AMHRU nurse-in-charge on her return to the unit. Ms Mtetwa noted that Ms Tran was at the Furlong Road bus stop in front of the Hospital.[5] She said that she was wearing a *pink checked pyjama top and a brownish coloured pair of pants*. Ms Tran's treating psychiatrist Dr Nareen Thomas was contacted and directed that the leave be considered as the approved eight-hour day leave, which resulted in Ms Tran's adjusted expected time for return to the ward as 7.00pm.

---

[4] The time is documented as 11.00am in the medical records. NorthWestern Mental Health digital medical records page 2567.

[5] The bus on this line, and in this direction, has a stop approximately six minutes' walk from Ms Tran's residence in Braybrook.

18. In the afternoon of 7 February 2018 (documented as 4.36pm) an occupational therapist and Dr Thomas completed a home visit to Ms Tran's home and discussed with her partner what needed to occur prior to Ms Tran being granted additional leave.[6]

19. At about 3.50pm, Ms Tran was located unresponsive in the street and was observed to be clothed in a black (thermal) jacket and long pants. Emergency Services were called at 3.53pm and Ambulance Victoria and MICA attended just after 4.00pm and attempted to cool Ms Tran, whose temperature was not readable. She was noted to be wearing a *thick jacket and long pants*. She was transported to Sunshine Hospital emergency department and admitted to the intensive care unit and was yet to be identified. Her first recordable temperature was 41.7 degrees Celsius.

20. At 7.00pm, as Ms Tran had not returned to the AMHRU Nurse Herman notified the on-call psychiatrist, Ms Tran's family, and Victoria Police, and faxed the missing person and mental health form MHA 124 apprehension of patient absent without leave to them.

21. At 10.58pm Senior Constable Jayden Gebbie (**SC Gebbie**) responded to a call at Sunshine Hospital where he was already in attendance, to try and identify the woman in ICU who was very unwell, and the hospital wanted to contact her next of kin. During this time SC Gebbie heard the "keep a look out for" alert by Victoria Police in response to the AMHRU report of Ms Tran's AWOL. Following further clarification SC Gebbie informed the ICU who contacted the AMHRU.

22. On 8 February 2018 at about 12.10am, AMHRU Nurse Jossy Joseph was contacted by ICU bed manager Olivia Johnston. Nurse Joseph attended the ICU and confirmed the identity of the unidentified woman was Ms Tran.

23. Ms Tran's family and partner were notified and attended the hospital, were informed of her prognosis and life support was turned off following discussion on 9 February 2018. She died at 6.48pm surrounded by her family.

IDENTITY

24. On 9 February 2018, Du Tran visually identified his sister, Thi Qui Tran, born on 14 January 1965.

25. Identity is not in dispute and required no further investigation.

---

[6] NorthWestern Mental Health digital medical records page 2571.

CAUSE OF DEATH

26. On 13 February 2018, Dr Joanna Glengarry, a specialist forensic pathologist practicing at the Victorian Institute of Forensic Medicine, performed an autopsy and provided a written report, dated 12 April 2018.[7] In that report, Dr Glengarry concluded that a reasonable cause of Ms Tran's death was *Heatstroke*.

27. The autopsy showed skin blisters, petechiae beneath the scalp and across the skin, acute gastritis and oedematous lungs. Dr Glengarry said that these findings are consistent with the diagnosis of *heatstroke* (sometimes referred to as hyperthermia), however it should be noted that the autopsy findings in deaths due to hyperthermia may be non-specific and one must consider whether the circumstances support the proposed finding. The skin blistering was consistent with heat-related injury.

28. Dr Glengarry noted that the ambulance and hospital records described warm dry, flushed skin with temperature readings up to 41.1 degrees Celsius (normal is approximately 37.5 degrees). She was unconscious, tachycardiac and testing showed renal impairment, muscle damage (probably rhabdomyolysis) and a coagulopathy, where clinically her condition was diagnosed as hyperthermia.

