IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004355

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Suong (Kelvin) Van Nguyen
Date of birth:	31 July 1969
Date of death:	Between 3-4 August 2020
Cause of death:	1(a) Covid 19 Pneumonia
Place of death:	2 / 17-19 Lindel Street, Newcomb, Victoria, 3219
Keywords:	Covid 19; Victoria 2nd Wave; Barwon Health

INTRODUCTION

1. On 9 August 2020, Suong Van Nguyen was 51 years old when he was found by police deceased at his home in Newcomb. At the time of his death. Mr Nguyen lived by himself and was known to many as 'Kelvin Nguyen.'

2. Mr Nguyen worked at the Turosi Golden Farm chicken processing plant.

Background of Mr Nguyen

3. Mr Nguyen was born in Vietnam and immigrated to Australia in approximately 1995 with his brother, So Nguyen, and his sister, Be Nguyen.

4. Mr Nguyen was in a relationship with his ex-partner Thi Mai Tran from 2011 until 2015 when they separated. During their relationship, they had a daughter together, Stephanie. Despite separating, Mr Nguyen and Ms Tran remained on good terms and would frequently communicate on the phone. Ms Tran remembers Mr Nguyen as "*always a happy man and always very helpful*."[1]

5. In a statement provided to the court, Mr Nguyen's treating General Practitioner, Dr Luke Khongmen, noted that Mr Nguyen was in good health prior to his death.[2] Mr Nguyen had previously been diagnosed with hyperthyroidism, hepatitis B, thalassaemia and asthma. For his asthma, Mr Nguyen was prescribed two puffs daily of Seretide MDI 250/25 dose inhaler, and two puffs every four hours of Ventolin 100mcg dose inhaler, or as required. Dr Khongmen stated that Mr Nguyen's asthma was well managed with the use of the inhalers.

THE CORONIAL INVESTIGATION

6. Mr Nguyen's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). 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. Although Mr Nguyen was required to isolate at home by the Department of Health directives in force in Victoria in July 2020, Mr Nguyen does not fall within the definition of 'in care or custody', however given the novel circumstances, I exercised my discretion to investigate this natural causes death in order to determine whether there was any

[1] Coronial Brief [CB], Statement of Thi Mai Tran pg 15.
[2] CB, Statement of Dr Luke Khongmen pg 18

aspect of his isolation that were problematic or contributory, and if there were any improvements that could be made to the isolation framework for future reference.

7. 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.

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 Tara Sawers to be the Coroner's Investigator for the investigation of Mr Nguyen's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. The Coroner's Investigator also obtained statements from Barwon Health and obtained a copy of the Barwon Health Clinical Incident Review. Having reviewed the brief, I requested and obtained two further statements from Barwon Health regarding their response and policies, two statements from Victoria Police regarding their response and policies, and information from ESTA regarding calls made to triple 000 emergency services.

10. This finding draws on the totality of the coronial investigation into the death of Suong Van Nguyen including evidence contained in the coronial brief. 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.[3]

[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.

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

Circumstances in which the death occurred

11. Mr Nguyen was employed at the Turosi Golden Farm chicken processing plant. On 24 July 2020, Mr Nguyen and his colleagues were directed to stop work and isolate at home after a Covid 19 outbreak was confirmed at the factory.

Timeline of Events

A timeline of Mr Nguyen's time in-home isolation can be constructed from evidence in the coronial brief and the Barwon Health Clinical Incident Review. The timeline sets out the relevant events in chronological order. Issues pertaining to the events within the timeline will be expanded upon later in this Finding where relevant:

12. **On 24 July 2020**, Mr Nguyen commenced home isolation due to potentially being exposed to Covid 19 at his workplace.

13. **On 27 July 2020**, Mr Nguyen was first contacted by the Barwon Health Community Monitoring Team (hereafter referred to as the 'CMT'). The contact was made via the phone and a screening questionnaire was completed.

14. **On 28 July 2020**, Mr Nguyen attended the Geelong Fever Clinic and underwent a Covid 19 test although at this time he was asymptomatic.

