JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN
HEARD	**:**	9 AUGUST 2022
DELIVERED	**:**	17 AUGUST 2022
FILE NO/S	**:**	CORC 483 of 2019
DECEASED	**:**	TRAN, QUOC XUAN

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Mental Health Act 2014 (WA)

Counsel Appearing:

Ms S. Markham appeared to assist the coroner.

Ms J. Buller (State Solicitor's Office) appeared for the East Metropolitan Health Service.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Quoc Xuan Tran*** *(also known as Xuan Quoc Tran) with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth on 9 August 2022, find that the identity of the deceased person was* ***Quoc Xuan Tran*** *and that death occurred on or about 10 April 2019 in the waters of the Swan River near Heirrisson Island, East Perth, from immersion (drowning) in the following circumstances:*

Table of Contents

INTRODUCTION

1. Quoc Xuan Tran, also known as Xuan Quoc Tran (Mr Tran) died on or about 10 April 2019 in the waters of the Swan River near Heirisson Island, East Perth from immersion (drowning).[1,2,3,4,5,6,7,8,9,10] At the time of his death, Mr Tran was 36-years of age and was the subject of a community treatment order (CTO)[11] made under the *Mental Health Act 2014* (WA) (the MHA).[12]

2. Accordingly, Mr Tran was an "*involuntary patient*" and thereby a "*person held in care*", so his death was a "*reportable death*".[13] In such circumstances, a coronial inquest is mandatory. Further, where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care that the person received while in that care.[14]

3. On 9 August 2022, I held an inquest into Mr Tran's death. The Brief of evidence tendered at the inquest consisted of two volumes and included reports on the police investigations into Mr Tran's death, medical reports, and Mr Tran's clinical notes. The following witnesses gave evidence during the inquest:

a. Senior Constable N. Foote (Investigating Officer);
b. Dr N. Armstrong (Mental Health Division, Royal Perth Hospital); and
c. Dr J. Soderstrom (Emergency Department, Royal Perth Hospital).

4. The inquest focused on the circumstances of Mr Tran's death and the supervision, treatment and care he received while he was an involuntary patient. I also referred to the issue of supported accommodation services for people with chronic mental illnesses and complex needs.

---

[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (11.04.19)
[2] Exhibit 1, Vol. 1, Tab 4, Life Extinct Form (10.04.19)
[3] Exhibit 1, Vol. 1, Tab 5.1, P92 - Identification of deceased person by other than visual means (11.04.19)
[4] Exhibit 1, Vol. 1, Tab 5.2, Coronial Identification Report (11.04.19)
[5] Exhibit 1, Vol. 1, Tab 5.3, Affidavit - Police Aux. Offr. J Aldridge (11.04.19)
[6] Exhibit 1, Vol. 1, Tab 5.4, Affidavit - Sen. Const. R Allison (12.04.19)
[7] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (23.04.19)
[8] Exhibit 1, Vol. 1, Tab 6.3, Post Mortem Report (12.04.19)
[9] Exhibit 1, Vol. 1, Tab 6.2, Post Mortem Report (16.04.19)
[10] Exhibit 1, Vol. 1, Tab 6.4, Letter - Dr C Cooke (12.04.19)
[11] An order made under the MHA that a person receive treatment on an involuntary basis in the community.
[12] Exhibit 1, Vol. 2, Tab 18, Form 5B - Continuation of Community Treatment Order (29.01.19)
[13] *Coroners Act 1996* (WA), s3
[14] *Coroners Act 1996* (WA), ss22(1)(a) & 25(3)

MR TRAN

Background[15,16,17]

5. Mr Tran was born in Vietnam on 23 February 1983, and came to Australia with his family in 1990 on a humanitarian visa. Mr Tran is the oldest of four children and attended school in Victoria. Although he left school after Year 10, he later completed Years 11 and 12 at TAFE.

6. There is a discrepancy in the records as to Mr Tran's movements after his arrival in Australia. According to a discharge summary from Bentley Hospital, Mr Tran said he came to Perth from Melbourne in 2004 and lived with his uncle, before returning to Melbourne in 2005. Mr Tran said he came back to Western Australia in 2010 and lived with his brother in Geraldton until May 2013, when he was asked to leave because of "*his gambling problems*".[18]

7. According to Mr Tran's brother (Mr T Tran), Mr Tran came to Perth in 2007, where he worked for Mr T Tran and lived with him and his family. This arrangement became untenable because of Mr Tran's behaviour, and he was asked to leave. From that time on, Mr Tran lived in hostels and shared accommodation in Perth.

8. In 2016, Mr Tran was convicted of unlawful trespass and fined. In 2017, he was convicted of unlawful trespass, breach of bail, and four counts of indecent assault. He was placed on a six-month community based order, and fined in relation to these offences.[19]

9. Mr Tran received the disability support pension[20] and his financial affairs were managed by the Public Trustee, following an order of the State Administrative Tribunal (SAT) on 7 November 2018. The SAT also ordered that the Public Advocate be appointed as Mr Tran's "*limited guardian*" to make treatment decisions, determine the services he should have access to, and where and with whom he should live.[21,22]

---

[15] Exhibit 1, Vol. 1, Tab 2, Report - Sen. Const. N Foote (04.08.19), pp2-3
[16] Exhibit 1, Vol. 1, Tab 8.3, Statement - Mr T Tran (06.05.19), paras 3-8
[17] Exhibit 1, Vol. 1, Tab 16.2, Client Management Plan (14.03.19), p1
[18] Exhibit 1, Vol. 2, Tab 18, Bentley Hospital - Inpatient discharge letter (01.06.16)
[19] Exhibit 1, Vol. 1, Tab 14, History for Court: Criminal & Traffic, Mr X Tran
[20] Exhibit 1, Vol. 2, Tab 18, Centrelink income statement (27.03.19)
[21] Exhibit 1, Vol. 2, Tab 18, Order of Member D Quinlan, State Administrative Tribunal, (07.11.18)

MANAGEMENT OF MR TRAN'S MENTAL HEALTH

Mental health issues[23,24,25,26]

10. Mr Tran's first recorded contact with mental health services appears to have been in Victoria in 2002, when he was diagnosed with paranoid schizophrenia. He was subsequently diagnosed with comorbid anxiety disorder in 2004, and his habitual and impulsive gambling was noted.

