OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	Inquest into the death of Luong Bang Nguyen
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 1415/08(8)
DELIVERED ON:	16 April 2010
DELIVERED AT:	Brisbane
HEARING DATE(s):	14 April 2010
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners Inquest, death in custody, natural causes, drug addiction

REPRESENTATION:

Counsel Assisting:	Mr Mark Plunkett
GEO Group Australia Pty Ltd:	Mr Peter Roney (instructed by Blake Dawson)
Department of Community Safety:	Mr Kevin Parrott (Crown Law)

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Introduction

The *Coroners Act 2003* (the Act) provides in s. 45 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of Mr Luong Bang Nguyen. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

At the time of his death Mr Luong Bang Nguyen was 31 years old. From the age of 14 he had been addicted to drugs. He had a long criminal history for property offences which he committed to feed his habit.

On 31 January 2008 Mr Nguyen was arrested on a warrant issued by the Drug Court for failing to comply with his rehabilitation drug program. On 6 February 2008 Mr Nguyen was remanded in custody and held at the Arthur Gorrie Correctional Centre.

On 5 March, at about 10:30pm, his cell mate awoke to find Mr Nguyen fitting on the floor. He attempted to alert corrective services staff by means of the intercom but to no avail.

At about 10:50pm a nurse and correctional services officers went to his cell to provide to Mr Nguyen his prescribed medication. They discovered him unconscious and being propped up by his cell mate who was trying to rouse him.

At 12:45am Mr Nguyen was taken to the Princess Alexandra Hospital, arriving there at 1.14am and admitted to the Emergency ward at 1.17am. A CT scan revealed he had suffered an untreatable subarachnoid hemorrhage.

Mr Nguyen never regained consciousness and at 4:20pm on 6 March 2008 Mr Nguyen died.

Because the death was a "death in custody" within the terms of the Act it was reported to the State Coroner for investigation and mandatory inquest.[1]

These findings:-

- confirm the identity of the deceased man and establish how he died and the time, place and cause of his death;
- consider whether the actions or inactions of any person contributed to the death;
- examine the actions of the staff of the Arthur Gorrie Correctional

[1] s. 8(3) defines "*reportable death*" to include deaths in custody and s7(2) requires that such deaths be reported to the state coroner or deputy state coroner. S27 requires an inquest be held in relation to all deaths in custody

Centre before and after Mr Nguyen went into an unconscious state;

- consider whether the medical treatment afforded to him while in custody was reasonable and adequate; and

- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

At 8:15am on 6 March 2008 detectives from the Corrective Services Investigation Unit were advised by the intelligence staff of the Arthur Gorrie Correctional Centre that Mr Nguyen had been taken to the Princess Alexandra Hospital where he was in the intensive care ward and was reported to be "brain dead". Inquiries made with the hospital revealed that Mr Nguyen had suffered from a cerebral aneurism and was on a ventilator machine.

The police secured Cell 22 as a crime scene and the prisoners in Secure Unit D2 were locked down. The cell was examined by Detectives from the Corrective Services Investigation Unit and Sergeant Hanson from police photographics.

The investigating police interviewed Mr Nguyen's cell mate and friend Giang Hoang Tran. Mr Tran was physically examined, photographed and found to be without injury. Mr Tran's clothes were taken and examined.

Inquires revealed that there was no Close Circuit Television record of Cell 22 or of the Secure Unit D2 at the time of the relevant events.

The medical records of Mr Nguyen and the Secure Unit D2 log book were taken possession of. It recorded that since the 5:30pm lock down no prisoners other than Mr Nguyen and his cell mate had been in Cell 22.

Police also interviewed the other 33 prisoners in the Unit who stated that they did not see or hear the incident.

A report was prepared by Sergeant Peter Rasmussen. Insofar as it went, it was professionally presented and adequate for the purpose of excluding foul play or third party involvement in the death. However, it did not address a number of issues raised by the evidence that staff of this office then had to resolve.

The inquest

An inquest opened on 16 April 2010. Mr Mark Plunkett of counsel was appointed to assist me. Leave to appear was granted to counsel for the Arthur Gorrie Correctional Centre and the Department of Community Safety.