15. **On 29 July 2020**, Mr Nguyen had his second contact with the CMT and another screening questionnaire was completed. In a copy of the screening questionnaire obtained by the Court, Mr Nguyen was reported as having a fever within the last 24 hours.[4]

16. **On 31 July 2020**, Mr Nguyen received a positive Covid 19 test result. Mr Nguyen was contacted by the Barwon Health Contact Tracing Team (hereafter referred to as the 'CTT') for a phone interview and completed the Department of Health and Human Services (hereafter referred to as the 'DHHS') 'New Case Questionnaire.' He was then referred back to the CMT for monitoring. Mr Nguyen spoke to Ms Tran and advised her he had tested positive to Covid 19. He asked Ms Tran to send him a photo of their daughter as it was his birthday.[5] Mr Nguyen had a telehealth consultation with his GP on this day. He reported he

[4] Bernadine McNamara [McNamara], Barwon Health General Counsel, *letter to the Coroners Court* dated 16 February 2022 pg 4.
[5] CB, Statement of Thi Mai Tran pg 15.

had a cold, cough and fever but no sore throat over the past two days, but he was already feeling better.[6]

17. **On 1 August 2020,** the Barwon Health Clinical Incident Review records a referral was received by the CMT and appointments booked daily for the following 14 days.

18. **On 2 August 2020,** the CMT contacted Mr Nguyen over the phone. Mr Nguyen reported he had shortness of breath when coughing and lying down, and that his shortness of breath improved when sitting up. This was the last contact the CMT had with Mr Nguyen. Mr Nguyen's landlord approximately 4.00pm observed a container of food being dropped off at his unit and spoke with those delivering, who confirmed that Mr Nguyen had tested positive to Covid 19.

19. **On 3 August 2020,** the CMT made three attempts to contact Mr Nguyen at 10.15am (phone call), 1.40pm (SMS) and 4.15pm (phone call). Mr Nguyen was unable to be contacted on each occasion. The Barwon Health Clinical Incident Review noted that the CMT leader was informed of the failed contact attempts and "*Coordinator confirmed a call to police was made*."[7] Further enquiries with the Emergency Services Telecommunications Authority (ESTA), Victoria's triple zero operator, confirmed that no call to police in respect of Mr Nguyen was made on 3 August 2020 by Barwon Health. In a statement dated 16 February 2022, Barwon Health later confirmed no call was made on 3 August 2020.[8]

20. Ms Tran spoke to Mr Nguyen on the telephone at an unknown time on 3 August 2020. Mr Nguyen told his former partner that "*he was feeling much better*"[9] but Ms Tran thought that "*He sounded short of breath and like he had trouble to breathe.*"[10] Ms Tran told Mr Nguyen that she thought he should go to hospital, but Mr Nguyen declined on the basis it was too busy in the hospitals and if he wasn't well, he would call an ambulance. This was the last known contact with Mr Nguyen.

21. **On 4 August 2020,** there were no attempts to contact Mr Nguyen by the CMT. Ms Tran tried to contact Mr Nguyen via phone and could not reach him. She called three hospitals in Geelong to see if he had been admitted but he had not. Mr Nguyen's neighbour and the

[6] CB, Statement of Dr Luke Khongmen pg 18.
[7] CB, Barwon Health Clinical Incident Review pg 3.
[8] McNamara pg 16.
[9] CB, Statement of Thi Mai Tran pg 16.
[10] As above.

partner of his landlord, Barry Patching, knocked on Mr Nguyen's window as he was worried as he had not seen him for several days however he received no response.[11]

22. **On 5 August 2020,** the CMT attempted to contact Mr Nguyen but it was not documented how many times. The CMT did escalate to Victoria Police via lodgement of an online form with the Police Assistance Line late on 5 August 2020. It was however escalated as a 'COVID 19 isolation breach' rather than a welfare check. Mr Patching again knocked on Mr Nguyen's window and did not receive a response. Mr Patching stated all the lights were off in the unit and also tried his front door which was locked which was unusual. Ms Tran attempted to contact Mr Nguyen but was unable to reach him. Ms Tran stated his phone would go straight to voicemail.[12] Ms Tran would continue to attempt to contact Mr Nguyen via phone everyday until he was located deceased on 9 August 2020.

23. **On 6 August 2020,** the CMT attempted to contact Mr Nguyen on three separate occasions. The CMT also attempted to contact Mr Nguyen's next of kin however a friend of the next of kin answered the call. When this friend was informed that Barwon Health couldn't discuss Mr Nguyen's matter with him as he wasn't the next of kin, the call was immediately terminated.[13] No escalation to Victoria Police was undertaken. Mr Patching observed two persons he described as 'Covid officials', one in civilian dress and another a soldier, knock on Mr Nguyen's door. When they didn't receive a response, Mr Patching observed them leave a card.[14]

24. **On 7 August 2020,** no attempts were made by the CMT to contact Mr Nguyen. Ms Tran attempted to call Mr Nguyen as she had done every day.