29. Dr Glengarry further noted that literature regarding certification of deaths due to high environmental temperatures say that one should consider hyperthermia as a cause of death when circumstances suggest this may be a factor and in the presence of a high body temperature.

30. Information available to Dr Glengarry noted the environmental temperature at the time Ms Tran was found was approximately (close to 40 degrees). High environmental temperature with physical activity can cause the development of hyperthermia. It was also noted that Ms Tran was wearing a 'large jacket' which, given the warm ambient temperature, is likely to have contributed to or exacerbated the development of heat stroke.

31. Toxicological analysis showed the antipsychotic medications zuclopenthixol and olanzapine.

32. Dr Glengarry noted that both zuclopenthixol[8] and olanzapine[9] have been associated with the development of heatstroke. She commented that the presence of these medications *may*

---

[7] A supplementary report dated 7 May 2018 confirmed that the cause of death remained unchanged after Dr Glengarry reviewed an immunohistochemical stain for myoglobin within the kidneys.
[8] Zuclopenthixol is an antipsychotic which can be used for initial treatment of acute psychotic episodes or exacerbation of psychosis associated with schizophrenia.
[9] Olanzapine is indicated for the treatment of schizophrenia and related psychoses.

therefore have rendered Ms Tran more susceptible to heatstroke (but are unlikely to be the sole cause, particularly given the suggestive circumstances).

33. I note that benztropine[10] was found in Ms Tran's blood in therapeutic quantities.

34. Further, Dr Glengarry noted that people with schizophrenia are recognized as being more vulnerable to the development of heatstroke, than those without.

35. The examination revealed no post-mortem evidence of violence or injury contributing to death.

36. I accept and adopt Dr Glengarry's opinion as to Ms Tran's medical cause of death.

INVESTIGATIONS

Medical Treatment

37. On 12 November 2018, the CPU reviewed the statements provided by Intensivists Doctors Gerard Fennessy and Mark Kubicki who provided medical treatment to Ms Tran at Sunshine Hospital intensive care unit. The review concluded that the treatment was appropriate, that they tried everything they could but Ms Tran did not respond to treatment.

Mental Health Care – general

38. The rehabilitation program and long-stay admission to the AMHRU had resulted in improvements to Ms Tran's mental state and level of functioning, which was supported by feedback from her family. The plan for her to return home was being implemented and there was a plan for her to have overnight leave. No issues were identified by the CPU in relation to the assessment, treatment and recovery focused mental health care provided by the AMHRU for Ms Tran.

Leave granted to Ms Tran

39. The CPU examined Ms Tran's medical records and noted that her completed CRAAMs leave description includes two unescorted 30 minute on hospital ground/kiosk leaves per day, group leaves, escorted leaves at staff discretion and unescorted leave for eight hours with the additional notation of 'grace period until 2200hrs for all leaves'.[11] This provided the opportunity for staff to restrict Ms Tran's leave and also on the occasions she did not return within the agreed timeframe, enabled the staff to extend the leave period up to eight hours

[10] Benztropine is a synthetic compound used in the treatment of Parkinson's Disease and in the control of extrapyramidal disorders.
[11] NorthWestern Mental Health digital medical records page 732.

before they were required to enact the absent without leave procedures for compulsory patients. In addition, it provided a further option to staff to allow additional hours of leave as a grace period before enacting the procedure.

40. On 7 February 2018, Ms Tran left the AMHRU at 10.00am for the 30 minute kiosk leave, had not returned to the AMHRU by 11.45am at which time she was sighted boarding a bus. After this time it was reported to the AMHRU nurse in charge and to the treating consultant psychiatrist Dr Thomas, and Ms Tran's leave was changed to an eight hour leave period. Ms Tran was recorded as not due back to the AMHRU until about 7.00pm at which time the absent without leave procedure was enacted, although according to the leave criteria, staff could have applied the grace period, and not have enacted the procedure until 10.00pm.