All of the statements, records of interview, photographs and materials gathered during the investigation were tendered into evidence. I accepted a submission made by counsel assisting and supported by the two agencies granted leave to appear that there was no forensic purpose to be served by the calling of any oral evidence.

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits but I consider it appropriate to record in these reasons, the evidence I believe is necessary to understand the findings I have made.

Personal background

Mr Luong Bang Nguyen was born in Vietnam on 16 December 1976. His father died when he was young and he had no memory of him growing up. He had no siblings.

Mr Nguyen arrived in Australia in 1985 when he was 9 years old. He became a citizen in 1988.

He had a close relationship with his mother, who, while very much against his drug use and criminal activities, was very supportive of his efforts at rehabilitating himself.

He had a conflictive relationship with his step father and at 13 years of age he ran away from home to Sydney where he made a living selling drugs on the streets. At 14 he commenced to use cannabis and heroin and by 18 years of age had become a regular user of heroin.

He soon became a drug addict and intravenous drug user. His history of drug abuse included, ice, speed, heroin and cannabis.

In 2000 Mr Nguyen was placed on the methadone programme. In 2002 and in 2004 he participated in the subutex program.

From 21 March 2007 to 19 May 2007 he participated in the Fairhaven Residential Program but ran away before completing the course.

Progress reports at Fairhaven indicated that while generally compliant he had difficulties completing the necessary homework and was assessed as requiring a literacy course.

As a result of his criminal convictions, Mr Nguyen was sentenced to serve many periods of imprisonment. From 1995 onwards he spent some time in jail most years.

Basis for final imprisonment

On 20 March 2007 Mr Nguyen was sentenced by the Southport Drug Court to 3½ years imprisonment for attempted fraud, forgery, false representations, dishonestly obtaining property, breaking and entering and stealing, and serious assault. This sentence was wholly suspended upon his agreeing to an intensive drug rehabilitation order.

As a consequence on the next day Mr Nguyen was admitted to the Salvation Army Fairhaven Residential Rehabilitation Centre at 947 Parklands Drive, Southport, which he stated he was willing to comply with.

On 11 April 2007 after an initial three week settling in period, he appeared at the Southport Drug Court for a review. He was struggling with literacy issues and trusting others but he was otherwise assessed as superficially compliant.

On 18 April 2007 Mr Nguyen appeared at the Southport Drug Court for a further review where it was noted he had made some improvement with some positive reports. On 16 May 2007 he was reported to have improved and was congratulated by the Drug Court for his progress.

On 19 May 2007 Mr Nguyen was granted day leave. He telephoned the Fairhaven Residential Rehabilitation Centre that night to say he wanted to stay over night with his mother as she was ill. Leave was granted to return the following day. He did not return to the Fairhaven Residential Rehabilitation Centre. On 21 May 2007 the Drug Court was advised that Mr Nguyen had absconded and a bench warrant was issued.

On 13 December 2007 the Drug Court issued another warrant for the arrest of Mr Nguyen because he had failed to comply with his drug rehabilitation program.

On 31 January 2008 at the Carindale Shopping Centre, Mount Gravatt, Mr Nguyen was arrested by officers of the Queensland Police Service on the Drug Court warrant.

On 6 February 2008 Mr Nguyen appeared in the Drug Court at Southport, where he was remanded in custody to re-appear on 5 March 2008. He was transferred to the Arthur Gorrie Correctional Centre. He remained there until his death.

Recent medical history

Upon arrival at the Arthur Gorrie Correctional Centre on 6 February, Mr Nguyen was given a medical assessment, wherein he stated that he was an intravenous drug user abusing valium, alprozolam, heroin, ecstasy and alcohol. He admitted he was using 3.5 grams of heroin and 3.5 grams of ice a day. As a result he was prescribed a drug withdrawal program consisting of 16 days of valium gradually reduced to be completed on 21 February 2008.

He was also found to be Hepatitis C positive and Hepatitis B complete. He reported that he regularly suffered from the adverse effects of this disease. Mr Nguyen also suffered from insomnia.

On 7 February 2008 Mr Nguyen complained to medical staff at the prison that he could not sleep, was tired and had little energy. He said he had been up all night because he was hearing voices that told him to pay police and harm others. He said it was like a noise inside his head which he had heard before. Also he reported he thought he had seen blood everywhere when he woke up. He also felt anxious. As a result he was recommended to see a visiting psychiatrist.