25. **On 8 August 2020,** the CMT attempted to contact Mr Nguyen on three separate occasions. The CMT team leader escalated the matter to the DHHS. Mr Patching observed officials again attend Mr Nguyen's property, knock on the door, and not receive an answer.

26. **On 9 August 2020,** the CMT attempted to contact Mr Nguyen a further three times. The CMT team leader again escalated the matter to the DHHS. The DHHS dispatched two Authorised Officers to attend Mr Nguyen's unit. The Authorised Officers knocked on Mr

[11] CB, Statement of Barry Patching pg 12.
[12] CB, Statement of Thi Mai Tran pg 16.
[13] CB, Barwon Health Clinical Incident Review pg 3
[14] CB, Statement of Barry Patching pg 13.

Nguyen's door but were unable to make contact. They observed food packages left at the door.

27. Victoria Police were contacted and attended Mr Nguyen's home at approximately 12.25pm. Police knocked and yelled out Mr Nguyen's name but did not receive a response. Police subsequently obtained a set of keys to Mr Nguyen's flat from the owner of the unit, Mr Nguyen's landlord

28. Police entered the property in full personal protective equipment. Mr Nguyen was located lying on his bed in his bedroom, in circumstances where he was clearly deceased. Police vacated the property shortly after finding Mr Nguyen due to the Covid 19 exposure risk. Ambulance Victoria attended soon after and declared Mr Nguyen deceased.

BARWON HEALTH POLICY

29. Barwon Health CMT last had contact with Mr Nguyen on 2 August 2020, his third day of being a confirmed Covid 19 positive patient. As detailed in the timeline earlier in this Finding, on 3 August 2020 the CMT attempted to contact Mr Nguyen three separate times without success. The court approached Barwon Health regarding what policies/procedures they had in place on 3 August 2020 in respect of the frequency and mode of conducting welfare checks on 'at home' Covid 19 positive patients, and subsequent escalation to external agencies if contact could not be made.

30. In a letter to the court dated 1 July 2022, Barwon Health advised that its policies/procedures were:

    i. If no answer to the 1st call, call again in 30 minutes (2nd call)

    ii. If no reply to 2nd call, send an SMS to the Covid 19 positive patient and call in a further 30 minutes. The text message should read:

        i. 'Barwon Health Call Centre. 2nd call no answer. 3rd call will be at XXX time today. If no answer, we will contact police for welfare check. Please do not reply to this message. You can contact us on 1300 942 241

    iii. If no reply to 3rd call, the matter should be escalated in the following way:

        i. ACTION: Call staff to follow up with confirmed Next of Kin;

ii. ACTION: Call staff to contact Police for welfare check (Refer Police Script)

iii. ACTION: Advise Coordinator on duty

31. As discussed above in the timeline at paragraph 19, Barwon Health initially indicated in the Clinical Incident Review that escalation was made to Victoria Police via 000, however enquires with ESTA revealed no 000 call was recorded from Barwon Health requesting a welfare check on 3 August 2020.

32. The team leader in charge on 3 August 2020 was Ms Linda Kar. When approached for comment by Barwon Health Counsel, Ms Kar expressed doubts that a call to 000 was made, fortified by the absence of any note made by her in Mr Nguyen's records that she had made such a call. Ms Kar stated it was her practice to make notes of actions taken.[15]

33. On the evidence, it is apparent that Barwon Health did not escalate Mr Nguyen's matter on 3 August 2020 to Victoria Police to conduct a welfare check. This omission also occurred on 6 August 2022.

34. On the evidence, it is also apparent that Barwon Health did not contact Mr Nguyen's next of kin on 3 August 2020 given the absence of a note in the contact note in the Barwon Health Clinical Incident Review. The only recorded attempt to contact Mr Nguyen's next of kin was on 6 August 2020.

35. It should also be noted that despite these policies, there were no documented attempts to contact Mr Nguyen on either the 4 or 7 August 2020.

ESCALATION TO POLICE 5 AUGUST 2022

36. Barwon Health's Clinical Incident Review asserted that on 5 August 2020 an undocumented number of attempts were made to contact Mr Nguyen who couldn't be reached, and the case was escalated to the Police Assistance Line, not 000. Barwon Health stated at the time the advice was to submit an online form.