11. At the time of his death, Mr Tran's diagnoses were schizoaffective disorder and autism spectrum disorder. He regularly reported auditory hallucinations and at times, he exhibited aggressive and/or agitated behaviour. He was described as "*always rather abrupt and concrete*" and was considered to have "*probable cognitive dysfunction/low IQ*" rather than linguistic difficulties.

Management as an inpatient[27,28,29,30,31,32,33]

12. Mr Tran's first recorded admission to a psychiatric facility was in Victoria in 2004. In July 2013, he had a one-week admission to Swan District Hospital following a dispute with a family member, and on 14 June 2015, police took Mr Tran to Joondalup Health Campus for examination. On that occasion, he presented as mute and appeared to be responding to unseen stimuli. He was transferred to Mills Street Centre (Centre), a part of the Bentley Hospital campus, on 16 June 2015.

13. Mr Tran was initially managed on a secure ward and an attempt to transfer him to an open ward on 12 July 2015, was unsuccessful because of his disinhibited and inappropriate behaviour towards women. He was eventually moved to an open ward on 24 July 2015, where he was managed with "*firm boundaries and lots of structure*".

---

[22] It appears that prior to this time, Mr Tran's affairs had been managed by the Victorian Civil and Administrative Tribunal
[23] Exhibit 1, Vol. 2, Tab 18, Mr Tran's medical records (various dates)
[24] Exhibit 1, Vol. 1, Tab 15.1, Report - Dr J Soderstrom
[25] Exhibit 1, Vol. 1, Tab 16.1, Report - Dr N Armstrong (11.02.22) & ts 09.08.22 (Armstrong), pp12-13
[26] Exhibit 1, Vol. 2, Tab 18, Bentley Hospital - Inpatient discharge letter (01.06.16)
[27] Exhibit 1, Vol. 2, Tab 18, Bentley Service Medical Records (various dates)
[28] Exhibit 1, Vol. 1, Tab 16.5, Letter Dr A Jaworska to Mental Health Review Board (undated, but apparently Sep 2015)
[29] Exhibit 1, Vol. 2, Tab 18, Bentley Hospital - Inpatient discharge letter (01.06.16)
[30] Exhibit 1, Vol. 1, Tab 16.3, Bentley Hospital Discharge summary (05.04.18)
[31] Exhibit 1, Vol. 1, Tab 16.2, Bentley Clinic Client Management Plan (14.03.19)
[32] Exhibit 1, Vol. 1, Tab 16.4, Report - Dr E Tay to Mental Health Tribunal (05.11.18)
[33] Exhibit 1, Vol. 1, Tab 16.1, Report - Dr N Armstrong (11.02.22), p1

14. Mr Tran's mental state appeared to improve, but on 13 August 2015 (while he was on leave from the Centre), Mr Tran attacked a shopping centre security guard who Mr Tran said was "*following him*". Mr Tran was returned to the Centre and expressed persecutory delusions relating to security guards and the police. Mr Tran was placed in a secure ward and managed there until 2 September 2015, when he was moved to an open ward. He was discharged home on a CTO on 14 September 2015.

15. On 20 October 2015, Mr Tran presented to the Centre in crisis after being evicted from his accommodation following a conflict with his "*landlady*". He was admitted for three days, during which time he told his treating psychiatrist that his depot medication (flupentixol) was "*making him ill*". Although consideration was given to trialling Mr Tran on olanzapine, he continued to be given depot injections of flupentixol.

16. Mr Tran was admitted to the Centre again on 19 May 2016, following behavioural concerns at his shared accommodation, where he had been screaming, shouting, and making inappropriate comments of a "*sexualised nature*". During this admission, Mr Tran was unsettled for long periods, but he was discharged home on a CTO on 1 June 2016. By this time, his depot medication had been changed to paliperidone.

17. On 27 March 2018, Mr Tran was taken to the Centre after he was found repeatedly pressing a pedestrian traffic signal on a busy highway. He was admitted as a voluntary patient and diagnosed with schizoaffective disorder and autism spectrum disorder. He displayed episodes of agitation and aggression without any obvious trigger, ongoing thought disorder, and persecutory delusions. He also had limited insight into his mental illnesses, but was eventually discharged home on 5 April 2018, again on a CTO.[34]

18. On 9 October 2018, Mr Tran presented to Royal Perth Hospital (RPH) with suicidal ideation after he was evicted from Tate Lodge, where he had been staying.