41. The leave criteria appeared to be designed to give Ms Tran more time to return to the AMHRU on her own and not involve Victoria Police. The medical records indicate that Ms Tran had historically not always returned from leave on time and on at least four occasions the absent without leave procedure had been enacted. In nearly all cases, Ms Tran had returned to the AMHRU alone or with family or her partner prior to Victoria Police locating her. This included an overnight absent without leave on 4 January 2018 when she returned to the unit at 6.50am the following day.

42. Consultant psychiatrist Dr Thomas stated with respect to Ms Tran's leave arrangements:

    The risk assessment was regularly updated and was last updated in the clinical review on 6/2/18. She was granted leaves including: group leaves, unescorted leaves on hospital grounds and 8 hour day leaves (unescorted).

43. Dr Thomas further stated regarding the *grace period* granted to Ms Tran:

    A grace period for reporting AWOL was allowed until 2200hrs each day as Ms. Tran would often extend her own leave but was low risk to others in the community and had demonstrated that she was safe herself. She would often make her way to her own flat in Braybrook and visit her partner and her dog, go shopping in St Albans or the city or visit her brother. Her late returns from leave were generally a matter of Ms. Tran losing track of time and she had been counselled regarding this on several occasions.[12]

44. On the morning of 7 February 2018, Ms Tran was already overdue on the 30 minute on-ground leave period for her return to the AMHRU when she was noted to be boarding a bus in Furlong

[12] NorthWestern Mental Health digital medical records MHA 15 Notice of death, page 3003.

Road. There is no information in the medical records that AMHRU staff had attempted to locate her prior to the sighting at the Furlong Road bus stop.

45. The evidence suggests that Ms Tran is likely to have travelled by bus to her home in Braybrook and returned via the same bus route, travelling past the Sunshine Hospital. I note that she was located in the vicinity of her brother's home, her mother's home as well as the St Albans shops. Neither her brother nor mother had however seen her on that day.

Extension of leave

46. The CPU noted that the AMHRU is a rehabilitation long-term unit and Ms Tran's progress was at the point of increasing her independence and self-monitoring. The CPU considered that the decision by Dr Thomas to extend the 30-minute leave to an 8-hour leave was reasonable because Ms Tran had successfully completed these periods previously.

47. However, given the extended leave had the potential to alter her risk profile, the question became whether proper consideration was given to the risk of the prevailing weather conditions that day as part of the decision to extend her leave.

48. The Chief Psychiatrist's guidelines (albeit March 2018) with respect to compulsory patients notes that, *leave can be granted for any period, and subject to any conditions that are considered necessary, if the health and safety of the person, and the safety of others, will not be seriously endangered.*[13]

49. The CPU noted that when a 30 minute leave period is extended to eight hours with or without an additional grace period, the potential risks profile changed. That is, on a 30 minute hospital ground leave it was reasonable there was less concern about practicable factors such as what Ms Tran was dressed in, or access to food and fluids. On an eight hour leave this potentially presented more of a problem in an already vulnerable woman.

50. The medical records document that the staff were aware of what Ms Tran was wearing and carrying when she left the AMHRU – *wearing pink PJs, black jacket, brown thongs, black bag (shoulder).*[14] At her mental state examination that morning she was noted to be *wearing pink checkered pyjama top, brown pants and black puffy jacket.*[15] The observation of Ms Tran boarding the bus when she was last seen, is absent any black jacket suggesting that she removed it during the morning. As already noted, when Ambulance paramedics find Ms Tran unconscious, she is wearing a black jacket.

[13] Leave of Absence from a Mental Health Inpatient Unit, March 2018. NorthWestern Mental Health digital medical records, page 3093.

[15] NorthWestern Mental Health digital medical records, page 2567.

Risks associated with extreme heat conditions

51. As part of Dr Glengarry's report, she noted that high environmental temperature with physical activity can cause the development of hyperthermia, which is likely, in this case, to have been contributed to or exacerbated by the wearing of a heavy jacket. She noted that both zuclopenthixol and olanzapine have been associated with the development of heatstroke and that people with schizophrenia are recognized as being more vulnerable to the development of heatstroke, than those without.