37. In a statement provided to the court, Acting Senior Sergeant Di-Mieri from the Police Assistance Contact Centre confirmed an isolation breach report was submitted by Linda Kar at 5.40pm on 5 August 2020.[16] The description of the online report submitted by Ms Kar was

[15] McNamara, pg 1.
[16] Statement of Acting Senior Sergeant Cody Di-Mieri 6 April 2022, pg 2.

"COVID Call Centre now [sic] answering the phone when should be in isolation."[17] The Police Assistance Line allowed reports to be placed into 5 categories, including 'isolation breach' which was how Ms Kar's report for Mr Nguyen was categorised. There was no 'welfare check' or similar category designed for the purpose of supporting Covid 19 positive patients.[18]

Police Response to Escalation

38. Acting Senior Sergeant Di-Mieri clarified the Police Assistance Line's responsibility regarding Covid 19 breach reports was to receive and triage reports based on the required level of police response. If a report was triaged and deemed to require immediate police response, the report would be escalated to ESTA for a police unit to be dispatched.[19] If a report did not require immediate police response, the report would be closed.

39. A memorandum provided to the court by Inspector Brett Kahan advised that on 5 August 2020, a total of 2422 Covid 19 reports were received by the Police Assistance Line.[20] The report received from Barwon Health on 5 August 2020 did not meet the threshold for escalation and therefore was closed by the Police Assistance Line without further action.[21]

IDENTITY OF THE DECEASED

40. On 21 August 2020 Suong Van Nguyen, born 31 July 1969, was identified via DNA comparison with a sample obtained from his brother, So Nguyen.

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

MEDICAL CAUSE OF DEATH

42. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 17 August 2020 and provided a written report of his findings dated 23 September 2020.

[17] Inspector Brett Kahan, *Memorandum re Coronial Investigation into the death of Suong (Kelvin) Van Nuyem,* 10 June 2022 pg 36.
[18] As above pg 2.
[19] Di-Mieri, 6 April pg 2.
[20] Kahan, pg
[21] As above.

43. The post-mortem examination was consistent with the described circumstances.

44. Toxicological analysis of post-mortem samples identified the presence of ethanol. Dr Bedford provided the opinion that the detection of ethanol was due to decompensation changes within the body and not due to ingestion. No other common drugs or poisons were detected.

45. Dr Bedford provided an opinion that the medical cause of death was 1(a) Covid 19 pneumonia.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

46. The purpose of a coronial investigation of a reportable death[22] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[23]

47. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[24]

48. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[25] Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety

[22] The term is exhaustively defined in section 4 of the ***Coroners Act 2008*** [the Act]. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act).

[23] Section 67(1).

[24] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[25] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

or the administration of justice.[26] These are effectively the vehicles by which the coroner's prevention role can be advanced.[27]

49. It is important to emphasise that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[28]

Covid 19 Pandemic in Victoria in August 2020

50. Whilst Mr Nguyen's death was ultimately one of natural causes, given the context of his isolation I determined the matter needed to be further investigated. The investigation required me to consider the circumstances in the context of the Covid 19 pandemic which had only reached Australian shores in March 2020. Mr Nguyen's home isolation and subsequent infection with Covid 19 occurred during the very peak of Victoria's 'second wave,' with peak daily infections being recorded on 5 August 2020 (725).

51. Barwon Health's response in this matter must be considered in the context of a national public health crisis and a rapidly evolving pandemic of an unprecedented magnitude.

52. The significant increase in demand encountered by the Barwon Health CMT at the height of the second wave is detailed in an email annexed to Barwon Health's statement dated 16 February 2022. On 29 July 2020, two days before Mr Nguyen returned a positive test, the Barwon Health CMT was responsible for the management of 99 active cases of Covid 19. This number grew to 165 cases on 1 August 2020, and to 207 cases by 4 August 2020.[29] These numbers did not include figures from Surf Coast and Golden Plains locales, or the identified close contacts, all of which required monitoring by the CMT.

53. In a further statement provided to the court dated 1 July 2022, Barwon Health elaborated on the challenges of responding in the early stages of the pandemic. Barwon Health described having no fit for purpose IT systems, no previously trained staff, training was on the job and

[26] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.
[27] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.
[28] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).
[29] McNamara pg 9.

processes were continually being developed and modified.[30] In the context of the pandemic in Victoria at the time that Mr Nguyen was Covid 19 positive, it is understandable that Barwon Health CMT was overwhelmed.

