STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Sony William Tran-Bui
Hearing dates:	9 to 12 October 2017, 5 March 2018
Date of findings:	13 July 2018
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, peritonitis, Health Problem Notification Form, cell call alarm, knock up, drug withdrawal, observation
File number:	2013/354840
Representation:	Dr P Dwyer, Counsel Assisting, instructed by Mr J Herrington, Crown Solicitor's Office Mr S Brennan for Ms N Crowther Mr G Gemmell for the Commissioner for Corrective Services NSW Ms P Kava for Registered Nurses N Boorer, N Keyes & E Poynter Mr D Nagle for Mr D Cassin and Mr J Lannan Mr D Nguyen for Mr H V Bui Mr P Rooney for Justice Health & Forensic Mental Health Network Mr S Russell for Mr P Katieli

Findings:

I find that Sony William Tran-Bui died on 24 November 2013 at Westmead Hospital, Westmead NSW 2150. Mr Tran-Bui died from complications of acute peritonitis caused by the rupture of a duodenal ulcer. Mr Tran-Bui died of natural causes whilst in lawful custody on remand at the Metropolitan Remand and Reception Centre, Silverwater.

Non-publication orders:

Pursuant to section 74(1)(b) of the *Coroners Act 2009*, I direct that the following material is not to be published:

From the brief of evidence tendered as Exhibit 1 in the inquest which commenced on 9 October 2017:

(a) Tabs 32, 64 and 65: the names, Master Index Numbers, non-association orders, phone numbers and employee daily schedules of any Corrective Services NSW (CSNSW) employee, any person in CSNSW custody, and any non-legal visitor to a CSNSW centre;
(b) Tab 74: any phone number and email address contained in Section 7.17.4.1;
(c) Tab 75;
(d) Tab 76: any phone number contained in Section 13.1.1; and
(e) Tab 77.

Recommendations: ***To the Commissioner for Corrective Services NSW:***

1. I recommend that consideration be given to amending the Custodial Operations Policy and Procedures (**COPP**) to provide that information contained in a Health Problem Notification Form (**HPNF**) relating to an inmate, particularly information that relates to the type of observation required, how frequently such observations are to be performed, and by whom the observation will be attended, be reproduced in a form and placed in a location that is readily accessible and visible by Corrective Services NSW (**CSNSW**) staff rotating between shifts.

2. I recommend that consideration be given to amending the COPP to provide that part of the responsibilities of a CSNSW Officer in Charge is to ensure that CSNSW staff under their supervision, who are rotating between shifts, are aware of:

   (a) information contained in a HPNF relating to an inmate, particularly information that relates to the type of observation required, how frequently such observations are to be performed, and by whom the observations will be attended; and

   (b) information provided by a Justice Health & Forensic Mental Health Network (**Justice Health**) clinical staff member, following the clinical assessment of an inmate, in relation to any ongoing health concern that the inmate may have.

3. I recommend that consideration be given to collaboration with Justice Health in order to devise appropriate and regular education and training programs delivered by Justice Health clinical staff to ensure that CSNSW staff are aware of:

   (a) the importance of the contents of a HPNF in relation to an inmate's good health;

   (b) how to correctly understand instructions contained in a HPNF which relate to observing an inmate's signs; and

   (c) how to effectively carry out instructions contained in a HPNF which relate to ensuring that inmate's good health, particularly those instructions which relate to the type of observation required, how frequently the observation should be made, and by whom the observation will be attended.

Recommendations:

4. I recommend that consideration be given to conducting a review of local procedures at the Metropolitan Remand and Reception Centre in order to determine whether:

   (a) appropriate directions are provided by senior CSNSW staff to other CSNSW staff; and

   (b) whether appropriate monitoring equipment exists; to allow for instructions contained in a HPNF which relate to observing an inmate are able to be followed and implemented effectively in order to ensure that inmate's good health.

5. I recommend that consideration be given to amending the COPP to provide that in response to a cell call alarm relating to an inmate with a health care issue previously identified by Justice Health clinical staff:

   (a) responding CSNSW staff should attend the cell in the company of a Justice Health clinical staff member in order to ascertain that the inmate is in good health;

   (b) in the event that a Justice Health clinical staff member is unable to attend the cell, responding CSNSW staff should approach the task of ascertaining whether the inmate is in good health with a high index of suspicion; and

   (c) in the event that a Justice Health clinical staff member is unable to attend the cell, responding CSNSW staff are to advise the Justice Health Nurse Unit Manager or Nurse in Charge as soon as possible after the cell attendance of the results of speaking directly to, and visually inspecting, the inmate.

To the Chief Executive, Justice Health & Forensic Mental Health Network (Justice Health):

1. I recommend that consideration be given to the circumstances of Mr Tran Bui's death (with appropriate anonymization, and conditional upon consent being provided by Mr Tran Bui's family and following appropriate consultation with them) being used as a case study as part of training provided to Justice Health clinical staff in relation to treatment of inmates presenting with drug withdrawal-like symptoms.

2. I recommend that consideration be given to collaboration with Corrective Services NSW (**CSNSW**) in order to devise appropriate and regular education and training programs delivered by Justice Health clinical staff to ensure that CSNSW staff are aware of:

    (a) the importance of the contents of a HPNF in relation to an inmate's good health;

    (b) how to correctly understand instructions contained in a HPNF which relate to observing an inmate's signs; and

    (c) how to effectively carry out instructions contained in a HPNF which relate to ensuring that inmate's good health, particularly those instructions which relate to the type of observation required, how frequently the observation should be made, and by whom the observation will be attended.

3. I recommend that consideration be given to requiring that following the clinical assessment of an inmate by a Justice Health clinical staff member, and where the inmate is deemed to have an ongoing health concern, the Justice Health clinical staff member is to provide a verbal and written handover to the first available CSNSW Officer in Charge (OIC) of the area where the inmate is housed in order to ensure that the inmate's health concerns are adequately and appropriately managed.

4. I recommend that consideration be to amending *Policy 1.231 Health Problem Notification Form (Adult)* to provide that in the event of a request from CSNSW staff relating to responding to a cell call alarm initiated by an inmate with a health care issue previously identified by Justice Health clinical staff, a Justice Health clinical staff member is to accompany CSNSW responding staff to the cell in order to assist in ascertaining that the inmate is in good health.

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Introduction

1. Mr Sony William Tran-Bui was being held in lawful custody in a NSW correctional centre on the evening of 23 November 2013. He had been remanded in custody nine days prior. Earlier in the day Mr Tran-Bui had been reviewed by nurses working in the correctional centre and had been attended on by correctional officers in the evening after his cellmate had activated a call alarm. Unbeknownst to those involved in these interactions, during the course of the evening Mr Tran-Bui suffered a catastrophic gastrointestinal event that ultimately caused his death the following day.

Why was an inquest held?

2. Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to be answered pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

3. When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the *Coroners Act 2009* (the Act) makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure that the State discharges its responsibility appropriately and adequately. This is so even in cases where the death of a person in lawful custody was due to suspected natural causes.

4. Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made, usually, to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

5. The coronial investigation into the death of a person is one that, by its very nature, occasions grief and trauma to that person's family. The emotional toll that such an investigation, and any resulting inquest, places on the family of a deceased person is enormous. A coronial investigation seeks to identify whether there have been any shortcomings, whether by an individual or an organisation, with respect to any matter connected with a person's death. It seeks to identify shortcomings not for the purpose of assigning blame or fault but, rather, so that lessons can be learnt from such shortcomings and so that, hopefully, these shortcomings are not repeated in the future. If families must re-live painful and distressing memories that an inquest brings with it then, where possible, there should be hope for some positive outcome. The recommendations made by Coroners are made with the hope that they will lead to some positive outcome by improving general public health and safety.

Mr Tran-Bui's life

6. Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future. Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge Mr Tran-Bui's life.

7. At the conclusion of the evidence in the inquest the Court was privileged to be given some insight into the man, father, son and brother that Mr Tran-Bui was. Ms Anh Bui, Mr Tran-Bui's younger sister, and Ms Narelle Crowther, the maternal grandmother of Mr Tran-Bui's five children, spoke some heartfelt words and shared some painfully treasured memories of Mr Tran-Bui's life. The courage and dignity that they showed in doing so was humbling and I express my sincere gratitude and appreciation to them both for doing so.

8. Mr Tran-Bui was known to his family as Bo-Bo, or just Bo. Anh cannot recall how Mr Tran-Bui came by that nickname but, like most things in his life, he embraced it with gusto. Mr Tran-Bui arrived in Australia from Vietnam at a young age after experiencing many struggles in his youth. Through perseverance and determination he completed Year 12 and his Higher School Certificate. This was one of his parents' proudest moments. Anh recalls that to recognise the momentous occasion Mr Tran-Bui's parents gave their son a Walkman CD player with matching earphones. This gift was perfect for Mr Tran-Bui who was a lover of all music, from the hip-hop of Cypress Hill, Wu-Tang Clan and Tupac to classical music. Indeed, Mr Tran-Bui had reached accomplished levels in both piano playing and music theory.

9. Some eight years before his death, Mr Tran-Bui met his partner, Faye Forster. Whilst they experienced some difficult times, like any relationship, they also shared many wonderful moments together, especially later as a young family. Ms Forster's loving concern for Mr Tran-Bui's well-being upon his admission into custody was obvious. She visited him in custody just days before she would tragically have to attend Westmead Hospital in response to his collapse.

10. Mr Tran-Bui had many friends from all walks of life. No doubt they were drawn to his quick smile, sense of fun and caring nature. While the loss they feel must be great, the loss that Mr Tran Bui's partner, parents and family feel is immeasurable.