Previous coronial recommendations

52. Previous coronial findings involving similar deaths include Coroner Phillip Byrne's investigation onto the deaths of C. Dokos[16] and K. Baron[17] as well as Coroner Audrey Jamieson's finding into the death of C. Prassad[18]. Coroner Byrne made recommendations to the Department of Health and Human Services (**DHHS**) that the Chief Psychiatrist issue a directive to each mental health service to develop a heat health plan for vulnerable mental health clients that addressed the safety of patients and staff in extreme weather events.

53. The factors shared across all three deaths and with Ms Tran include individuals with obesity, those prescribed and administered more than one psychoactive medication, a diagnosed and treated severe mental illness, and they were current public mental health patients/clients.

Chief Psychiatrist Clinical Practice Advisory Notice

54. In response to the coronial recommendation, the Chief Psychiatrist issued a Clinical Practice Advisory Notice *Heat health plans for vulnerable mental health consumers (2016)* (**Advisory Notice)** which acknowledges the serious implications of hot weather for mental health patients and more so, those on combination antipsychotics.

55. The Advisory Notice requested that services develop appropriate policies and procedures to care for highly vulnerable groups of individuals in extreme weather conditions. Strategies included delaying leave until conditions improved, arranging or providing transport, or meeting the person's need in some other way.

[16] COR 2014 430
[17] COR 2014 431
[18] COR 2013 273

AMHRU (NWMH)

56. Malcolm Park, Nurse Unit Manager, AMHRU provided information to the Court on the training and actions in place following the NWMH's response to the Advisory Notice, which was aimed at reducing the potential adverse effects of heat on their mental health patients and, which was in place at the time of Ms Tran's death. The actions include:

    - The distribution and display of the DHHS *Surviving the Heat* information brochures,
    - The roll out of the *Mid West Area Mental Health Service Heat Plan* to staff which is laminated and posted on the front door to the AMHRU with the forecast temperature entered each day,
    - Slabs of water are purchase throughout the summer as well as frozen icy poles which are distributed free of charge to patients,
    - Encouraging patients to make alternative arrangements, and
    - For more vulnerable clients, nurses request that the consultant psychiatrist cancel leaves on days of extreme heat.

57. Whilst Mr Park indicated that there had been no real changes to the already existing heat-related procedures since Ms Tran's death (noting that they had already met the requirements of the Advisory Notice), he said that heat related risks were more at the forefront of nursing practice throughout the summer:

    With patient safety in mind, nurses have been more proactive in postponing and cancelling leaves when considered necessary and it remains a regular topic for discussion in reflective practice sessions and at staff meetings. The risk assessment leading to the granting of leave by a consultant psychiatrist indicates that the client is generally responsible and capable of adequate self-care when unescorted in the community. Nurses will only intervene if the situation appears to have changed on assessment prior to the leave. The doctors are reviewing leave for more vulnerable patients when the temperature is expected to be over 30 degrees Celsius.[19]

Extension of leave

58. Dr Thomas indicated that the granting of leave resides with the treating Consultant Psychiatrist, following collaboration and consultation with other professional colleagues, and the following matters are taken into consideration when approving leave:

[19] Statement of Malcolm Park dated 14 January 2019.

- The patient's legal status,
- The patient's mental state over the preceding days,
- Feedback from nursing and allied health staff about the patient's level of functioning and organisation,
- The patient's capacity to follow staff direction,
- The patient's capacity to adhere to previous leave arrangements i.e. Did the patient return on time, did she/he consume drugs or alcohol while on leave etc.,
- The patient's level of understanding about early warning signs of stress or exacerbation or relapse of acute illness,
- The patient's level of understanding about how to contact the ward if any problems arise during the leave period, and
- Consultation with the patient's family if she/he is having leave with family members.

