IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004817

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Tan Van Tran
Date of birth:	16 January 1970
Date of death:	14 February 2023
Cause of death:	1(a) Gastrointestinal haemorrhage complicating recent PEG insertion <u>Contributing factor(s)</u> 2 Stroke
Place of death:	Caulfield Hospital 260-294 Kooyong Road Caulfield Victoria 3162
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 14 February 2023, Tan Van Tran was 53 years old when he passed away at Caulfield Hospital.

2. Mr Tran was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by the then-Department of Health and Human Services. Mr Tran was receiving these supports after suffering a stroke in July 2021 and experiencing dense right-sided hemiparesis, aphasia and an acquired brain injury. After the stroke, Mr Tran required significant rehabilitation and therapy. Mr Tran's medical history also included fatty liver, chronic pancreatitis, hypothyroidism, longstanding oropharyngeal dysphagia and prior alcohol and drug use.

3. Mr Tran spoke Vietnamese as his first language and enjoyed cooking Vietnamese food. He also enjoyed visiting and being visited by his family and friends, particularly his mother, sister, brother, nephew and son.

THE CORONIAL INVESTIGATION

4. Mr Tran's death fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as he was a 'person placed in custody or care' within the meaning of the Act, as a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to his death. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The

[1] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Mr Tran's death, is a permanent dwelling that provides long-term accommodation for one or more SDA residents, that is enrolled as an SDA dwelling under relevant NDIS (Specialist Disability Accommodation) Rules in force at the relevant time. An SDA resident means a person who is an NDIS participant funded to reside in an SDA enrolled dwelling, or who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). The definition of SDA resident was amended on 1 July 2024 pursuant to the *Disability and Social Services Regulation Amendment Act 2023* to extend to include persons who are residing, or propose to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. This finding draws on the totality of the coronial investigation into the death of Tan Van Tran including information from the National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safeguards Commission, as well as a Medical Certificate Cause of Death (**MCCD**) completed by a medical practitioner at Caulfield Hospital. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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

Circumstances in which the death occurred

8. On 24 January 2023, Mr Tran was transported via ambulance to the Alfred Hospital Emergency and Trauma Centre after carers at his SDA observed excessive drooling, coughing and possibly shortness of breath. Concern was also expressed regarding his swallowing.

9. Staff thought Mr Tran's condition was thought to be the result of progressive deconditioning from previous spinal injuries and stroke, resulting in severe dysphagia and severe malnutrition. Mr Tran's sister opined that his swallowing was worse than usual and that he appeared to be choking. Mr Tran's family were keen for him to receive assistance in the form of a percutaneous endoscopic gastrostomy (**PEG**).

10. Mr Tran underwent a chest x-ray which demonstrated aspiration pneumonia, and he received a course of antibiotics. On 2 February 2023, Mr Tran underwent a video swallow test to assess his swallowing function. During this time, an aspiration event occurred. After the test,

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[2] 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.

Mr Tran became unwell which later resulted in a Medical Emergency Team (**MET**) call being made. Clinicians inserted a nasopharyngeal airway and ceased his nasogastric (**NG**) feeds.

11. On 5 February 2023, Mr Tran's pneumonia was noted to have resolved, and his course of antibiotics was complete. He was noted to be well and comfortable. On 6 February 2023, Mr Tran had a PEG inserted during a gastroscopy and was placed on a three-day course of piperacillin-tazobactam. Feeds were commenced after the PEG insertion and nursing observations documented that he appeared to be improving.

12. Mr Tran was transferred to Caulfield Hospital on 9 February 2023 for continued dietician input of his PEG feeds. At about 11.45pm that evening, a Code Blue was called for Mr Tran as he experienced an increased work of breathing, tachycardia and became diaphoretic. Clinicians were able to stabilise his oxygen levels on a non-rebreather mask. He had a low blood pressure reading early on 10 February 2023, which necessitated further medical intervention.

13. On 11 February 2023, Mr Tran experienced melaena and was commenced on pantoprazole. Clinicians updated Mr Tran's family via phone and explained that it was likely that he would experience further aspiration events, and he would not benefit from long-term steroids. Clinicians explained that their main focus was to ensure Mr Tran's comfort.

14. On 13 February 2023, Mr Tran continued to experience melaena and a nosebleed. His family attended the hospital and met with the treating clinicians, who emphasised the need to prioritise his comfort. Mr Tran passed away on the evening of 14 February 2023.

Identity of the deceased

15. On 14 February 2023, Tan Van Tran, born 16 January 1970, was identified by medical practitioner Dr Judy D'Souza via review of medical records and visual identification.

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

Medical cause of death

17. On 14 February 2023, medical practitioner Dr Judy D'Souza reviewed Mr Tran's complete medical history, conducted an examination of the body and completed a MCCD. Dr D'Souza provided an opinion that the medical cause of death was *gastrointestinal haemorrhage* secondary to *aspiration pneumonia* due to *stroke*.

18. On 30 September 2024, Forensic Pathologist Dr Paul Bedford at the Victorian Institute of Forensic Medicine (**VIFM**) reviewed the MCCD and the medical records at my direction. Dr Bedford opined that the PEG insertion procedure that Mr Tran underwent appeared to be causally related to the death and therefore his death was reportable, pursuant to the Act, regardless of Mr Tran's status living in an SDA enrolled dwelling.

19. Dr Bedford provided an opinion that the medical cause of death was *gastrointestinal haemorrhage complicating recent PEG insertion* with *stroke* as a significant contributing factor.

20. I accept Dr Bedford's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Tan Van Tran, born 16 January 1970;

    b) the death occurred on 14 February 2023 at Caulfield Hospital, 260-294 Kooyong Road, Caulfield, Victoria 3162, from *gastrointestinal haemorrhage complicating recent PEG insertion* with *stroke* as a significant contributing factor; and

    c) the death occurred in the circumstances described above.

22. The available evidence does not support a finding that there was any want of clinical management or care on the part of the SIL provider, or clinical staff at the Alfred or Caulfield Hospitals that caused or contributed to Mr Tran's death.

23. Having considered all the available evidence, taking into account my finding that there is no want of clinical management or care and as I can see no public interest in holding an inquest (public hearing) into the death, I have determined that I will finalise the investigation into Mr Tran's death in chambers.

24. I convey my sincere condolences to Mr Tran's family, friends and carers for their loss, and acknowledge the distress caused by the delay in the reporting and investigation of Mr Tran's death.

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

26. Pursuant to section 49(2) of the Act, I direct the Registrar of Births, Deaths and Marriages to amend the cause of death to the following "1(a) GASTROINTESTINAL HAEMORRHAGE COMPLICATING RECENT PEG INSERTION; 2 STROKE".

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

Dung Tran, Senior Next of Kin

Alfred Health

Accommodation and Care Solutions

Signature:

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Date: 4 February 2025

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