Barwon Health Policy Changes

54. On 3 September 2020, Barwon Health updated their policy for the external escalation path for non-contactable Covid 19 patients. It was confirmed that escalation was to be made internally to the Co-Director of the Community Health Rehabilitation and Palliative Care, who was then responsible for escalating to the DHHS and a local police contact by phone and email.[31] This policy remained in place until May 2021 and was fortunately rarely used due to a decrease in positive case numbers and non-contactable Covid 19 patients.

55. As of 3 May 2022, Barwon Health's current process for Covid 19 positive patient who could not be contacted was as follows:

    i. First missed call: Leave voice message that you will call again in 10 minutes.

    ii. Send the following SMS from COVID Monitor

        i. "*Dear [name], Barwon Health Covid Monitoring Team have tried to call you and will try again in 10 minutes. This will be from a private or unknown phone number, please answer. Alternatively you can call us on 42157733*"

    iii. Second missed call (10 minutes after last): Leave voice message that we will contact NOK to perform a welfare check. Send the following second SMS to listed client mobile number from COVID Monitor:

        ii. *"Hi, Barwon Health has again tried to call you again to check in on your wellbeing. Could you call us back on 03 4215 7733 or text us on 0435 184 790 with your full name to let us know you are OK as soon as possible. We will also try your Next of Kin. Thank you*"

    iv. If patient does not respond to above, the Team Leader should be consulted and the level of concern should be considered based on the patient's risk factors. Barwon

[30] As Above pg 3.
[31] Barwon Health, *COVID Monitoring Work Instructions,* 20 September 2020 cl 13.4.

Health has determined a framework to determine a patient's risk considering factors such as whether they live alone, age, comorbidities, last recorded symptoms, amongst other factors.

Adequacy of Victoria Police Response

56. It is clear on the available evidence, and entirely understandable in the circumstances, that Victoria Police had a law enforcement role, focused on compliance with Chief Health Officer's Directions. Given the volume of reports received daily by the Police Assistance Line at the time, and that the service was not established to provide support or welfare checks of Covid 19 positive patients, I have not identified any issues with the action taken by Victoria Police.

FINDINGS AND CONCLUSION

57. The last known contact with Mr Nguyen was a telephone conversation with his former partner, Ms Tran on 3 August 2020. Ms Tran tried to contact Mr Nguyen on 4 August 2020 by phone but was unable to contact him. Mr Nguyen did not respond to Mr Patching's attempt to contact him either on 4 August 2020.

58. Based on the above evidence, I am satisfied on the balance of probabilities that Mr Nguyen died at some time between 3-4 August 2020.

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

i. the identity of the deceased was Suong Van Nguyen, born 31 July 1969;

ii. the death occurred between 3- 4 August 2020;

iii. the death occurred at 2 / 17-19 Lindel Street, Newcomb, Victoria, 3219;

iv. I accept and adopt the medical cause of death as ascribed by Dr Bedford and I find that Suong Nguyen died from Covid 19 Pneumonia; and

v. the death occurred in the circumstances described above.

59. The Covid 19 pandemic challenged Victoria's health system in a manner that was unprecedented. At the time, the rapidly evolving circumstances required ad hoc and innovative responses, however, despite the many and rapidly evolving challenges, I find that Barwon Health's care and clinical management of Mr Nguyen as a Covid 19 positive patient

in home isolation from 3 August 2020 to the date he was found deceased was sub-optimal with respect to its own policies and procedures[32].

60. I find that Barwon Health's failure to escalate Mr Nguyen's case on 3 August 2020 to Victoria Police in accordance with the escalation policy represented a missed opportunity to provide timely treatment to Mr Nguyen, however there is insufficient evidence of a causal link between Barwon Health's failure to escalate Mr Nguyen's lack of response on 3 August 2020 and Mr Nguyen's death as Mr Nguyen's age, respiratory condition (asthma), thalassaemia and hyperthyroidism, and the lethality of Covid 19 likely complicated his experience. Even with the best possible care Mr Nguyen may have succumbed to the disease. Furthermore, I accept that the height of the second wave when Mr Nguyen tragically died was an extremely challenging time for health care providers including Barwon Health.

61. The management of the Covid 19 pandemic by the health profession and supporting government agencies is vastly different now, and such I do not consider it necessary to make any recommendations.

I convey my sincere condolences to Mr Nguyen's family for their tragic 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.

[32] The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the Briginshaw gloss or explications.[32] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

So Nguyen, Senior Next of Kin

Bernadine McNamara, Barwon Health

Inspector Brett Kahan, Covid Response Command

Sergeant Tara Sawers, Coroner's Investigator

Signature:

Coroner Leveasque Peterson

Date : 30 March 2023

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.