59. With respect to the decision to extend Ms Tran's leave on 7 February 2018 and whether proper consideration was given to her known vulnerabilities in the prevailing conditions on that day, Dr Thomas was asked to clarify his decision making.

60. In his statement to the Court dated 17 September 2020, Dr Thomas said that he was *aware of the prevailing conditions,* that Ms Tran's discharge was *already arranged for the next few weeks depending on how the leave went* and,

    Consequently, I was confident on her ability to look after herself from prior experience as she was utilising regular extended hours of day leaves before the incident and on those occasions she has demonstrated that she was not over dressing for the weather.

    Also the staff consistently reminded Ms Tran to remain well hydrated during the warmer weather and there is every indication that she heeded that message.

    Given the Adult Mental Health Rehabilitation Unit (AMHRU) role as a professional unit treating patients with treatment-resistant schizophrenia, there is a high level of awareness by clinical staff of the phenomena of thermal dysregulation in schizophrenia and staff are particularly attuned to the risk of patients over dressing for the weather.

61. Dr Thomas also noted that since Ms Tran's death, the Director of Operations at NWMH *proactively distributes a bulletin to the 1,900 strong NWMH workforce via a 'NWMH Everyone' email list when the daily temperature exceeds* 30 degrees. The Chief Psychiatry Advisory Notice is also attached to the email.

Conclusion

62. Dr Thomas was well acquainted with Ms Tran having treated her over the course of her long-stay admission to the AMHRU which had resulted in improvements to her mental state and level of functioning with a plan that she return home. Dr Thomas has stated that he did not have any concerns regarding Ms Tran's vulnerability in the heat conditions of that day and was *confident* in her ability to look after herself. On the basis of the statements provided by Dr Thomas, I accept that he gave proper consideration to these matters.

FINDINGS

63. Having investigated the death of Ms Tran and having held an inquest in relation to her death on 25 November 2020, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) the identity of the Deceased is Thi Qui Tran born on 14 January 1965;

    (b) Thi Qui Tran died on 9 February 2018, at Sunshine Hospital, 176 Furlong Road, St Albans, Victoria from *heatstroke*; and

    (c) her death occurred in the circumstances described above.

COMMENTS

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

    The investigation has been unable to account for Ms Tran's precise whereabouts and activities between approximately 11.45am and 3.55pm on 7 February 2018. There is however no evidence of a suspicious nature surrounding the circumstances leading to her discovery. On the presumption that Ms Tran succumbed to the prevailing weather conditions as the evidence suggests, her death appears to have been preventable, although Dr Thomas' evidence suggests that this observation can only be made with the benefit of hindsight.

    Ms Tran's death highlights that patients in high risk categories remain at significant risk, even if they are due for discharged in the near future. Ms Tran also demonstrated a history of independent and frequent travel.

    In cases where leave is extended, it is also important to recognise that the risk profile of a patient may also change significantly, such as the clothing worn, or access to food and fluids.

NWMH has demonstrated a high level of attention to reducing the risks associated with extreme heat conditions for vulnerable patients. I note that daily advice (and publication) is provided to staff regarding weather events over 30 degrees Celsius and a more proactive approach by nursing staff to postponing and cancelling leave arrangements has been adopted. In addition, doctors are reviewing leave for more vulnerable patients when the temperature is expected to be over 30 degrees Celsius.

This approach promotes vigilance regarding patient safety and welfare and is clearly warranted given the known risks and serious implications of hot weather for mental health patients and more so, those on combination antipsychotics.

PUBLICATION

65. Pursuant to section 73(1) of the Act, I order that a redacted version of this Finding be published on the internet.

66. I convey my sincere condolences to Ms Tran's family for their loss.

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

Du Tran, senior next of kin

Ms Jan Moffat, DTCH Lawyers on behalf of North Western Mental Health Services

Office of Chief Psychiatrist

Senior Constable Timothy Farrant, Victoria Police, Coroner's Investigator

Signature:

SARAH GEBERT

CORONER

Date: 25 November 2020

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.