[34] Exhibit 1, Vol. 2, Tab 18, Bentley Hospital - Discharge Summary (05.04.18)

19. A psychiatric assessment found no psychotic symptoms, and Mr Tran guaranteed his safety. Temporary accommodation was arranged and Mr Tran was discharged.[35,36] He returned to RPH on 11 October 2018 saying he had nowhere to live and had "*tried to jump into (the) river*". Mr Tran asked if he could stay in the RPH emergency department (ED) overnight and he was subsequently admitted. A social worker arranged weekend accommodation for Mr Tran at Globe Backpackers, a hostel in Wellington Street in Perth (the Globe) and he was discharged from RPH on 12 October 2018.[37]

20. When Mr Tran was reviewed by the RPH social worker on 15 October 2018, he said he had "*thoroughly enjoyed*" his time at the Globe and asked for this to be made a permanent arrangement. The social worker emailed Mr Tran's case manager at Bentley Clinic (Clinic) to confirm that his "*administrator*" had been asked to fund the placement. Mr Tran told the social worker he no longer wished to pursue the option of private rental accommodation, and a planned referral to an "*interim accommodation service*" was not pursued as Mr Tran said he was happy at the Globe.[38]

Management in the community[39,40]

21. Other than infrequent inpatient admissions, Mr Tran was managed in the community on a succession of CTO's from 2015. He received regular depot injections of antipsychotic medication at the Clinic and although his mental health appears to have been stable for extended periods, Clinic records do contain several examples of management issues.

22. On 8 September 2018, the landlord of Mr Tran's shared accommodation contacted the Clinic to advise that other residents had complained that Mr Tran was "*screaming at the top of his lungs*". Although Mr Tran usually calmed down when spoken to by his landlord, on this occasion Mr Tran had kept screaming "*I own this, I own this*" down the phone.

[35] Exhibit 1, Vol. 1, Tab 17, RPH Emergency Department Notes - E7811214 (09.10.18)
[36] Exhibit 1, Vol. 1, Tab 17, RPH Adult Triage Nursing Assessment - E7811214 (09.10.18)
[37] Exhibit 1, Vol. 1, Tab 17, RPH Adult Triage Nursing Assessment - E7811214 (11.10.18)
[38] Exhibit 1, Vol. 2, Tab 18, Email - RPH Social worker (16.10.18)
[39] Exhibit 1, Vol. 1, Tab 15.1, Report - Dr J Soderstrom & ts 09.08.22 (Sonderstrom), pp22-29
[40] Exhibit 1, Vol. 1, Tab 17, RPH Medical Records - E7811214,

23. When Clinic staff arrived on the scene, police were in attendance. Mr Tran appeared to have calmed down and he accepted a dose of olanzapine. No issues were noted when he was followed up in the Clinic on 11 September 2018.[41]

24. On 4 February 2019, Mr Tran told his treating psychiatrist (Dr Tay) that he was happy at the Globe and enjoyed living in the city. Although he declined to seek alternative accommodation, Dr Tay noted: "*the plan is to go and look for alternative accommodation in the near future*".

25. On 18 March 2019, Mr Tran attended the Clinic with an obviously swollen and discoloured left eye. When his case manager asked him about the injury, Mr Tran said, "*I can't talk*" and that someone had "*hurt him*". When reviewed by Dr Tay, Mr Tran said someone had walked into his room and assaulted him, but that he had heard the voices of his brother and his "*girlfriend*" telling him that the assault was part of a "*health check*" to see how well his body would "*heal*". Mr Tran disclosed previous assaults but repeated his "*fixated belief*" that the Globe was the best place for him.[42,43]

26. During the last 30 months of his life, Mr Tran was evicted from his accommodation on five occasions and he experienced an exacerbation of his symptoms when this occurred.[44] Mr Tran's case manager at the Clinic was extremely proactive in trying to secure alternative accommodation for him, and made referrals to:

a. Access Housing Supported Accommodation (10.08.18);[45]
b. Department of Housing (16.08.18);[46]
c. Richmond Wellbeing Recovery House (01.10.18);[47]
d. St Bartholomew's House (05.10.18)[48] & Bentley Village (20.10.18);[49] and
e. Individualised Community living Strategy (26.03.19).[50]

[41] Exhibit 1, Vol. 2, Tab 18, Bentley Clinic - Service Events (08.09.18 & 11.09.18)
[42] Exhibit 1, Vol. 2, Tab 18, Bentley Clinic - Service Events (04.02.19 & 18.03.19)
[43] Exhibit 1, Vol. 2, Tab 18, Email - Dr E Tay to Case manager (18.03.19)
[44] Exhibit 2, Root Cause Analysis (26.09.19), p2
[45] Exhibit 1, Vol. 2, Tab 18, Access Housing - Application form (10.08.18)
[46] Exhibit 1, Vol. 2, Tab 18, Department of Housing - Application form (16.08.18)
[47] Exhibit 1, Vol. 2, Tab 18, Richmond Wellbeing Recovery House - Application form (01.10.18)
[48] Exhibit 1, Vol. 2, Tab 18, Letter - St Bartholomew's House (05.10.18), confirming Mr Tran was on the waitlist
[49] Exhibit 1, Vol. 2, Tab 18, Letter - Bentley Village - St Bartholomew's House (20.10.18)
[50] Exhibit 1, Vol. 2, Tab 18, Individualised Community Living Strategy - Nomination form (26.03.19)

27. Mr Tran's fixed belief that staying at the Globe was "*in his best interests*" clearly hampered his case manager's efforts to find him alternative accommodation. It is also the case that non-Government accommodation services have various levels of expertise in dealing with long-term mental illnesses and/or challenging behaviours, meaning that some services are unable to accept people presenting with these issues.[51]

Community treatment orders and the Mental Health Tribunal[52]

28. Under the MHA, a person is not to be placed on a CTO unless: "*[T]he person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making a community treatment order*".[53] Mr Tran was placed on a CTO following his discharge from the Centre on 14 September 2015, and managed on a succession of CTOs thereafter.