On 13 February 2008 he was seen by Psychiatrist Dr Aboud. He told Dr Aboud that the voices were sometimes in the Vietnamese language and were distressing. He was prescribed Seroquel - 300 mg per day to be taken in the afternoon - with a follow up on 5 March 2008 but this did not eventuate because of Mr Nguyen's court commitments. Seroquel is an anti-psychotic drug used in the treatment of schizophrenia. The medical records show that Mr Nguyen was non compliant and regularly missed medication at his own discretion.

Mr Nguyen did not complain of any other ailments in the weeks and days prior to his death.

Circumstances of the death

On 4 March 2008, Mr Nguyen was taken from the Arthur Gorrie Correctional Centre to the Southport Watchhouse to appear in the Southport Drug Court on 5 March 2008. At the watchhouse he advised staff that he was prescribed Seroquel because he heard voices and had last seen a psychiatrist two weeks earlier.

Registered Nurse Brendan Simmon of Blue Care, states that records kept by them indicate that prisoner Nguyen was not seen by medical staff and no medication was given to him.

However, Mr Nguyen's medical register and medical record sheet records signed by Mr Nguyen shows that Seroquel was sent with Mr Nguyen on 4 March 2008 to the watchhouse.

On 5 March 2008 the Southport Drug Court sentenced Mr Nguyen to 4 years imprisonment. He arrived back at the AGCC at about 3:00pm. In accordance with the Local Procedure he was assessed as not exhibiting 'at risk' indicators and was returned to his unit.

Usually, medical rounds commence at 2:45pm, when a call is made to each unit for prisoners to attend for medication who go to the airlock area for medication.

At 3:46pm medical staff attended Secure Unit D2 where Mr Nguyen was housed. At 3:53pm they departed. Mr Nguyen did not attend for his medication.

At Secure Unit D2, Mr Nguyen met his friend Mr Giang Hoang Tran. Mr Tran stated that when he saw Mr Nguyen return from Court he appeared to be in good health and made no complaints about his health or general well-being.

Mr Nguyen asked his friend Mr Tran, who had been in Cell 21, to stay with him in Cell 22, which is a two bed cell. Mr Nguyen asked the Unit Officer if Mr Tran could move to Cell 22. The Unit Officer gave permission for Tran to move. Mr Tran packed his belongings and moved into Cell 22.

At 5:30pm the cells were locked down with Mr Nguyen and Mr Tran as the only prisoners locked in Cell 22.

After lockdown, they each showered, played cards, had some noodles and watched television. Mr Tran stated that Mr Nguyen seemed normal that evening and spoke about his family.

At 7:20pm, 7:28pm and 7:29pm Mr Nguyen used the intercom to request his medication. The Corrective Services Officer he spoke to advised him that the medication would be provided at 10:30pm when the nurse did her rounds.

At 7:28pm the intercom recorded his voice: "*Yeah Chief I missed out on my meds Chief cause I went to court. Um is there any chance, can you ask the nurse to come down later so I can have my meds please".* He was advised: "*She comes down at about half past ten."* A minute later he is recorded as asking: "*Yeah Chief can you please tell the nurse I really need my medication please Chief."* He was advised: "*I told you she doesn't come around till 9.30 and she won't change it because when she comes down she has to have three officers with her."*

At about 8:30pm Mr Tran went to bed. Mr Nguyen was watching television.

At 10:09pm Mr Nguyen used the intercom stating that he needed his psychiatric medication. Asked by the prison officer over the intercom what "*Psych meds*" he was on Mr Nguyen replied: "*Yeah. I just, yeah, I have just been rolling, in and out, head my way(sic)."*

Mr Tran was awaken by a loud sound like a clap. He saw Mr Nguyen on the floor of their cell apparently having a fit.

Mr Tran stated that he immediately activated the intercom to obtain help calling for a nurse, but there was no response. The officer who was manning the station where the intercom would have sounded had it been activated, denies this occurred. The evidence supports this conclusion.

Investigating police report that there was no malfunction in the intercom system.