11. Whilst his parents were immensely proud of his academic achievements, Mr Tran-Bui's own proudest achievements were his five children: Tanh, Alex, Thomas, Lily and Grace. All five of Mr Tran-Bui's children were less than seven years old (and in Grace's case she had not yet been born) at the time of their father's death. It was therefore heartbreaking to hear the words spoken by Ms Crowther of the enormous void that has been created in the lives of Mr Tran-Bui's children due to the loss of their father.

12. It is sometimes easy to forget how seemingly everyday occurrences in life can sometimes cause painfully distressing memories for family members of a loved one, particularly so for children. It was upsetting to hear from Ms Crowther how Mr Tran-Bui's children become distraught when

they see their cousins and friends going camping with their fathers and are unable to do so themselves; how Father's Day is a sensitive time for them; and how Tanh is unable to do something so simple as spend time with his father, amongst the other fathers and sons, after a football game.

13. Mr Tran-Bui was a loving father who is so greatly missed by Tanh; who shared a special bond with Alex (who he nicknamed, Ace) and went everywhere with him; who Thomas described as amazing; and who will never be able to share in and cherish his daughters' special moments in life. To those who knew him best and loved him the most, Mr Tran-Bui's life was enormously treasured and valued, and his death equally tragic and devastating.

14. Ms Forster, Ms Crowther, and Mr Tran-Bui's father and siblings were present in Court throughout the inquest. The enormous grief and loss that they have experienced, and continue to experience, along with other members of Mr Tran-Bui's family who were unable to be present in Court, should be acknowledged.

Background to events

15. On 14 November 2013 Mr Tran-Bui was arrested and charged in relation to a number of criminal offences. He was refused bail and remanded to appear at Burwood Local Court on 22 January 2014. On 15 November 2013 Mr Tran-Bui was taken to the Metropolitan Remand and Reception Centre (**MRRC**) at Silverwater.

16. Rochelle Abustan, a Primary Health Care Nurse, conducted a reception interview with Mr Tran-Bui when he arrived at the MRRC. RN Abustan became aware that Mr Tran-Bui had a recent history of drug and alcohol abuse, anxiety, depression and asthma and completed a Health Problem Notification Form (**HPNF**).[1] It was noted during the interview that Mr Tran-Bui was displaying withdrawal symptoms in the form of vomiting, cramps, moodiness, and flu-like symptoms.[2] RN Abustan made appointments for Mr Tran-Bui to be reviewed by a drug and alcohol nurse, a mental health nurse, and a chronic care nurse. Ms Abustan noted that Mr Tran-Bui was not exhibiting any signs of withdrawal during her assessment, that his vital signs were within normal limits, and that he appeared "*comfortable, calm and cooperative*".[3] At the conclusion of the interview, RN Abustan made the following notation in Mr Tran-Bui's progress notes: "*HOLD in Darcy until cleared by Detox*". This instruction meant that Mr Tran-Bui was to be housed in the Darcy pod until he had been reviewed by a drug and alcohol nurse.

17. RN Yang Guo later performed an initial drug and alcohol assessment the following day, 16 November 2013. RN Guo and RN Elaine Poynter reviewed Mr Tran-Bui again on 17 November 2013. At this time they noted that all of Mr Tran-Bui's vital signs were within normal parameters, although he was displaying some minor symptoms (tremor in his extremities) of alcohol withdrawal.[4] The next morning, RN Poynter reviewed Mr Tran-Bui again in order to monitor the progress of his opiate withdrawal. RN Astrid Munoz later performed a mental health review on 20 November 2013. On the same day Mr Tran-Bui was cleared from detox resulting in his transfer from Darcy pod to Goldsmith pod on 21 November 2013.

[1] Exhibit 1, tab 87, para 8.
[2] Exhibit 1, tab 87, annexure C.
[3] Exhibit 1, tab 87, para 9.
[4] Exhibit 1, tab 93.

21 November 2013

18. On the evening of 21 November 2013 Mr Tran-Bui was in a cell with another inmate. At about 9:45pm the inmate activated a cell alarm for Mr Tran-Bui to receive medical attention. Corrective Services NSW (**CSNSW**) officers responded to the cell alarm and in turn alerted RN Margaret Matambanadzo that Mr Tran-Bui was experiencing a medical issue. RN Matambanadzo attended on Mr Tran-Bui and saw that he was lying in his bed and complaining of lower back pain. RN Matambanadzo examined Mr Tran-Bui and found that he was diaphoretic (sweating heavily) but with nil respiratory distress and no complaint of chest pain.[5] Mr Tran-Bui described his pain as being 5 out of 10. He was offered a wheelchair to be taken to the main clinic, but he refused the offer and instead made his own way there.

19. RN Natalie Boorer reviewed Mr Tran-Bui in the clinic. She noted that Mr Tran-Bui was sweating heavily, had goosebumps and was shivering intermittently.[6] RN Boorer noted that Mr Tran-Bui's vital signs were within normal parameters, that he had a history of heavy daily alcohol use and that his last drink was one week prior. She also noted that Mr Tran-Bui had been cleared from detox the previous day. RN Boorer formed the view that Mr Tran-Bui's symptoms were likely the result of detoxing[7] and she gave him 200mg of thiamine, charted as a standing order. She also gave Mr Tran-Bui 4 tablets of Panadeine (with a further 2 tablets to take overnight) and told him to notify nursing staff if his pain persisted or if he had any other symptoms after he returned to his cell. RN Boorer also placed Mr Tran-Bui on the detox waitlist so that he could be seen the following morning by drug and alcohol staff.

23 November 2013

20. RN Poynter reviewed Mr Tran-Bui on 23 November 2013 after he had been complaining of sweating and goosebumps. RN Poynter took a history from Mr Tran-Bui in which he reported his past alcohol use and abuse of diazepam. He also told RN Poynter that he had had been feeling unwell since being transferred to Goldsmith Pod and that he had smoked some heroin, having last used the day before (22 November 2013).[8]

21. Later that day, at about 2:00pm on 23 November 2013, RN Poynter called Dr Judith Meldrum (a general practitioner with a speciality in drug and alcohol treatment) as part of a routine review. According to notes taken by Dr Meldrum at the time, Mr Tran-Bui was described as appearing generally unwell. Dr Meldrum asked if Mr Tran-Bui had any other conditions or symptoms to indicate the cause of his presentation but none were reported.[9] Dr Meldrum prescribed diazepam for any residual alcohol, opiate, or benzodiazepine withdrawal. It was agreed that Mr Tran-Bui was to have his observations checked again at 5:00pm and that he should be transferred from Goldsmith pod to a medical observation cell in Darcy pod until cleared by detox.[10]

22. RN Poynter completed a HPNF at about 2:11pm.[11] The form contained instructions directed to CSNSW officers in the following terms:

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[5] Exhibit 1, tab 90.
[6] Exhibit 1, tab 91.
[7] Exhibit 1, tab 91.
[8] Exhibit 1, tab 88, page 2.
[9] Exhibit 1, tab 86.
[10] Exhibit 1, tab 88, para 11.
[11] Exhibit 1, tab 97.

Signs/symptoms to look for in the inmate: *DCS officers – please monitor the inmate for the following signs and report any observations of these to JH staff so that they can address the health issue.*

What signs/symptoms DCS officers need to look for:

In withdrawal, paranoid thoughts. Observe for bizaar [sic] behaviour.

23. Later in the HPNF, the following further instructions were provided:

What the DCS officers need to do: *DCS officers – This inmate has special health needs that should be addressed. Please implement the recommendations specified below.*

What DCS officers need to do:

Medical obs cell until clear by detox.

24. RN Nicole Keyes reviewed Mr Tran-Bui later in the day at about 5:15pm. She noted that his vital signs were normal and that he did not appear to have any symptoms of alcohol or opioid withdrawal. RN Keyes also noted that Mr Tran-Bui had no complaints of pain or any other presenting symptoms.[12] Mr Tran-Bui indicated that the diazepam had worked well, that he had slept during the day, and that it was the first time he had slept for several days. Mr Tran-Bui later returned to his cell and was scheduled to be reviewed by a nurse from the drug and alcohol team the following morning.

25. Following his review in the clinic Mr Tran-Bui was taken back to his cell sometime between 5:00pm and 6:00pm.[13] He was sharing the cell with another inmate, Tho Truong Ly. Mr Tran-Bui initially appeared well after his return. However after about an hour or two Mr Tran-Bui began to experience pain in his abdomen.[14] Mr Ly described Mr Tran-Bui as holding his stomach and complaining of pain. He also recalled that Mr Tran-Bui "*screamed that he had pain*" when he used the toilet to open his bowels.[15] Mr Tran-Bui managed to eat some of his dinner[16] but he later vomited in the toilet a couple of times.[17] When Mr Ly told Mr Tran-Bui that he was concerned for his welfare, Mr Tran-Bui told him not to worry. However, Mr Tran-Bui's obvious pain appeared to worsen, leading Mr Ly to activate the cell call alarm (commonly referred to as a **knock up**).

26. Officers David Cassin and James Lannan attended the knock up at 9:52pm. Officer Cassin saw that Mr Tran-Bui was crouched down next to the toilet and not saying anything.[18] Officer Cassin did not ask Mr Tran-Bui any questions.[19] Mr Ly said that Mr Tran-Bui had stomach cramps and that he wanted some food. The officers advised Mr Ly that there was no food to provide to Mr Tran-Bui and left. Both officers reported their attendance at the cell to their supervising officer, Pepe Katieli. After the officers departed Mr Ly noted that Mr Tran-Bui appeared to look a little

[12] Exhibit 1, tab 93, para 8.
[13] Exhibit 1, tab 100, page 4.
[14] Exhibit 1, tab 100, page 4.
[15] Exhibit 1, tab 100, page 5.
[16] Exhibit 1, tab 19, page 10.
[17] Exhibit 1, tab 19, page 7.
[18] Exhibit 1, tab 10, page 12.
[19] Exhibit 1, tab 9, page 10.

better.[20] Mr Tran-Bui told Mr Ly that he felt better around this time and Mr Ly went to sleep at around 10:00pm.[21]

27. However, between about midnight and 6:00am on 24 November 2014 CCTV cameras in Mr Tran-Bui's cell recorded footage of Mr Tran-Bui in distress, holding and rubbing his stomach, crouched on the ground, and repeatedly going to the toilet.