29. Mr Tran's management was the subject of periodic reviews by the Mental Health Tribunal (Tribunal). At these hearings, the Tribunal reviewed Mr Tran's care, and the Brief contains reports prepared by clinicians for hearings in 2016, 2017 and 2018.[54,55,56] In a report to the Tribunal dated 5 November 2018, Dr Tay stated:

> I would recommend that Mr Tran remains under a Community Treatment Order with regular depot long acting anti-psychotic medication to control the worst of his psychotic symptoms which will afford him the best opportunity for treatment in the least restrictive option in order that he can live safely in the community.[57]

30. A CTO was required in Mr Tran's case because he lacked insight into his mental illness and was unable to make treatment decisions. There was also a high risk he would be non-compliant with his medication, and the CTO provided a mechanism by which Mr Tran could be admitted to hospital on an involuntary basis if he refused to accept his depot injections.[58]

---

[51] ts 09.08.22 (Armstrong), p17
[52] Exhibit 1, Vol. 2, Tab 18, Bentley Service Medical Records (various dates) and ts 09.08.22 (Armstrong), pp13-14
[53] *Mental Health Act 2014* (WA), s25(2)(e),
[54] Exhibit 1, Vol. 2, Tab 18, Report for Mental Health Tribunal - Dr A Jaworska (27.06.16 & 19.09.16)
[55] Exhibit 1, Vol. 2, Tab 18, Reports for Mental Health Tribunal - Dr S Sharma (26.04.17 & 31.01.18)
[56] Exhibit 1, Vol. 2, Tab 18, Report for Mental Health Tribunal - Dr E Tay (30.4.18)
[57] Exhibit 1, Vol. 2, Report for Mental Health Tribunal - Dr E Tay (05.11.18), p3
[58] See: *Mental Health Act 2014* (WA), Division 4, Part 8

EVENTS LEADING UP TO MR TRAN'S DEATH

Presentation to RPH - 8 April 2019[59,60,61]

31. Mr Tran presented to RPH's ED at 9.47 am on 8 April 2019, asking for help with accommodation. In common with all patients presenting to the ED, Mr Tran was assessed by a triage nurse and given an "Australian Triage Score" (ATS), indicating how quickly he needed to be seen. Mr Tran's ATS was "5", meaning his presentation was assessed as non-urgent.[62]

32. Mr Tran was referred to the Homeless Health Care Team ("HHCT"), which provides an "*in-reach*" service to ED patients experiencing homelessness. Mr Tran was seen by a HHCT worker at 11.43 am. The worker reminded Mr Tran of the previous referrals to supported accommodation services, including Richmond Wellbeing and St Bartholomew's House that had been made on his behalf, and their respective waitlist requirements.

33. Although Mr Tran reportedly told the HHCT worker "*I have no options, nowhere to stay and I will die soon*", he confirmed he was able to live at the Globe until 21 April 2019. Mr Tran declined case management under RPH's "Choices program", and the HHCT worker gave him written information about emergency accommodation options including drop-in centres and 55 Central, a 24-bed crisis accommodation service located in Maylands.[63]

34. Mr Tran was seen by an ED consultant at 12.53 pm, who assessed him as experiencing a "*situational issue*". The ED consultant's entry in the medical notes includes the words "*Nil acute medical or mental health issue(s)*". At the inquest, Dr Jessamine Soderstrom[64] confirmed that this entry meant that the ED consultant had conducted an assessment of Mr Tran's risk of self-harm and/or suicide.[65]

---

[59] Exhibit 1, Vol. 1, Tab 15.1, Report - Dr J Soderstrom & ts 09.08.22 (Sonderstrom), pp23-27
[60] Exhibit 1, Vol. 1, Tab 17, RPH Homeless Health Care Team notes - E7811214 (08.04.19)
[61] Exhibit 1, Vol. 1, Tab 17, RPH Emergency Department Notes - E7811214 (08.04.19)
[62] ts 09.08.22 (Sonderstrom), pp22-23
[63] See: www.55central.asn.au
[64] Dr Soderstrom is the Co-Deputy Head of the Emergency Department at RPH
[65] ts 09.08.22 (Sonderstrom), pp27-29

35. Dr Soderstrom confirmed that not every patient presenting at the ED with a "situational crisis" is assessed by the psychiatric team. Nevertheless, it is standard procedure for the ED clinician who reviews the patient to conduct an assessment of the person's risk of self-harm and/or suicide. Dr Soderstrom maintained that the ED consultant's entry in the notes confirmed that a risk assessment had been performed, although she agreed that the entry could have been more comprehensive.[66,67]

36. I note that when Mr Tran presented to RPH on 9 October 2018, he was assessed by the psychiatric team. The medical notes for that presentation say that Mr Tran had been evicted from his accommodation and had expressed suicidal ideation, namely: "*I need something to die quickly*". The psychiatric team found Mr Tran was not experiencing any formal thought disorder and had no psychotic features. Temporary accommodation was provided, and Mr Tran subsequently left the ED.[68]

37. In contrast, when Mr Tran presented to RPH on 8 April 2019, he still had accommodation at the Globe until 21 April 2019, and did not specifically express suicidal ideation, although as mentioned, he did tell a HHCT worker that he would *"die soon*".[69]

38. Following an inquest I conducted in 2021, I referred to a Health Department policy that required clinicians to make contemporaneous entries in a patient's clinical record. The policy also states that: "*The absence of documentation infers care is not completed and may be interpreted by a court of law as evidencing neglect of the patient*".[70]

39. Whilst it is unfortunate Mr Tran's risk assessment on 8 April 2019 was not documented more fully, I accept there is a significant tension between providing clinical services in a busy emergency department and documenting that service in the medical notes.

