IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002392

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Ho Hai Vu
Date of birth:	05 December 1967
Date of death:	29 April 2024
Cause of death:	1(a) Basal ganglia haemorrhage with intra-ventricular extension 1(b) Moyamoya Disease
Place of death:	The Royal Melbourne Hospital 300 Grattan Street Parkville Victoria 3052
Keywords:	In care, SDA resident, basal ganglia haemorrhage, moyamoya disease, natural causes death

INTRODUCTION

1. On 29 April 2024, Ho Hai Vu **(Mr Vu)** was 56 years old when he died at The Royal Melbourne Hospital **(RMH)**. He is survived by his wife, Mrs Hieu Thi Minh Le and three children.

2. Mr Vu's medical history included moyamoya disease, left and right basal ganglia haemorrhages (2019 and 2020), weakness and paralysis of face aphasic and PEG tube feeding, dyslipidaemia and type 2 diabetes mellitus. He required full time care and was a Specialist Disability Accommodation **(SDA)** resident in an SDA enrolled dwelling at 110 Roberts Street West Footscray Vic 3012. Mr Vu enjoyed participating in music therapy and community groups as well as spending time with his family.

THE CORONIAL INVESTIGATION

3. Mr Vu's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* **(the Act)**.[1] Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the coroner, even if the death appears to have been from natural causes. In this instance, Mr Vu was a *"person placed in custody or care"* pursuant to the definition in section 4 of the Act, as he was *"a prescribed person or a person belonging to a prescribed class of person"* due to his status as an *"SDA resident residing in an SDA enrolled dwelling."*[2]

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. This finding draws on the totality of the coronial investigation into the death of Ho Hai Vu. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to

[1] Section 4(1), 4(2)(c) of the Act

[2] Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a *"prescribed person or a prescribed class of person"* includes a person in Victoria who is an *"SDA resident residing in an SDA enrolled dwelling",* as defined in Reg 5.

my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

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

Circumstances in which the death occurred

6. On 28 April 2024 at 6am, Mr Vu was located in his room by nursing staff. He was unresponsive and covered in vomit. Following the arrival of emergency services, Mr Vu was transported to the Emergency Department of the RMH.

7. CT imaging at the RMH showed a basal ganglia (brain) haemorrhage with intra-ventricular extension. Evidence of Moyamoya disease was demonstrated with prominent collateral formation surrounding the midbrain.

8. Given Mr Vu's poor prognosis, discussions were held with the neurosurgery team, the stroke team, and Mr Vu's family. It was determined that he be referred to end of life care. Mr Vu died peacefully at 4.15am on 29 April 2024.

Identity of the deceased

9. On 2 May 2024, Ho Hai Vu, born 05 December 1967, was visually identified by his daughter, Jacqueline Phan.

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

Medical cause of death

11. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an external examination on 1 May 2024 and provided a written report of his findings dated 6 May 2024.

12. The post-mortem CT scan revealed right basal ganglia haemorrhage with intraventricular extension. The external examination was otherwise unremarkable.

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[3] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

13. Dr Burke provided an opinion that the medical cause of death was *1(a) Basal ganglia haemorrhage with intra-ventricular extension, 1 (b) Moyamoya Disease.*

14. Dr Burke noted that there was no evidence to suggest that the death was due to anything other than natural causes.

15. I accept Dr Burke's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Ho Hai Vu, born 05 December 1967;

    b) the death occurred on 29 April 2024 at The Royal Melbourne Hospital, 300 Grattan Street Parkville, 3052 Victoria from basal ganglia haemorrhage with intra-ventricular extension in the context of moyamoya disease; and

    c) the death occurred in the circumstances described above.

17. I note that section 52 of the Act requires that an inquest be held, except in circumstances where the death was due to natural causes. I am satisfied that Mr Vu died from natural causes and I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death.

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

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.

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

Hieu Thi Minh Le, Senior Next of Kin

First Constable Alexander Sarto, Coroner's Investigator

National Disability Insurance Agency

Signature:

Coroner Kate Despot

Date : 21 November 2024

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.