24 November 2013

28. At about 6:45am on 24 November 2013 Mr Tran-Bui left his cell for a shower. A correctional officer described him as appearing off colour and unsteady on his feet[22], and saw him squat down several times. Mr Tran-Bui later approached the pod office and made a comment that he wanted to "*get out*".[23] Mr Tran-Bui was subsequently taken back to his cell.

29. At about 6:50am CSNSW Officer Karieann Odermatt checked on Mr Tran-Bui and saw that he was sliding from his bed onto the floor and appeared to have, what she described as, a "*fit*".[24] Other CSNSW officers were alerted and Justice Health & Forensic Mental Health Network (**Justice Health**) nurses were also called, arriving at the cell within about 5 minutes. Mr Tran-Bui was initially lying on the floor but attempted to sit up when the Justice Health nurses asked if he could hear them. Mr Tran-Bui was unable to sit up and it was noted that he was cyanotic. Mr Tran-Bui was given oxygen but the nursing staff were unable to take his pulse or measure his blood pressure.[25] An ambulance was called as the nurses continued to treat Mr Tran-Bui. It was noted that Mr Tran-Bui was unable to follow simple commands and unable to verbalise anything. A short time later Mr Tran-Bui stopped responding to verbal stimuli and his were no longer responsive or opening spontaneously.[26]

30. Paramedics arrived on scene at about 7:20am and began treating Mr Tran-Bui. By this time Mr Tran-Bui was in sinus tachycardia and his condition continued to deteriorate. A second ambulance was called at 7:35am. At 7:45am Mr Tran-Bui went into cardiac arrest and was in asystole. Cardiopulmonary resuscitation (**CPR**) was commenced and Mr Tran-Bui was given one shock with a defibrillator which was effective. At 8:08am Mr Tran-Bui was transferred by ambulance to the emergency department at Westmead Hospital.

31. Once there, Mr Tran-Bui was provided with Advanced Life Support measures, including oxygen therapy and inotropic agents to support cardiac function. Spontaneous circulation was eventually restored after about an hour of resuscitation but it was noted that Mr Tran-Bui was acidotic with multi-organ failure and fixed and dilated pupils. Given Mr Tran-Bui's very poor prognosis, and following discussions with his family, a decision was made to withdraw all life support measures. Mr Tran-Bui was later pronounced life extinct at 3:46pm.

What was the cause of Mr Tran-Bui's death?

32. Mr Tran Bui was later taken to the Department of Forensic Medicine at Glebe where Dr Rebecca Irvine, senior staff specialist forensic pathologist, performed an autopsy on 28 November 2013.

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[20] Exhibit 1, tab 19, page 3.
[21] Exhibit 1, tab 100, page 6.
[22] Exhibit 1, tab 12.
[23] Exhibit 1, tab 12.
[24] Exhibit 1, tab 14.
[25] Exhibit 1, tab 89.
[26] Exhibit 1, tab 89.

The autopsy revealed evidence of murky fluid in the peritoneal cavity, organising peritonitis and an obvious perforation of the anterior proximal duodenum due to an ulcer. On further examination of the stomach and proximal small bowel, three ulcers were eventually identified in this region, with an ulcer on the posterior wall appearing to penetrate into the head of the pancreas. Ultimately, Dr Irvine concluded that the cause of Mr Tran-Bui's death was complications of acute peritonitis, with rupture of a peptic (duodenal) ulcer being an antecedent cause.

What issues did the inquest examine?

33. During the course of the coronial investigation, and the inquest itself, a number of issues came into focus. These issues fell into three general categories:

    i. Communication of information regarding an inmate's health and welfare between Justice Health staff and CSNSW staff;

    ii. The type of monitoring performed on an inmate in an observation cell;

    iii. The response provided by CSNSW staff in relation to a knock up.

34. Within these categories a number of further issues were also examined. Each of these issues is examined in detail below.

Expert evidence

35. Given the sudden and unexpected nature of Mr Tran-Bui's death, opinion was sought from two independent consultant gastroenterologists in relation to a number of issues below. The Crown Solicitor's Office engaged Dr Christopher Vickers whilst Dr Johan van den Bogaerde was engaged on behalf of Mr Tran-Bui's family. Both of these experts set out their opinions in reports prepared prior to the inquest. A summary of the opinions offered by each of the experts is set out below.

36. In his reports, Dr Vickers:

    i. Opined that Mr Tran-Bui died of complications arising from perforated peptic ulcer disease;

    ii. Described peptic ulceration as a chronic condition with a typical symptom of epigastric pain which waxes and wanes over several months but which, in some patients, can cause no symptomology and result in an acute complication, without warning, of haemorrhage or perforation;

    iii. Explained that diagnosis of peptic ulceration is most commonly made by a gastroscopy and that the usual complication if untreated is haemorrhage or perforation;

    iv. Opined that it was most likely that Mr Tran-Bui perforated his ulcer between 9:20pm on 23 November 2013, when he was seen to hold his stomach, and when Mr Ly sounded the cell alarm at 9:52pm.

v. Explained that an acute perforated ulcer is usually heralded by sudden severe pain and collapse, followed by a period of partial recovery for a few hours until the signs of peritonitis start to develop;

vi. Opined that it was reasonable in the circumstances for Justice Health staff not to have detected Mr Tran-Bui's gastrointestinal pathology and described his case as "*one of those rare and tragic cases where the patient presented with a sudden acute severe complication of peptic ulcer disease without the typical preceding history of months of dyspepsia or epigastric pain*";

vii. Indicated that simple demands for food could not in any way be indicative of the presence of chronic peptic ulcer disease;

viii. Noted that Mr Tran-Bui's main symptoms when he presented on 21 November 2013 were lower or mid-thoracic back pain, sweatiness and diaphoresis, shivers and goosebumps which could have been accounted for by many simple conditions such as drug withdrawal, painful spondylitis or an evolving influenza;

ix. Opined that appropriate vital signs were taken and that nothing about Mr Tran-Bui's presentation on 21 November 2013 could have predicted later events;

x. Opined that the diagnosis of drug withdrawal in relation to Mr Tran-Bui's presentation on 23 November 2013 was reasonable, with nothing in the presentation that could have predicted later events;

xi. Ultimately concluded that "*there were no clues or history at all…that could have reliably predicted an ulcer diagnosis, let alone the sudden and unexpected occurrence of an acute severe complication*".

37. In his report, Dr van den Bogaerde:

i. Opined that Mr Tran-Bui's thoracic back pain when he presented on 21 November 2013 was the foundation symptom, for which an explanation should reasonably have been sought, and was the key to the clinical presentation;

ii. Opined that the thoracic back pain was not explicable by drug withdrawal, and did not fit in the clinical timeframe as Mr Tran-Bui had been cleared of withdrawal on 20 November 2013;

iii. Asserted that there was 48 hours (between 21 November and 23 November 2013) of herald symptomology in the form of thoracic back pain, stomach pain, vomiting, dyspepsia, and inability to tolerate oral intake.

iv. Opined that it was highly unlikely that focused questioning would have missed the presence of three large ulcers and that an appropriate history ought to have been elicited from Mr Tran-Bui;

v. Opined that Mr Tran-Bui's blood pressure measurements on 21 November 2013 showed a "*worrying trend*" and indicated haemodynamic compromise;

vi. Expressed the view that between 21 November and 23 November 2013 nursing staff ought to have performed an abdominal examination of Mr Tran-Bui, and that Mr Tran-Bui ought to have been reviewed and examined by a doctor;

vii. Opined that the diagnosis of Mr Tran-Bui's presentation on 21 and 23 November 2013 as being related to drug withdrawal represented adherence to an incorrect diagnosis and resulted in the poor outcome.

Was Mr Tran-Bui appropriately assessed and treated on 21 November 2013?

38. Following a complaint of thoracic back pain, Mr Tran-Bui was taken to the Justice Health clinic for review. There, he was seen by RN Boorer. In evidence RN Boorer said that she formed the view that all the symptoms which Mr Tran-Bui was presenting with (sweating, goosebumps, shivering) were all linked to drug withdrawal. When asked about Mr Tran-Bui's back pain she explained that complaints of body pain can also sometimes be associated with drug withdrawal. When asked specifically about Mr Tran-Bui's back pain being in the mid-thoracic region she acknowledged that this area would generally not be associated with symptoms of drug withdrawal. However, RN Boorer noted that Mr Tran-Bui did have a history of cardiac issues and, accordingly, explained that this was why she referred him for an ECG test. RN Boorer said that by doing so she was considering other possibilities for the source of Mr Tran-Bui's back pain.

39. When taken to the reference in Dr Van Den Bogaerde's report regarding thoracic back pain being inexplicable by drug withdrawal Ms Boorer explained that this was (to her knowledge) Mr Tran-Bui's first presentation with back pain and that a "*one-off*" presentation was not diagnostic of "*anything in particular*".[27] RN Boorer agreed that withdrawal from drugs and alcohol was a common health condition faced by inmates and that, in her estimation, approximately 50% of inmates experience such issues. Although RN Boorer explained that she did not believe that the back pain was related to any condition other than drug withdrawal, she explained that she referred Mr Tran-Bui for a review by a drug and alcohol nurse in order to be certain.