---

[66] Exhibit 1, Vol. 1, Tab 17, RPH Emergency Department Notes - E7811214 (12.53 pm, 08.04.19)
[67] ts 09.08.22 (Sonderstrom), p29
[68] Exhibit 1, Vol. 1, Tab 17, RPH Emergency Department Notes - E7811214 (09.10.18)
[69] Exhibit 1, Vol. 1, Tab 17, RPH HHCT notes - E7811214 (08.04.19)
[70] Inquest into the death of Mr Cyril Churchill [2021] WACOR 9 (published 26.03.21), paras 236-237

40. After carefully considering the available evidence, I have concluded that Mr Tran was the subject of a risk assessment during his presentation at RPH on 8 April 2019. Further, on the basis of Dr Soderstrom's evidence, I am satisfied that had Mr Tran exhibited psychotic symptoms, and/or been assessed as suicidal, he would have been referred to the psychiatric team for assessment. In any event, the medical notes indicate that Mr Tan left RPH at about 2.15 pm and it appears he returned to the Globe, where it is known he slept the night on 9 April 2019.[71]

Attendance at the Clinic - 9 April 2019[72,73,74]

41. On 8 April 2019, Mr Tran failed to attend the Clinic for his depot injection, and his case manager went to the Globe. Hostel staff told her that Mr Tran had checked out that morning, claiming his mobile had been stolen. Staff also said they thought Mr Tran "*was scared by something or someone*" and had given them a packed suitcase "*to dispose of*". The case manager retrieved Mr Tran's suitcase, and after conferring with Dr Tay, decided to wait until Mr Tran presented to hospital, (as he had done on other occasions).

42. On 9 April 2019, Mr Tran attended the Clinic for his depot injection. Whilst the observations of Globe staff the previous day suggest he may have been experiencing psychotic symptoms, Mr Tran was described as "*well-groomed, polite and cooperative*" during this presentation. Mr Tran accepted his depot injection and Clinic notes make no mention of any psychotic symptoms or self-harm/suicidal ideation.

43. At the request of his case manager, the nurse giving Mr Tran his depot injection asked where he had spent the previous night. Mr Tran said he had slept at the Globe and this was confirmed when the nurse called hostel staff, who also said the Globe was closing down on 21 April 2019. Mr Tran was given back his suitcase and he told the nurse he would catch a bus back to the city. Clinic notes state: "*Clinician trying to secure him a place at Bentley Villas*".[75]

[71] Exhibit 1, Vol. 2, Tab 18, Bentley Clinic - Outpatient Notes (09.04.19)
[72] Exhibit 1, Vol. 2, Tab 18, Bentley Clinic - Service Events (09.04.19)
[73] Exhibit 1, Vol. 2, Tab 18, Bentley Clinic - Outpatient Notes (09.04.19)
[74] Exhibit 1, Vol. 2, Tab 18, Bentley Clinic - Outpatient Notes (08.04.19)
[75] Exhibit 1, Vol. 2, Tab 18, Bentley Clinic - Outpatient Notes (09.04.19)

44. When Mr Tran's case manager called him on 10 April 2019 there was no reply, and she left a voice message asking him to call back. The Clinic notes state: "*Visit tomorrow to backpackers to discuss move and possible accommodation*." However, for reasons I will now explain, the case manager's planned home visit did not take place.[76]

Mr Tran's body is located[77,78,79,80,81]

45. Shortly before 12.30 pm on 10 April 2019, a member of a water-skiing display team (Skier) was in a boat on the Swan River in the vicinity of the Western Australian Water Sports Centre located on Camfield Drive in Burswood. The Skier was checking for debris prior to the start of a skiing event and noticed an object floating in the water. This turned out to be Mr Tran, who was floating on his back and not moving. The Skier contacted the event organiser, and she contacted police.

46. Police arrived on the scene and used a private boat to bring Mr Tran's body to shore. Ambulance officers, who had arrived before the police, confirmed that Mr Tran had died.[82,83] Mr Tran showed no obvious signs of trauma and was wearing dark blue tracksuit pants, black socks, brown sneakers, black underwear, and a dark blue top. Digital photographs of Mr Tran's fingerprints were taken and used to identify him, and his body was taken to the State Mortuary for a post mortem examination.[84,85,86,87]

47. At about 2.25 pm on 11 April 2019, a cyclist (Cyclist) noticed what appeared to be a new grey and black jacket next to a tree on the north-eastern end of Heirisson Island. A pensioner concession card bearing Mr Tran's name and address had been placed on top of the jacket, along with a Smartrider card, and a key with a tag bearing the number "19". Nobody was in the vicinity of the jacket, and the Cyclist called police.[88]