40. The overall view expressed by Dr van den Bogaerde in evidence was that the initial diagnosis of drug withdrawal was adhered to "*relatively obstinately*" by nursing staff, and that any of Mr Tran-Bui's presenting symptoms would have been ascribed to drug withdrawal.[28] Dr van den Bogaerde summarised it, bluntly, in this way: "*…if your only tool is a hammer, every problem looks like a nail. And unfortunately in medicine, patients present with different pathologies*".[29]

41. In evidence, Dr van den Bogaerde explained that he would have expected RN Boorer to have in mind a number of differential diagnoses. He explained that whilst lumbar back pain is common, thoracic back pain is an unusual presentation and that such a presentation, particularly in someone of Mr Tran-Bui's age, would be a concerning symptom. Dr van den Bogaerde further explained that drug withdrawal could produce arthritic and joint pain but could find no reference in academic literature which discussed thoracic back pain in the context of drug withdrawal. However he did acknowledge that the most common cause of thoracic back pain was muscular-skeletal in origin and that in the context of drug withdrawal this might have been caused by muscle spasm, particularly if a person had sensitivity in the spine.

[27] 9/10/17, T40.12.
[28] 10/10/17, T8.43.
[29] 10/10/17, T8.46.

42. As Dr van den Bogaerde was of the view that thoracic back pain in the context of suspected drug withdrawal was not easy to explain he was also of the view that a proper examination of Mr Tran-Bui's back and abdomen should have been performed. In expressing this view Dr van den Bogaerde emphasised that he had no expectation that RN Boorer, or any other Justice Health nurse, would have diagnosed Mr Tran-Bui's penetrating ulcer; rather Dr van den Bogaerde's view was that RN Boorer should have approached the question of diagnosis with a higher index of suspicion and sought appropriate input from a doctor.

43. Dr Vickers had a different view generally to that of Dr van den Bogaerde. Dr Vickers said that in his view that it was reasonable to assume that Mr Tran-Bui's mid thoracic pain was due to drug withdrawal. He explained that when a person is sweating and shivering (common symptoms of drug withdrawal) their whole muscle system is tense, and that it is very simple for a person to pull or strain a muscle attached to the spine (as a result of spasms associated with withdrawal), thereby causing pain in the mid-thoracic region.[30] Further, Dr Vickers said that a single presentation of pain would not alert a nurse to the presence of another underlying condition unless the pain was severe or accompanied by another serious symptom such as difficulty breathing or walking. Dr Vickers went on to say that if the pain was severe then he would have expected there to be follow up to determine if the pain was still present on any future presentation. Dr Vickers indicated that this, effectively, was why he was not critical of the overall review conducted by RN Boorer: because Mr Tran-Bui had presented with a one-off episode of pain which did not repeat itself.[31]

44. Dr Vickers was asked in evidence whether he considered Mr Tran-Bui's mid-thoracic pain to be an unusual presentation. He explained that if a person had been experiencing spasms and shaking then he would not expect that pain to indicate any other pathology. When referred to the opinions expressed by Dr van den Bogaerde in his report, Dr Vickers said the mid-thoracic back pain "*absolutely*" could have been explained by drug withdrawal.[32] Dr Vickers elaborated by explaining that the physical symptoms of withdrawal might involve spasms or the arching of a person's back which could cause pain anywhere in the body. He explained further that if the pain continued it would warrant further investigation, but if it subsided it could be attributed most likely to muscular skeletal pain.

45. **Conclusion:** Dr van den Bogaerde and Dr Vickers disagreed on the issue of whether it was reasonable to attribute Mr Tran-Bui's mid thoracic pain to drug withdrawal. Given the difficulty in reaching a consensus opinion between two experts in their field, there is no basis to conclude that the review conducted by RN Boorer on 21 November 2013 was inappropriate or inadequate in any way.

46. However, it appears that the consideration given by Dr Vickers to this issue was more carefully considered and should be preferred. Dr Vickers noted two important aspects specific to Mr Tran-Bui's presentation: firstly, that it was single presentation of pain which was not accompanied by any other serious symptoms; secondly, that the physiological effects of drug withdrawal could have resulted in pain to the mid-thoracic region, and indeed any other region, of the body. On this basis, it was reasonable for RN Boorer to consider that Mr Tran-Bui's presenting pain could be attributed to drug withdrawal.

[30] 12/10/17, T23.14.
[31] 12/10/17, T25.19.
[32] 12/10/17, T26.33.

47. Further, the evidence does not support Dr van den Bogaerde's view that a diagnosis of drug withdrawal was adhered "*relatively obstinately*" by RN Boorer and that all of Mr Tran-Bui's symptoms were attributed to this diagnosis. To the contrary, the evidence establishes that, by requesting that an ECG test be performed and being aware of Mr Tran-Bui's cardiac-related history, RN Boorer had considered other diagnostic possibilities.

48. What the events of 21 November 2013 clearly demonstrate is the fact that inmates in correctional centres undergoing drug withdrawal often present with multiple co-morbidities which may sometimes not be causally related to the process of withdrawal. Given the high incidence of persons within the correctional setting that present with drug-related health issues (and the anecdotal evidence given during the inquest was that it was as high as 50%[33]), it is necessary to make the following recommendation.

49. **Recommendation 1:** I recommend to the Chief Executive, Justice Health & Forensic Mental Health Network (**Justice Health**) that consideration be given to the circumstances of Mr Tran Bui's death (with appropriate anonymization, and conditional upon consent being provided by Mr Tran Bui's family and following appropriate consultation with them) being used as a case study as part of training provided to Justice Health clinical staff in relation to treatment of inmates presenting with drug withdrawal-like symptoms.

Was Mr Tran-Bui appropriately assessed and treated at around 1:00pm on 23 November 2013?

50. After complaining of sweating and goosebumps, Mr Tran-Bui was taken to the Justice Health clinic at about 1:10pm on 23 November 2013 where he was seen by RN Poynter. She indicated that she did not review any of Mr Tran Bui's previous progress notes because she did not have access to Mr Tran-Bui's medical file. As a result RN Poynter was unaware that Mr Tran-Bui had reported experiencing mid-thoracic back pain when he presented two days earlier on 21 November 2013. In evidence RN Poynter said that if she had been aware of this presentation she would have elicited further history from Mr Tran-Bui and determined whether he continued to experience such pain. She also said that she would have discussed the issue in her subsequent phone call with Dr Meldrum. In evidence Dr Meldrum herself said that, hypothetically, if the issue had been raised with her she would have queried whether Mr Tran-Bui was still experiencing the same symptoms, and may have suggested that the on-call GP be advised.[34]

51. Dr van den Bogaerde initially said that it was difficult to focus on drug withdrawal issues because the timing "*makes no sense*". He went on to say that if Mr Tran-Bui had been using heroin whilst in custody it would make withdrawal unlikely. However, when asked if a few spots of heroin would alleviate symptoms of withdrawal Dr van den Bogaerde said that he did not know.

52. Dr Vickers said that he would expect that a nurse who was reviewing Mr Tran-Bui on 23 November 2013 to review the progress notes from two days earlier and that it was important to do so. However Dr Vickers acknowledged that even in a non-correctional hospital setting this is sometimes not practically possible.[35] Dr Vickers agreed that good medical practice suggests that a nurse should have at least had access to the notes. If Mr Tran-Bui's previous progress notes had been available to RN Poynter then Dr Vickers said that he would have expected her to

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[33] 9/10/17, T32.16.
[34] 12/10/17, T7.6.
[35] 12/10/17, T32.34.

enquire about the past complaint of back pain in order to determine whether the symptoms had worsened or resolved.

53. **Conclusion:** As RN Poynter did not have available to her any information relating to Mr Tran-Bui's previous complaint of mid thoracic back pain, there is no basis to conclude that the review conducted at about 1:00pm on 23 November 2013 was inadequate. The clear evidence is that if RN Poynter had possessed such information, appropriate enquiry would have been conducted and the issue would have been raised with Dr Meldrum for discussion.

54. Evidence received during the inquest[36] established that health records for all inmate patients in the MRRC are now stored in the main Justice Health clinic, or in a satellite health centre in proximity to a pod. Inmate patients are reviewed in the same health centres where their records are located. If an inmate patient is seen in Darcy pod (such as Mr Tran-Bui was) then their health record must be retrieved from the main clinic. Given the clarification of the current state of health record keeping within Justice Health at the MRRC it is neither necessary nor desirable to make any recommendation.

Was Mr Tran-Bui appropriately assessed and treated at around 5:00pm on 23 November 2013?

55. The evidence established that RN Keyes also did not refer to Mr Tran-Bui's earlier progress notes when she reviewed him later in the afternoon on 23 November 2013. In evidence RN Keyes explained that it was not her usual practice to do so unless the clinical situation warranted it. She explained that because of the volume of the other duties that she was required to perform (looking after approximately 130 inmates during a night shift, distributing medication, monitoring observation cells) she would not spend time reviewing an inmate's progress notes unless she had a particular concern regarding that patient.

56. When asked to compare Mr Tran-Bui's previous vital signs with the vital signs that she took, noting a drop in blood pressure from 123/96 to 108/82, RN Keyes explained that such a change would not have concerned her. She said that the vital signs were still within normal parameters and could be explained by the fact that Mr Tran-Bui had been given diazepam and that he had just woken up shortly before the time of review.

57. RN Keyes was also asked if she turned her mind to other conditions that Mr Tran-Bui may have been suffering from. She explained that she had only been requested to assess Mr Tran-Bui for opioid withdrawal, that she performed that assessment, and that Mr Tran-Bui did not complain of any other condition during that assessment.

58. In evidence Dr van den Bogaerde said that it was understandable that Tran-Bui's first presentation (on 21 November 2013) was not escalated given the dominance of his drug and alcohol issues. However Dr van den Bogaerde went on to express the view that by the time of his second and third presentations (on 23 November 2013) the "*cavalry*" should have been called in, meaning seeking input from a doctor and requesting that they attend on Mr Tran-Bui.[37]

59. Dr van den Bogaerde expressed concern at the measurement of Mr Tran-Bui's vital signs and said that the decreasing blood pressure but increasing pulse rate required an explanation that

[36] Exhibit 6 at [7] to [11].
[37] 10/10/17, T10.8.

could not be attributed only to drug withdrawal.[38] When asked about RN Keyes' reasoning that Mr Tran-Bui's vital signs were explicable by his ingestion of diazepam and the fact that he had just woken up, Dr van den Bogaerde described this "*not a really good explanation*".[39] Accordingly Dr van den Bogaerde remained of the view that Mr Tran-Bui's vital signs demonstrated haemodynamic compromise and that his increased pulse rate in particular, particularly for someone of Mr Tran-Bui's relatively young age, was a concern.

60. In evidence, Dr Vickers was asked about the vital signs taken on 23 November 2013. He said that the presumption made by Dr van den Bogaerde that Mr Tran-Bui was showing hemodynamic compromise was a serious one because it presumed that the previous higher blood pressure reading (leading to a suggestion that there had been a drop by 23 November 2013) was normal. However, Dr Vickers explained that it might equally have been the case that Mr Tran-Bui's normal blood pressure was lower, meaning that the decrease was not as marked. Further, Dr Vickers said that with Mr Tran-Bui's liver disease, state of stress, and dehydration (from drug withdrawal) it was reasonable to expect that Mr Tran-Bui's blood pressure would be elevated over normal.

61. When asked to examine the history of Mr Tran-Bui's blood pressure readings Dr Vickers accepted there was an increase in pulse rate but not a significant one. He explained that examining the readings in isolation was unhelpful without taking into account the clinical context. Dr Vickers expressed it in this way:

> "*…you're looking at figures not what's going on, okay, you've got to see the trees out of the woods. What's going on, he's been arrested, he's in a state of stress, he's then going through a drug withdrawal, and he's been anxious, he's been given diazepam because of anxiety, so all of these things are going to put up his blood pressure, and several days later on the 23rd he's had diazepam, he's been drugged, he's feeling better and his blood pressure has come down. You're not, you've got to look at everything together, not just figures*".[40]

62. Having regard to the above Dr Vickers offered the view that he would expect Mr Tran-Bui's blood pressure to initially increase in such circumstances, but for it to then drop after Mr Tran-Bui came through a period of withdrawal. Dr Vickers went on to explain that the process of withdrawal keeps pulse rate low and a "*vagal state*" predominates.[41] Once released from withdrawal the body normalises and Dr Vickers explained that he would expect pulse rate to increase as overcompensation but then eventually settle. On this basis Dr Vickers did not accept that the changes in Mr Tran-Bui's vital signs represented haemodynamic compromise. It should also be noted that Dr Meldrum in evidence expressed no concern regarding Mr Tran-Bui's vital signs, noting that elevation in pulse rate could have been attributed to drug withdrawal.[42]

63. **Conclusion:** Again, the evidence established disagreement in the expert evidence as to whether Mr Tran-Bui was haemodynamically unstable by the later afternoon of 23 November 2013, and whether such a clinical finding (if it could reasonably have been made) was representative of a more serious underling condition other than drug withdrawal. Again, the more considered evidence provided by Dr Vickers in this regard is to be preferred on the basis that it was based

[38] 10/10/17, T14.18.
[39] 10/10/17, T14.32.
[40] 12/10/17, T62.19.
[41] 12/10/17, T41.2.
[42] 12/10/17, T5.35-50.

on consideration of Mr Tran-Bui's clinical history, and consistent with the opinion expressed by Dr Meldrum.

64. On this basis, the evidence does not establish that Mr Tran-Bui was haemodynamically compromised at this time. Further, the variations apparent in Mr Tran-Bui's vital signs were reasonably attributed to drug withdrawal and there was not an equally reasonable basis to conclude that they were indicative of some underlying pathology. This then leads to the conclusion that the review performed by RN Keyes was adequate and appropriate.

Was there adequate and appropriate communication between Justice Health staff and CSNSW staff regarding Mr Tran-Bui's welfare?

65. At the conclusion of her review of Mr Tran-Bui RN Poynter completed the HPNF dated 23 November 2013 in the terms described above. Any fair reading of the HPNF indicates that it contains instructions as to what signs and symptoms CSNSW staff need to look out for, and what considerations need to be taken into account in housing an inmate. In Mr Tran-Bui's particular case the HPNF established that he was:

    i. in withdrawal, had exhibited paranoid thoughts and was to be observed for bizarre behaviour; and

    ii. was to be held in a medical observation cell until cleared by detox.

66. The answer is perhaps so obvious that it does not require confirmation, but RN Poynter was asked in evidence whether she intended for her instructions to be read by CSNSW staff. She confirmed that this was indeed her intention.[43]

67. However, this did not occur. Officers Lannan, Cassin and Katieli all said in evidence that they had never even seen the HPNF before, let alone read it. Further, the evidence established that at the time of Mr Tran-Bui's death there was no applicable CSNSW policy providing for any requirement to do so.[44] Instead, the combined evidence from all three officers was that, in general, information contained in a HPNF was only used to determine where to house an inmate. Officer Katieli expressed it in this way:

    Q: *Does that mean that in practice in your experience Corrective Services officers ignore that front box [containing information relating to what signs and symptoms CSNSW officers need to look for] and you really just look at the information in the middle about where to place the prisoner?*
    A: *Pretty much, yeah.*

68. The evidence also established that after a HPNF is so used, it is not referred to again by CSNSW staff. Officer Katieli again confirmed the following:

    Q: *That just gets filed and is not given regard to any further in the management?*
    A: *That's correct.*

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[43] 5/3/18, T34.7.
[44] 9/10/17, T80.8.

69. Despite the above, both Officers Cassin and Lannan were taken to the section of the HPNF which indicates what signs and symptoms a CSNSW officer is to look out and agreed that being given such information would be helpful in ensuring the welfare of an inmate.[45] Further, both officers also agreed that it would be useful for CSNSW officers to be provided with further instructions and training regarding how such observations are to be carried out.

70. However, notwithstanding this stated willingness to actually put into effect the intended purpose of the HPNF, a further consideration was revealed during the course of Officer Katieli's evidence. When asked whether he considered the content of the HPNF to be relevant to his duties, Officer Katieli indicated that it was a "*touchy subject*". When asked to explain what he meant by this he said the following:

> "*It's because it's become a union issue because the officers are saying we're not medically trained to recognise - even though they give us the symptoms we're not - how can we recognise or know if an inmate that is sitting, for example, that doesn't tell us anything. That just tells us, someone that's not trained, that he's just sitting there. Now, in our centre alone they don't even get an assigned officer to watch the medical obs because our governor says it's the [sic] duty*".[46]

71. The issue raised by Officer Katieli was put to Mr Terry Murrell (General Manager, State Wide Operations, CSNSW Custodial Corrections Branch) in evidence. Mr Murrell said that it was the first time he had heard of such an issue, expressed concern if such an issue had developed in practice, and that he did not condone such a practice.[47] With respect to the "*union issue*" raised by Officer Katieli, Mr Murrell indicated that whilst CSNSW could provide training to, and re-education of, CSNSW officers in relation to the importance of the HPNF, any union-related issue was a matter for Human Resources.[48]

72. The evidence establishing that the HPNF is not read in its entirety came as a surprise not only to RN Poynter and Mr Murrell but also to Therese Sheehan (Deputy Director of Nursing & Midwifery Services – Custodial Health, Justice Health).[49] During the inquest, Ms Sheehan was asked whether she could think of any way to improve existing systems to allow for the transferral of information contained in a HPNF from Justice Health staff to CSNSW staff, particular in relation to where the HPNF is kept. She answered in this way:

> "*I must admit, not really, because I assumed that the officers would have to look at the case file notes, just [like] the nurses have to look at the medical file"*.[50]

73. In December 2017 CSNSW developed a new Custodial Operations Policy and Procedures (**COPP**) to replace the Operations Procedures Manual (**OPM**) that was in force at the time of Mr Tran-Bui's death. Section 6.1 of the COPP[51] specifically relates to Justice Health notifications and provides for the following in relation to a HPNF:

> "*Make sure advice or recommendations detailed in HPNF are implemented, unless there are overriding security concerns or issues impacting implementation.*

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[45] 9/10/17, T81.5.
[46] 11/10/17, T20.35.
[47] 5/3/18, T43.15-37.
[48] 5/3/18, T44.40-T45.9.
[49] 5/3/18, T45.15; T56.30.
[50] 5/3/18, T56.46.
[51] Exhibit 7.

Any concerns or issues about implementation must be discussed immediately with the Nursing Unit Manager (NUM) or Nurse in Charge (NIC) to make sure the inmate's immediate management is addressed and their health is not compromised".

74. **Conclusion:** Instructions given by RN Poynter in the HPNF dated 23 November 2013 regarding what signs and symptoms CSNSW officers were to look for relating to Mr Tran-Bui were ineffectual. This was due to the simple reason that the HPNF was not read by any of the CSNSW officers on shift at the time.

75. The failure to read the HPNF was the product of a practice which seems to have been adopted by CSNSW officers where information contained in the HPNF was only used for half its intended purpose; that is, to determine where inmates were to be housed, and not to also ensure their general welfare and well-being. In this regard it is important to remember that this was the understood practice of Officer Katieli, a CSNSW officer of more than 27 years experience, and Officer Lannan, a CSNSW officer of more than 17 years experience. Such a practice is plainly inconsistent with ensuring the well-being of inmates with an identified health issue. The surprise expressed by senior personnel within both CSNSW and Justice Health at this general practice only serves to highlight the degree of inadequacy.