---

[76] Exhibit 1, Vol. 2, Tab 18, Bentley Clinic - Outpatient Notes (10.04.19)
[77] Exhibit 1, Vol. 1, Tab 10, Statement - GP (24.05.19), paras 2-12
[78] Exhibit 1, Vol. 1, Tab 2, Report - Sen. Const. N Foote (04.08.19), pp1-2 and ts 09.08.22 (Foote), pp6-11
[79] Exhibit 1, Vol. 1, Tab 3, Report - Det. Const. C Alexander (11.04.19), pp1-3
[80] Exhibit 1, Vol. 1, Tab 11, Statement - Det. Sen. Const. A Clarke (07.05.19), paras 2-12
[81] Exhibit 1, Vol. 1, Tab 13, Scene photographs - Heirisson Island, showing Mr Tran's belongings (JSG1- JSG18)
[82] Exhibit 1, Vol. 1, Tab 12, St John Ambulance Patient Care Record, Crew VPK22D2 (10.04.19)
[83] Exhibit 1, Vol. 1, Tab 4, Life Extinct Form (1.50 pm, 10.04.19)
[84] Exhibit 1, Vol. 1, Tab 5.1, P92 - Identification of deceased person by other than visual means (11.04.19)
[85] Exhibit 1, Vol. 1, Tab 5.2, Coronial Identification Report (11.04.19)
[86] Exhibit 1, Vol. 1, Tab 5.3, Affidavit - Police Aux. Offr. J Aldridge (11.04.19)
[87] Exhibit 1, Vol. 1, Tab 5.4, Affidavit - Sen. Const. R Allison (12.04.19)
[88] Exhibit 1, Vol. 1, Tab 9.2, Statement - HP (11.04.19), paras 1-11

48. Police went to Heirisson Island (which is about 400 metres from where Mr Tran's body was located) at about 3.22 pm. They searched the area around the tree where Mr Tran's jacket had been found and concluded there was no evidence of "*suspicious activity*" and no sign of drag marks leading to the water's edge. The address on Mr Tran's pensioner card led police to the Globe, where a search of his room (Room 19) found nothing of significance. Following an investigation, the Perth Detectives Office concluded that Mr Tran's death was "*non-suspicious*" for the following reasons:

> The absence of visible injuries, the deceased's mental health history, no disturbances reported in the area and the location of property belonging to the deceased folded and orderly on the riverbank.[89]

49. Having carefully assessed the available evidence, I am satisfied the police investigation was sufficiently comprehensive enough to exclude the possibility that another person or persons were involved in Mr Tran's death. In passing, I also note an important observation by Mr T Tran, who subsequently told police that Mr Tran: "*did not know how to swim however (he) enjoyed walking in nature near to waterways*".[90] This information may explain why it was that Mr Tran decided to go walking on Heirisson Island, the rocky banks of which are encircled by a walking/cycling track (see photograph below).[91]

[89] Exhibit 1, Vol. 1, Tab 3, Report -Det. Const. C Alexander (11.04.19), p3
[90] Exhibit 1, Vol. 1, Tab 3, Report - Det. Const. C Alexander (11.04.19), p5
[91] Photo sourced from: https://commons.wikimedia.org/wiki/File:Heirisson_Island_Aug2020.jpg

CAUSE AND MANNER OF DEATH

Post mortem examination

50. Dr Clive Cooke, a forensic pathologist, conducted an external post mortem examination of Mr Tran's body on 12 April 2019. Dr Cooke noted dark coloured congestion to the skin on Mr Tran's face and frothy foam material at the nostrils and mouth. There were no evident injuries and the surface of Mr Tran's body was moist and covered with scattered vegetation particles.[92]

51. At the conclusion of his examination, Dr Cooke wrote to the State Coroner in these terms:

> In the absence of further findings, it appears that death is most likely a consequence of immersion (drowning), but as (the) police investigation is apparently continuing, and the results of toxicology analysis are not yet available, I advise a cause of death as 1a. Undetermined (Pending Investigations).[93]

52. On 16 April 2019, Dr Cooke conducted an internal post mortem examination and noted increased fluid and congestion in Mr Tran's lungs, fatty enlargement of the liver, and early atherosclerotic hardening of the arteries, with narrowing of the arteries on the surface of the heart (coronary arteriosclerosis). There were no evident internal injuries, and Dr Cooke noted that toxicological analysis would be conducted, before expressing the opinion that the cause of death was: "1a. Undetermined (Pending Toxicology Analysis)".[94]

Toxicological analysis and cause of death

53. Subsequent toxicological analysis found the antipsychotic, paliperidone, and its metabolite in Mr Tran's system, but alcohol and common drugs were not detected.[95] On 23 April 2019, Dr Cooke expressed the opinion that the cause of death was "*Immersion (drowning)*" and I accept and adopt Dr Cooke's conclusion as to the cause of Mr Tran's death.[96]

---

[92] Exhibit 1, Vol. 1, Tab 6.3, Post Mortem Report (12.04.19)
[93] Exhibit 1, Vol. 1, Tab 6.4, Letter - Dr C Cooke (12.04.19)
[94] Exhibit 1, Vol. 1, Tab 6.2, Post Mortem Report (12.04.19 & 16.04.19)
[95] Exhibit 1, Vol. 1, Tab 7.1, Toxicology report - Amended (30.04.19)
[96] Exhibit 1, Vol. 1, Tab 6.1, Supplementary Post Mortem Report (23.04.19)

Manner of death

54. In addition to determining the cause of Mr Tran's death, I am required to determine, where possible, "*how the death occurred*". This is a reference to the circumstances surrounding the death, or to put it another way, the manner of death.[97]

55. In this case, there is evidence suggesting Mr Tran took his own life. In making that observation, I have regard to the following facts:

a. The prospect of homelessness caused Mr Tran significant distress;
b. When homeless in October 2018, Mr Tran said he would "*jump in the river*";
c. Mr Tran had expressed concern about the Globe's imminent closure;
d. Mr Tran had given Globe staff a packed suitcase to dispose of;
e. Mr Tran had told ED staff on 8 April 2019 he "*would die soon*";
f. Mr Tran's body was found in the Swan River, fully clothed;
g. Mr Tran's jacket was folded neatly; and
h. Mr Tran's cards and room key were found on top of the jacket.