76. Notwithstanding the above, the need for a robust policy to ensure that instructions contained in a HPNF are actually implemented by CSNSW officers has been identified by CSNSW. The introduction of Section 6.1 of the COPP is reflective of this. Such an improvement is a welcome one. However it should be noted that Section 6.1 of the COPP does no more than repeat in general terms instructions that were contained in the version of the HPNF that was in operation at the time of Mr Tran-Bui's death. Those instructions provided the following:

"***Department of Corrective Services:*** *Please advise Justice Health staff if you cannot understand the contents of the form, or if you are unable to implement the recommendations.*
…
It is important to follow the recommendations on this form to maintain and improve the inmate's health. If the recommendations cannot be implemented, please notify a Justice Health staff member promptly".

77. It would seem therefore that the issue returns to one of simply making the HPNF accessible to CSNSW staff, not only at the time of the placement of an inmate, but also for the duration that the inmate requires observation. Whist it was indicated by Mr Murrell that he proposed to place the issue of targeted training of CSNSW officers as to the importance of the HPNF on the agenda of his bi-monthly meeting with Justice Health, there is no evidence that this has yet been put into practice.

78. Having regard to all the above considerations it is necessary to make the following recommendations.

79. **Recommendation 2:** I recommend to the Commissioner for Corrective Services NSW that consideration be given to amending the Custodial Operations Policy and Procedures to provide that information contained in a Health Problem Notification Form (**HPNF**) relating to an inmate, particularly information that relates to the type of observation required, how frequently such

observations are to be performed, and by whom the observation will be attended, be reproduced in a form and placed in a location that is readily accessible and visible by CSNSW staff rotating between shifts.

80. **Recommendation 3:** I recommend to the Commissioner for Corrective Services NSW that consideration be given to amending the Custodial Operations Policy and Procedures to provide that part of the responsibilities of a CSNSW Officer in Charge is to ensure that CSNSW staff under their supervision, who are rotating between shifts, are aware of: (a) information contained in a HPNF relating to an inmate, particularly information that relates to the type of observation required, how frequently such observations are to be performed, and by whom the observations will be attended; and (b) information provided by a Justice Health & Forensic Mental Health Network clinical staff member, following the clinical assessment of an inmate, in relation to any ongoing health concern that the inmate may have.

81. **Recommendation 4:** I recommend to the Commissioner for Corrective Services NSW that consideration be given to collaboration with Justice Health & Forensic Mental Health Network (**Justice Health**) in order to devise appropriate and regular education and training programs delivered by Justice Health clinical staff to ensure that CSNSW staff are aware of: (a) the importance of the contents of a HPNF in relation to an inmate's good health; (b) how to correctly understand instructions contained in a HPNF which relate to observing an inmate's signs; and (c) how to effectively carry out instructions contained in a HPNF which relate to ensuring that inmate's good health, particularly those instructions which relate to the type of observation required, how frequently the observation should be made, and by whom the observation will be attended.

82. **Recommendation 5:** I recommend to the Chief Executive, Justice Health & Forensic Mental Health Network that consideration be given to collaboration with Corrective Services NSW (**CSNSW**) in order to devise appropriate and regular education and training programs delivered by Justice Health clinical staff to ensure that CSNSW staff are aware of: (a) the importance of the contents of a HPNF in relation to an inmate's good health; (b) how to correctly understand instructions contained in a HPNF which relate to observing an inmate's signs; and (c) how to effectively carry out instructions contained in a HPNF which relate to ensuring that inmate's good health, particularly those instructions which relate to the type of observation required, how frequently the observation should be made, and by whom the observation will be attended.

83. Counsel for Justice Health submitted that **Recommendation 5** may be unnecessary in circumstances where CSNSW staff are obliged to read a HPNF and inform Justice Health staff if they can or cannot undertake any of the instructions contained within it. This underscores the fundamental issue identified by the evidence at inquest – namely, that the HPNF is not read by CSNSW with an understanding as to its importance in ensuring an inmate's welfare and good health (and not just as an inmate placement tool), or, worse, not read at all – and is precisely why Recommendation 5 is necessary.

84. Indeed, there is a need to ensure that CSNSW staff are provided with the most up-to-date and ongoing information regarding an inmate's health condition that may extend beyond the contents of an initial HPNF. Therefore, the following recommendation is also necessary.

85. **Recommendation 6:** I recommend to the Chief Executive, Justice Health & Forensic Mental Health Network that consideration be given to requiring that following the clinical assessment of an inmate by a Justice Health clinical staff member, and where the inmate is deemed to have an ongoing health concern, the Justice Health clinical staff member is to provide a verbal and written handover to the first available CSNSW Officer in Charge (OIC) of the area where the inmate is housed in order to ensure that the inmate's health concerns are adequately and appropriately managed.

86. It was submitted by counsel for Justice Health that such a recommendation is also unnecessary because any verbal handover would not contain information that was not already contained in a HPNF. The difficulties relating to a HPNF actually being read by CSNSW staff in the way which is intended have already been discussed above and will not be repeated. Suffice to say, the recommendation for there to be some kind of handover between Justice Health staff and CSNSW staff is necessary in order to act as a safeguard in the event that a HPNF is not read as intended (or not read at all), and to ensure that the most current information concerning an inmate's health condition is available.

87. Counsel for Mr Huu Vien Bui submitted that a recommendation should also be made that provides for "refresher" training courses to CSNSW staff in relation to the COPP, suggesting that such training be provided at a minimum of every two years. In this regard it is noted that the COPP was published on 16 December 2017 and has only been in operation for some six months. Further the evidence from Mr Murrell is that onsite training regarding the COPP was provided at the time of its inception.[52] Further, there was insufficient evidence adduced at the inquest to establish that "refresher" training is required in relation to the COPP as a whole. Having regard to these factors, and the terms of **Recommendations 4 and 5** which provide for regular training specific to the issues identified at inquest, it is neither necessary nor desirable to make the recommendation as submitted by counsel for Mr Huu Vien Bui.

Did Mr Tran-Bui's placement in an observation cell allow for effective observation?

88. The above evidence indicates that information contained in the HPNF was used to determine that Mr Tran-Bui needed to be placed in an observation cell (as it was known at the time).[53] The question that arises, even leaving aside the fact that the instructions to observe Mr Tran-Bui for specific signs and symptoms were not read and therefore ineffectual, is whether such a placement actually provided for effective observation of Mr Tran-Bui.

89. The evidence at inquest established that the cell in which Mr Tran-Bui was housed contained two cameras. Footage recorded by the cameras was displayed on monitors both in a central control area, and also on monitors within Darcy pod. In evidence Officer Katieli said that it was his understanding that there were two CSNSW officers in the central control area watching at least 40 monitors, with two monitors dedicated to the 21 safe cells in the entire MRRC.[54]

90. Further, Officer Katieli indicated that footage from Mr Tran-Bui's cell, and 12 other cells, was also displayed on one of two monitors within the office in Darcy pod. However, with respect to these two monitors Officer Katieli said that he was not aware of any policy governing how the footage from Mr Tran-Bui's cell was to be monitored, that no officer during a shift was

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[52] Exhibit 7 at [14].
[53] The new COPP no longer refers to "observation cells" and instead uses the terms "camera cell" and "assessment cell".
[54] 11/10/17, T15.20-50.

designated the task of watching the monitor, and that it was simply the case that any officer on might glance at the monitor if they happened to be in the office during a shift.[55] However, Officer Katieli acknowledged that with the need to attend to other duties it was quite plausible that no officer would look at the pod office monitor for an entire shift.[56] Further, Officer Katieli explained that images displayed on the monitors changed every 1.5 seconds as footage from the 13 cells was cycled through on a continuous basis. On this topic, Officer Katieli gave the following evidence[57]:

Q: *How did you view the utility of those screens changing over every one and a half seconds, was that effective or not?*
A: *No.*

Q: *Why was that?*
A: *Well, it wouldn't give us a true indication of what's going on in the cell.*

Q: *Has that system changed?*
A: *No.*

Q: *Have you ever expressed your frustration or concerns about that system to anybody in senior management?*
A: *No, yeah.*

Q: *Are you aware of any changes being discussed in terms of that system?*
A: *No, I'm not aware.*

Q: *Are there staff meetings that you attend, Officer Katieli, where you can raise any of these operational issues.*
A: *No.*

91. These issues were raised with Mr Murrell in evidence. He initially said that he was unable to comment because he was unfamiliar with local procedures at the MRRC.[58] After being asked to accept that the evidence demonstrated that the footage from Mr Tran-Bui's cell, and others, was not being regularly monitored by any CSNSW officer, Mr Murrell expressed the belief that such footage should be monitored and expressed uncertainty as to why this was not occurring.[59]

92. Mr Murrell was invited to address the issue regarding the cyclic nature of the footage rendering effective observation of an inmate in a cell either difficult or impossible. He explained that there were advantages and disadvantages to having cyclic footage from a number of cells, as opposed to having the ability to focus on one particular cell, and said that this would be "*discussed by management and decision made*".[60] In evidence Mr Murrell explained that the advantage of having static footage was that it would allow for more time to be spent observing an inmate in a cell, whereas the disadvantage would be that this would mean that other cells were not being monitored.[61] Mr Murrell went on to explain that "*if there is a particular concern on one of the*

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[55] 11/10/17, T17.15-35.
[56] 11/10/17, T17.39.
[57] 11/10/17, T28.13-42.
[58] 5/3/18, T45.23,
[59] 5/3/18, T45.42; T46.4.
[60] Exhibit 7 at [17].
[61] 5/3/18, T52.28.

inmates/cells [sic], then [a CSNSW officer] can contact Central Control and alert them to view and monitor a particular cell".[62]

93. Despite the coronial investigation, it appears that the uncertainty expressed by Mr Murrell remains. Information included as part of the written submissions by counsel for the Commissioner for CSNSW indicates that new monitors and cameras are in the process of being installed in the MRRC in various locations, including Darcy pod. There are also further proposals to upgrade camera covers in Darcy Pod and add a dedicated monitor room. However, clarification sought regarding these new changes revealed that the cyclic nature of the footage remains unchanged, with only image quality being improved. Further, there appears to be no change to the matters raised by Officer Katieli regarding the absence of any policy, guideline, or instruction in relation to how footage from cells is to be actually monitored, by whom, and with what frequency.

94. Tragically, in Mr Tran-Bui's case it appears that even if the footage from his cell had been continuously monitored by a CSNSW staff member it would have been unlikely to prompt any further action. During his evidence Officer Cassin was referred to the written log of the footage from about 12:00am to 6:00am on 24 November 2013. He was asked whether, after having attended on Mr Tran-Bui in his cell, he would be prompted to return to the cell if he had seen what was described in the footage as Mr Tran-Bui appearing to be in obvious discomfort, holding and rubbing his stomach, crouching down and repeatedly going to the toilet. Officer Cassin said that he would not necessarily have been so prompted and would have only returned to the cell if there had been a call for assistance.[63] In contrast, Dr Vickers offered the opinion that any layperson who viewed the footage from Mr Tran-Bui's cell from 12:00am to 6:00am on 24 November 2014 would want to call someone for assistance on the basis that Mr Tran-Bui was in "*obviously in distress*".[64]

95. Quite apart from any potential observation that could have been made of Mr Tran-Bui from the footage of his cell, the evidence established that no other effective observation was performed by any CSNSW officer. Although the cell in which Mr-Tran Bui was housed contained Perspex walls to allow for greater visibility into the cell, it appears that no physical observation was performed. This issue was explored with Officer Cassin in evidence[65]:

Q: *Is it your understanding that there is then - as at November 2013 at least there was no particular obligation on night staff to go and check on prisoners in an observation cell?*
A: *At the beginning of the shift we check, we do a head check in the observation cells, but apart from that, no.*

Q: *What does the head check involve, at the beginning of the shift?*
A: *Basically going to the, to the door and turning the light on and checking and making sure they're alive.*

96. It should be noted that Officer Lannan said in evidence that he did not consider that he had any responsibility to even check whether an inmate was alive at any time.[66]

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[62] Ibid.
[63] 9/10/17, T114.40.
[64] 12/10/17, T76.14.
[65] 9/10/17, T78.22.
[66] 10/10/17, T56.23.

97. In her evidence RN Poynter said that she thought Mr Tran-Bui should have been observed at four-hourly intervals, agreed that intervals for observation should be specified on a HPNF, and acknowledged that she had made no such specification on the HPNF which she completed.[67] To address these shortcomings evidence was provided by Justice Health regarding updates that have been made to two relevant policies: *Policy 1.231 Health Problem Notification Form (Adults)* and *Policy 1.340 Accommodation - Clinical Recommendations (Adults)*. The updates provide for the following:

> "*If clinical staff is recommending that a patient be placed in a camera cell for any reason, the HPNF must provide information on the type of observation required and by whom the observation will be attended. For example:*
>
> - *…*
> - *The patient may require CSNSW to observe the patient via the monitor at set intervals for the duration of their placement in the camered cell;*
> - *The patient may need to be physically observed by CSNSW at set intervals for the duration of their placement in the camered cell;*
> - *The patient may need to be physically observed by JH&FMHN staff at set intervals for the duration of their placement in the camered cell.*
> - *If custodial staff advise that they are unable to undertake the type or frequency of observation recommended by JH&FMHN staff, consultation with the Remote Offsite Afterhours Medical Service must occur as the patient may need to be transferred to an external health service for the required level of observation.*"

98. **Conclusion:** Despite placement in a specific cell, with physical measures to facilitate observation, no effective observation of Mr Tran-Bui was actually performed by any member of CSNSW staff on 23 or 24 November 2013. This was due to a combination of factors: lack of direction and guidance regarding how, when and by whom monitoring of cell footage was to occur; the rapid cyclic nature of the footage preventing effective viewing even if it had been monitored; lack of direction and guidance regarding how, when and by whom physical observation at the cell was to be performed; and insufficient instructions being provided on the HPNF dated 23 November 2013, if it had actually been read.

99. The footage from Mr Tran-Bui's cell between at least 12:00am and 6:00am on 24 November 2013 both shows Mr Tran-Bui in obvious distress, and is distressing to watch. Even with the benefit of hindsight, given the degree of distress that Mr Tran-Bui is clearly in, it is difficult to understand how any viewing of the footage for a reasonable time, even by a non-medically trained person, would not prompt at least an enquiry being made as to Mr Tran-Bui's welfare, let alone a call for medical assistance.

100. It is of course not possible to know whether if medical assistance had eventually been sought it might have altered the outcome. Dr Vickers expressed the view in his second report that "*if the perforation were diagnosed or strongly suspected at any time prior to Mr Tran-Bui's collapse then it is likely that his life would have been saved by surgery*". This view is obviously dependent on a diagnosis having been made. Elsewhere in both his reports Dr Vickers also indicated that even the expert medical teams at Westmead Hospital were unable to make the diagnosis of peritonitis despite their combined expertise and available equipment, and in circumstances where Mr Tran-

[67] 5/3/18, T34.43-T35.18.

Bui's condition was at an advanced stage. On this basis, it cannot be stated with certainty whether the outcome might have been different; rather, diagnosis (if it had occurred) resulting in eventual surgery would have given Mr Tran-Bui the best chance of survival.

101. It should be noted at this point that Dr Vickers' reference to the medical teams at Westmead being unable to diagnose Mr Tran-Bui's condition was also the subject of independent expert review. Opinion was sought from Associate Professor John Raftos, an emergency physician. In a report prepared prior to the inquest Associate Professor Raftos noted that no feature of Mr Tran-Bui's history or examination at Westmead Hospital suggested that he had peritonitis. Associate Professor Raftos offered the opinion that the care and treatment provided to Mr Tran-Bui at Westmead Hospital was reasonable and appropriate.

102. It would appear that the policy updates made by Justice Health address the shortcomings identified above regarding the type of observation to be performed, when they are to be performed and by whom. Given that instructions relating to such observations are contained in a HPNF, it is obviously of critical importance that the HPNF is read, and referred to for the duration of the observation. **Recommendations 2, 3, 4, 5 and 6** above have addressed this issue in part.

103. The remaining issue which has not been addressed concerns the effectiveness of any observation performed by a CSNSW officer watching video footage of an inmate which is shown on a monitor. There are obvious technology and resource limitations to take into account in this regard. However, there is no demonstrated evidence that indicates that appropriate consideration is being given to these limitations and their resultant impact on effective observation of inmates. Therefore, it is necessary to make the following recommendation.

104. **Recommendation 7:** I recommend to the Commissioner for Corrective Services NSW that consideration be given to conducting a review of local procedures at the Metropolitan Remand and Reception Centre in order to determine whether (a) appropriate directions are provided by senior CSNSW staff to other CSNSW staff; and (b) whether appropriate monitoring equipment exists; to allow for instructions contained in a Health Problem Notification Form which relate to observing an inmate are able to be followed and implemented effectively in order to ensure that inmate's good health.

Was there an appropriate response to the cell call alarm on 23 November 2013?

105. Officers Cassin and Lannan attended Mr Tran-Bui's cell at 9:52pm on 23 November 2013 following the knock up made by Mr Tran-Bui's cellmate, Mr Ly at 9:48pm. CCTV footage indicates that both officers remained outside the cell and departed at 9:53pm. Neither officer spoke to Mr Tran-Bui. No record was made of the cell attendance and no Justice Health staff member was advised or consulted.

106. In evidence Officer Cassin accepted that he had an obligation to *investigate* the knock up on the evening of 23 November 2013. Whilst initially accepting the premise that investigation would have involved a conversation with Mr Tran-Bui directly, Officer Cassin explained that his investigation was directed to Mr Ly because he was the one who had made the knock up. Officer Cassin agreed that he did not speak to Mr Tran-Bui because Mr Ly had mentioned food and this gave him the belief that the knock up was related to hunger and nothing else. Officer Cassin

agreed that in hindsight he should have spoken to Mr Tran-Bui directly but said that at the time he did not even think twice about it. Officer Cassin also agreed that if Mr Ly had not spoken then he would have made an enquiry with both Mr Tran-Bui and Mr Ly.

107. By way of explanation Officer Cassin said that he had seen many inmates crouching in the manner that Mr Tran-Bui was crouching and that Mr Tran-Bui did not show any symptoms of pain that he could observe. Officer Cassin further explained that Mr Ly was "*taking the lead*" in talking and that if Mr Tran-Bui had said that he was in pain he would have taken Mr Tran-Bui to the clinic or called for assistance from someone with medical knowledge. It was put to Officer Cassin that if Mr Tran-Bui was in fact experiencing pain that this would have prevented his ability to communicate. Officer Cassin did not accept this proposition and instead offered his opposing view which was that if someone was in pain it would make it more likely that they would call for assistance themselves.

108. Officer Lannan was asked why he did not speak to Mr Tran-Bui directly after Mr Ly mentioned that Mr Tran-Bui had cramps. Officer Lannan said that when food was mentioned he deemed the situation not to be a medical emergency. Officer Lannan explained that he believed hunger was the explanation for the cramps and did not consider any other possible explanation. It was put to Officer Lannan that if a cellmate used the knock up and mentioned cramps that some further enquiry was required. However Officer Lannan explained that if confronted now with the same situation as on 23 November 2013 he would not act differently. He said that it was not unusual for a cellmate to not speak to a CSNSW officer and that the mere fact that Mr Tran-Bui was in an observation cell was not suggestive of anything because sometimes inmates are placed in such cells for overflow reasons. Ultimately, however, he agreed that if he had only been told that Mr Tran-Bui was experiencing cramps (without any mention of hunger or food) he would have called a nurse. He also said that he believed that if Mr Tran-Bui needed medical assistance he would have asked for it.