56. As noted, Mr Tran reportedly enjoyed walking along the banks of waterways "*enjoying nature*", but it seems strange that he would have placed his cards and room key on top of his folded jacket if he was merely going for a walk. However, when last seen at the Clinic on 9 April 2019, Mr Tran did not display psychotic symptoms, nor did he express any self-harm or suicidal ideation. Instead, he was described as "*well-groomed, polite and cooperative*". Nothing untoward was found in Mr Tran's room at the Globe, and I note he slept there on the night of 9 April 2019.

57. However, despite the fact that suicide is perhaps the most likely explanation for Mr Tran's death, after careful consideration, I have been unable to exclude the possibility that Mr Tran fell while walking along the banks of the Swan River and subsequently drowned. If that was what happened to Mr Tran, then manner of his death would be accident, not suicide. On the basis that I have been unable to determine how Mr Tran's death occurred, I make an **open finding** as to the manner of his death.

[97] *Coroners Act 1996* (WA), s25(1)

CLINICAL REVIEW

58. The East Metropolitan Health Service (EMHS) conducted a Root Cause Analysis investigation (RCA) to determine whether there were any "*systems factors*" which had contributed to Mr Tran's death. After summarising Mr Tran's clinical history and recent presentations, the RCA made the following observations:

> Risk Assessment
> The Panel determined that the consumer lacked insight into his illness and did not recognise the nature or severity of his symptoms or functional impairment. He could be neglectful of his self-care and was socially withdrawn. The Panel determined that the most recent risk assessment was conducted on 14/3/19 with an overall score of "Low" (suicidality = 1, aggression/violence = 5).[98]
>
> Assistance with Accommodation
> The Panel ascertained that the consumer had been evicted from five (5) different accommodations over the past 2½ years and had recently been happy living in hostel accommodation. The Panel also determined that he had recently been told that this hostel was due to close and he would have to find alternate accommodation. His Case Manager was due to visit him to discuss this on the day he was found deceased.[99,100]

59. The RCA expressed the following conclusion, along with a request for declassification:

> Conclusion and Rationale for Declassification
> The Panel concluded that there were no systems factors contributing to this incident. The Panel had received the preliminary findings from the post mortem which were inconclusive as to whether the drowning was deliberate or accidental and this remains unclear at the time of writing this report. Initial toxicology however, has ruled out medication overdose. The Panel concluded that the Service in collaboration with his Legal Guardian, had made significant effort to secure a more appropriate accommodation for the consumer.[101]

[98] Exhibit 1, Vol. 2, Tab 18, Brief Risk Assessment (14.03.19)
[99] In fact, Mr Tran was found on 10 April 2019 and his case manager had planned to visit him on 11 April 2019
[100] Exhibit 2, Root Cause Analysis (26.09.19), p2
[101] Exhibit 2, Root Cause Analysis (26.09.19), p3

60. The RCA rightly acknowledges the efforts of Mr Tran's case manager to obtain long-term, secure accommodation for Mr Tran. However, in my view the RCA is deficient because it does not identify the lack of suitable accommodation services for people with chronic mental illnesses and/or behavioural issues, as a factor which may have contributed to Mr Tran's death.

61. I accept that the RCA's use of the term "*systems factors*" is intended to be a reference to matters within the control of the EMHS. However, in my view, it would have been appropriate for the RCA to have referred to the paucity of suitable supported accommodation services at the time of Mr Tran's death.

ACCOMMODATION OPTIONS

Overview

62. As I have mentioned, the prospect of homelessness was clearly of significant concern to Mr Tran, and his mental health deteriorated whenever he was evicted from places where he was staying. The evidence also establishes that Mr Tran had resisted attempts to place him in alternative, stable accommodation. A further issue confronting Clinic staff as they sought to help Mr Tran was the limited accommodation options available for people with chronic mental illnesses.

Review by Office of Chief Psychiatrist[102]

63. In 2020, the Office of the Chief Psychiatrist conducted a review of the services available to mental health consumers with complex needs and challenging behaviours (Review). In relation to accommodation options, the Review noted:

> There is a lack of safe, suitable and sustainable accommodation for individuals with challenging behaviours, particularly for people with a history of treatment in the forensic mental health system.[103]

[102] Chief Psychiatrist's Review: *Building rehabilitation and recovery services* (2020)
[103] Chief Psychiatrist's Review: *Building rehabilitation and recovery services* (2020), p12

64. As to the urgency of the need, The Review also noted that:

> Access to stable, secure and affordable housing has important ramifications not only for consumers, but also for their use of inpatient and forensic services. While there has been a significant investment by the Mental Health Commission in supported housing for people with mental illness, there remains a sizeable cohort of people with severe and enduring mental illness, complex needs and challenging behaviour who continue to fall through the gaps. There is an urgent need to develop a strategy to specifically address their housing needs.[104]

65. The Review also observed that during its consultation phase with mental health consumers:

> A consistent message was that consumers are often unable to access supported accommodation as these services are not structured to meet the needs of people with severe mental illness and challenging behaviour. There was concern that very high risk consumers can end up in caravan parks or similar low cost accommodation but without the standards and safeguards required of a licenced psychiatric hostel or supported accommodation service.[105]

66. The accommodation issues referred to in the Review were echoed by Dr Nigel Armstrong, who made the following observation in his report:

> The major issue…in my opinion is not so much a lack of accommodation, but rather the lack of proper Rehabilitation Services/Programs for this patient cohort. There is a recognised lack of extended care and Transitional Units which enable these patients to receive support to find stable accommodation and to receive counselling services for substance misuse syndrome and programs which facilitate recovery from their mental illness. The Mental Health Commission is in the process of attending to the essential clinical requirements for the recovery process for the severely mentally ill.[106]

[104] Chief Psychiatrist's Review: *Building rehabilitation and recovery services* (2020), p12
[105] Chief Psychiatrist's Review: *Building rehabilitation and recovery services* (2020), pp45-46
[106] Exhibit 1, Vol. 1, Tab 16.1, Report - Dr N Armstrong (11.02.22), p2 & see also: ts 09.08.22 (Armstrong), pp15-22

Response by the Mental Health Commission[107]

67. The Mental Health Commission (the Commission) was established in March 2010, and works closely with the Department of Health and service providers to "*lead mental health reform throughout the State and work towards a modern effective mental health system that places the individual and their recovery at the centre of its focus*".

68. In a report to the Court in relation to the inquest I conducted into the death of Mr Boris Drleski, the Mental Health Commissioner (Ms Jennifer McGrath) outlined the Commission's response to the issues raised in the Review. Ms McGrath also noted that the Commission is leading the Community Treatment and Emergency Response Roadmap, which is planning the future of community mental health services "*that will meet the needs of the people of WA, including those with complex and multiple needs*".

69. Ms McGrath referred to the following accommodation services which may have been relevant to Mr Tran:[108,109]

a. *Secure Extended Care Units* (SECU): these facilities are intensive inpatient rehabilitation units. They are designed for individuals admitted on an involuntary basis, who have severe and chronic mental health illnesses with co-occurring conditions and challenging behaviours, who pose a significant risk. The goal of treatment at a SECU is for the patient to be transitioned to community rehabilitation and eventually to either supported, or independent living. A 12-bed SECU opened at RPH on 14 June 2022. A similar facility is planned for the Bentley Hospital campus, "*in the future*".

b. *Community Care Units* (CCU): these facilities provide long-term treatment, rehabilitation and recovery care for individuals transitioning out of inpatient facilities, including SECUs. CCUs provide "*open, home like environments*" and are staffed by a multi-disciplinary team that offers recovery-based psychosocial and clinical care in a residential setting…

[107] Inquest into the death of Mr Boris Drleski, 2022 WACOR 24 (13.04.22), paras 80-82
[108] Inquest into the death of Mr Boris Drleski, 2022 WACOR 24 (13.04.22), para 83
[109] Email - Ms J Buller to Ms S Markham (12.08.22)

> Two CCUs are planned. One is located in Orelia and will offer 20-beds to individuals aged between 18-64 years with severe and persistent mental health issues and complex needs who require a high level of support. Unfortunately, the Commission has been unable to confirm an opening date for this facility.
>
> The other CCU is a facility in St James that will offer a total of 40-beds. A 20-bed Prevention and Recovery Unit will open on 23 August 2022, and 20-bed Rehabilitation and Recovery Unit is planned to open on 1 November 2022, "*subject to delays that may be caused by factors such as workforce shortages, defects resolution and regulatory compliance issues*".

70. While there is no guarantee that Mr Tran would have accepted placement in a CCU or similar facility, there is a possibility that he might have. I therefore **strongly urge** the Commission to do everything possible to ensure that these innovative accommodation facilities are made available to mental health consumers as quickly as possible.

RECOMMENDATION

71. In order to support the work of the Commission in relation to the provision of supported accommodation for mental health consumers such as Mr Tran, I make the following recommendation:

Recommendation
The East Metropolitan Health Service should **strongly** lobby and encourage the Mental Health Commission to use its best endeavours to ensure that the planned Secure Extended Care Units and the Community Care Units are operational as soon as practicable.

QUALITY OF SUPERVISION, TREATMENT AND CARE

72. Mr Tran's chronic mental illnesses and complex behavioural needs were largely managed in the community on a succession of CTOs. On several occasions when his mental health deteriorated, he was admitted to psychiatric facilities.

73. Having carefully reviewed the available evidence, I am satisfied that the decision to place Mr Tran on a succession of CTOs was justified on the basis that this was the least restrictive way to ensure that he was provided with appropriate treatment for his mental health conditions.

74. I am also satisfied that the supervision, treatment and care that Mr Tran received whilst he was an involuntary patient in hospital and whilst he was the subject of a succession of CTOs, was appropriate and of a good standard.

75. I accept that clinical staff were hampered in their efforts to manage Mr Tran by a lack of appropriate accommodation options for people with complex needs and a history of chronic mental illness. Secure accommodation was understandably a very important issue for Mr Tran and it is significant that in 2018 and 2019, his mental state deteriorated when his accommodation became insecure.

76. When Mr Tran presented to the Clinic on 9 April 2019, efforts were underway to secure alternative accommodation for him. Further, his case manager had planned to visit him on 11 April 2019 to discuss alternative accommodation options, but Mr Tran died before this could occur.

77. Mr Tran's care may have been enhanced had his clinical team been able to admit him to a CCU, where his mental illness and psychosocial issues could have been addressed in a coordinated fashion. Whilst there is no guarantee that Mr Tran would have accepted placement in such a facility, there is at least the possibility that he might have.

78. On behalf of the Court, I wish to convey to Mr Tran's family (as I did at the conclusion of the inquest) my very sincere condolences for their loss.

MAG Jenkin
Coroner
17 August 2022