109. The reference to food seems to have taken a position of primacy in the minds of both Officers Cassin and Lannan in their investigation of the knock up. By way of background, Officer Cassin explained that he was aware that inmates receive their last meal of the day between 3:00pm and 3:30pm and that, in his experience, it was not uncommon for inmates to be hungry and requesting food at around 10:00pm. However, Officer Lannan rejected the suggestion that the mention of food by an inmate in relation to a knock up caused him to lose interest. Officer Lannan also agreed that, as general matter, inmates use a knock up for unintended purposes but rejected the suggestion that he had become complacent in his response.

110. Officer Katieli said that he could not recall whether Officers Lannan and Cassin made any mention of food or cramps to him after they had attended Mr Tran-Bui's cell. Officer Katieli was asked what his expectation of an officer would be if the officer was told that an inmate had cramps, was crouching, and wanted food. Officer Katieli said that he expected the officer to pass on the information to him and that he would make a decision about any further action. Officer Katieli was asked to assume that this information had been given to him and asked whether it would cause him to make any further inquiry. He responded by saying that it might have. Finally, the following matter was posed to Mr Katieli[68]:

Q: *Do you agree with this proposition that if somebody is in an observation cell and you find out as one piece of information that they've got stomach cramps, so you know they've got detox*

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[68] 11/10/17, T37.39.

issues and they've got stomach cramps, aren't you better to be safe than sorry and get Justice Health to have a look at them?

A: *Yes, if that's what's required.*

111. In this regard Officer Cassin agreed that it would have been helpful if he was in possession of information relating to any prior health problem that an inmate had had and whether a knock up had previously been used for a health-related problem. He also agreed that it would have been useful for him to have had such information on 23 November 2013.

112. Dr van den Bogaerde considered the issue of hunger to be irrelevant and described the failure to enquire with Mr Tran-Bui as a "*dereliction of duty*" on the part of the CSNSW officers.[69] Dr van den Bogaerde went on to express the view that the CSNSW officers should have entered the cell to look at Mr Tran-Bui and subsequently reviewed CCTV footage from the cell.

113. Dr Vickers was more guarded in his assessment of the cell attendance by CSNSW officers. In his second report he said from the CCTV footage Mr Tran-Bui did not appear to be in any great distress as he had in the previous hour before the knock up. On this basis, and also noting that "*abdominal pain is a very common complaint in the general population and can indicate a multitude of common benign causes*" Dr Vickers offered this opinion:

> "*There just does not appear to be any great display of distress by Mr Tran-Bui at the time of the Officer's visit to the cell door that would have made any reasonable non-medical person be concerned that a Justice Health review was required*".

114. Section 12.1.5.1 of the OPM in operation at the time of Mr Tran-Bui's death concerns the response by CSNSW officers to cell call alarms (knock ups). It provided as follows:

> "*Correctional Officers must respond to every call. Once notified of a cell call or alarm, the night senior or officer-in-charge shall proceed directly to the cell to further investigate the call and if necessary respond to any serious incident. If the night senior or officer-in-charge is not available to immediately respond, the night senior or officer-in-charge must delegate responsibility to another officer*".

115. Section 5.5 of the new COPP concerns cell security or alarm calls. In contrast to the above, procedure 2.3 within Section 5.5 provides that responding CSNSW staff are to proceed directly to the cell identified and:

> "*Ascertain if the inmate(s) that occupy the cell are in good health by:*
> - *Speaking directly with the inmate(s) to identify the cause for the cell call; and*
> - *Visually inspecting the inmate(s)*".

116. **Conclusion:** Given the opinion expressed by Dr Vickers, which is preferred and accepted, there is no basis to conclude that the non-medically trained officers who attended Mr Tran-Bui's cell on the evening of 23 November 2013 should have escalated the attendance to Justice Health staff for further action. However, this opinion is based on the information known to the officers at the time. The questions that arise from this are whether further information ought to have been obtained by: (a) making a direct enquiry with Mr Tran-Bui as to his welfare; and (b) arranging

[69] 10/10/17, T26.31.

for a medically trained person, in the form of a Justice Health staff member, to attend the cell and check on Mr Tran-Bui's welfare.

117. As to the first question, it appears from all of the available evidence that no direct enquiry was conducted with Mr Tran-Bui simply because he did not activate the knock up, and because he did initiate any conversation with the attending officers; rather, it was Mr Ly who did so on both accounts. Given that Officer Cassin accepted in hindsight that he should have spoken to Mr Tran-Bui directly, and that, as a general matter, the need to do so is now reflected in the new COPP, this leads to the conclusion that such a direct enquiry should have occurred.

118. There is no doubt that such an enquiry was simple to undertake and could have been accomplished in a matter of seconds. Even though Mr Ly made the knock up call, the knock up itself related to Mr Tran-Bui. Seeking some confirmation from Mr Tran-Bui that he was experiencing cramps due to hunger (as was thought to be the case) would have represented a thorough and appropriate investigation of the knock up. Of course, it is impossible to know what Mr Tran-Bui might have said if such a direct enquiry had been made (or if he would have responded at all, given the pain he had been experiencing), and whether any response from him might have prompted any action by the attending officers.

119. As to the second question, the idea of arranging for a Justice Health nurse attending knock ups with CSNSW officers was raised during the course of the inquest. In response, Ms Sheehan indicated that arrangements have been made with CSNSW for Justice Health staff to be notified of all knock ups that CSNSW staff at the MRRC were attending after lock-in so that a 3-month trial could be conducted. That trial commenced in December 2017 and appears to have continued at least until May 2018.

120. Expecting non-medically trained personnel, such as CSNSW officers, to be able to make an accurate assessment of the welfare of an inmate is fraught with difficulty, except in cases where an inmate's condition is so obvious as to plainly indicate that medical attention is required. It is therefore necessary to make the following recommendations.

121. **Recommendation 7**: I recommend to the Commissioner for Corrective Services that consideration be given to amending the Custodial Operations Policy and Procedures be amended to provide that in response to a cell call alarm relating to an inmate with a health care issue previously identified by Justice Health & Forensic Mental Health Network (**Justice Health**) clinical staff: (a) responding CSNSW staff should attend the cell in the company of a Justice Health clinical staff member in order to ascertain that the inmate is in good health; (b) in the event that a Justice Health clinical staff member is unable to attend the cell, responding CSNSW staff should approach the task of ascertaining whether the inmate is in good health with a high index of suspicion; and (c) in the event that a Justice Health clinical staff member is unable to attend the cell, responding CSNSW staff are to advise the Justice Health Nurse Unit Manager or Nurse in Charge as soon as possible after the cell attendance of the results of speaking directly to, and visually inspecting, the inmate.

122. **Recommendation 8:** I recommend to the Chief Executive, Justice Health & Forensic Mental Health Network (**Justice Health**) consideration be to amending *Policy 1.231 Health Problem Notification Form (Adult)* to provide that in the event of a request from Corrective Services (CSNSW) staff relating to responding to a cell call alarm initiated by an inmate with a health care

issue previously identified by Justice Health clinical staff, a Justice Health clinical staff member is to accompany CSNSW responding staff to the cell in order to assist in ascertaining that the inmate is in good health.

123. It was submitted by counsel for Justice Health that **Recommendation 8** is unnecessary because such attendances are already occurring, and that it should be noted that Justice Health staff are not normally present during the evening in many correctional centres. However, the evidence which the inquest received to date from Ms Sheehan has been that attendances of Justice Health staff in response to cell call alarms has only been in relation to a trial period to allow for collection of data, and only at the MRRC. **Recommendation 8** envisages arrangements being made beyond any trial period, on a permanent basis, and at all correctional centres.

124. Counsel for Ms Crowther submitted that a recommendation should be made for CSNSW officers "*to make every attempt to communicate directly with any inmate they have concerns about or is the subject of their attention rather than rely on other inmates to provide opinions or second hand information about them*". In view of the introduction of the COPP, and in particular Section 5.5 of the COPP, such a recommendation is already provided for and therefore unnecessary.

Findings

125. Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Dr Peggy Dwyer, Counsel Assisting, and his instructing solicitor, Mr James Herrington of the Crown Solicitor's Office. Their assistance during both the preparation for inquest, and during the inquest itself, has been invaluable. I would also like to thank them both for the sensitivity and empathy that they have shown throughout this matter. I also thank Principal Investigator Mark Farrell, CSNSW Investigations Branch, and Detective Senior Constable Michael Roberts, NSW Police Corrective Services Investigation Unit, for their role in the initial investigation of the matter.

126. The findings I make under section 81(1) of the Act are:

Identity
The person who died was Sony William Tran-Bui.

Date of death
Mr Tran-Bui died on 24 November 2013.

Place of death
Mr Tran-Bui died at Westmead Hospital, Westmead NSW 2150.

Cause of death
Mr Tran-Bui died from complications of acute peritonitis caused by the rupture of a duodenal ulcer.

Manner of death
Mr Tran-Bui died of natural causes whilst in lawful custody on remand at the Metropolitan Remand and Reception Centre, Silverwater.

Epilogue

127. One of the most precious items that belongs to Tanh, Mr Tran-Bui's eldest son, is a photo of his father which is in frame that he bought on Father's Day one year and which he keeps next to his bed. Every night Tanh selflessly says a prayer for his father, to make sure that is happy. This is both an upsetting reminder of how much Mr Tran-Bui is missed by his family, but also an uplifting example of the positive legacy which he has left behind.

128. On behalf of the Coroner's Court, and the counsel assisting team, I extend my deepest sympathies and offer my respectful condolences to Mr Tran-Bui's father; Ms Forster, Mr Tran-Bui's children, Tanh, Alex, Thomas, Grace and Lily; Mr Tran-Bui's siblings; and the rest of Mr Tran-Bui's family for their most painful and tragic loss.

129. I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
13 July 2018
NSW State Coroner's Court, Glebe