In Unit D2 the intercom system is located above the inmates' desk. It has four buttons, red, green and two black buttons. Pressing the red button will cause a call to be made to Unit Control, Movement Control or Master Control. An intercom call made from a cell will be followed by a beep sound at that end. It causes a continuous beeping alarm sound to occur at the other end until the call is answered. There is no capacity for Master Control to override this function. The green button operates a two station radio in the cell. The two black buttons control the radio's volume.

I am of the view that in his shock at waking to find his friend so seriously disposed, Mr Tran has pressed the wrong button.

When Mr Tran saw Mr Nguyen unconscious on the floor he thought about taking him to the shower but decided instead to prop him up to get him breathing. He sat Mr Nguyen up between his legs and shook him to try and rouse him. Mr Nguyen's eyes were half open. He did not respond to his name or at all. Mr Tran could feel a weak pulse. At this time Mr Nguyen vomited fluid.

Mr Tran says he kept shaking Mr Nguyen to make sure he was breathing. He did not yell out as he was both in shock and was waiting for a response from his intercom call.

Mr Tran did not have a watch on, however he thought the nurse arrived about 15 to 20 minutes after he found Mr Nguyen on the floor.

Registered Nurse Luffman was an employee of the Arthur Gorrie Correctional Centre. She was rostered for duty on 5 March 2008 from 6:00pm to 6:00am.

Nurse Luffman usually contacts Central Control before 10:00pm in order to obtain a list of the names of prisoners who have requested medication and who may have missed out. These names are collected by the Unit Officer who passes the names to Central Control staff who prepared the list at about 9:30pm. That evening Mr Nguyen's name was on the list for having missed his medication but no information was provided that there was anything out of the ordinary with Mr Nguyen. The Medical Intervention Register lists five prisoners to be seen in Secure Unit D2, including Mr Nguyen, with the reason noted as "MM", meaning "missed medication".

Nurse Luffman commenced her rounds at 10:00pm to finish at 11:30pm. She was accompanied by Corrective Services Officers Fulcher, Dahn, Aume, and Graham. At about 10:50pm they went into Security Unit D2. Corrective Services Officer Fulcher went downstairs to complete a head count while the other officers went upstairs to Cell 22 where Mr Nguyen was held.

As Nurse Luffman approached the cell a CSO went ahead to see if Mr Nguyen was appropriately dressed and had water to take his medication. Nurse Luffman says that officer alerted her that Mr Nguyen was on the cell floor in a pool of vomit and being held up by his cell mate.

She entered the cell and saw the cell mate sitting on the edge of the bed supporting Mr Nguyen who was sitting between his knees. The cell mate was stressed and asked: *"Why is he like this nurse? What is wrong with him?"*

Nurse Luffman shook Mr Nguyen by the arm. He made a noise but did not otherwise respond. Nurse Luffman could feel a pulse, but was unable to perform any other observations as she had no equipment.

They called for immediate assistance. At 11:15pm Corrective Services Officer McInnes received radio call asking that the medical trolley be delivered to Unit D2.

At this time Mr Fulcher was completing the head count, he heard a radio call for a medical trolley for Cell 22 and went to Cell 22.

When the medical trolley arrived, Nurse Luffman performed further observations such as testing blood pressure, blood sugars and neural observations. She thought that Mr Nguyen had suffered a drug overdose because of his physical signs, pin point pupils, unresponsiveness and vomiting.

Corrective Services Officers Fulcher, McInnes and Dhann placed Mr Nguyen on a gurney. Registered Nurse Michie also assessed Mr Nguyen checking his pulse and eyes.

At 11:24pm the ambulance service was called to attend to the Arthur Gorrie Correctional Centre.

Mr Nguyen was taken to the medical unit where Corrective Services Officer Fulcher remained until the ambulance arrived.

The nurses administered oxygen (8 litres per minute) to Mr Nguyen and he was given an injection of 0.8 mg of Naloxone (Narcan) to reverse the effects of the narcotics overdose she suspected he was suffering.

Mr Nguyen appeared to improve. He was breathing on his own and his level of consciousness improved to a GCS level of 7. There was no verbal response but he responded to painful stimuli by opening his eyes and withdrawing from the pain.

At 11:34pm, 11.52pm and 12.05am three QAS crews arrived at the scene. The first crew found Mr Nguyen unconscious but all his vital signs were normal.

It was concluded that Mr Nguyen was suffering from a suspected narcotic overdose.

At 12:13am he was placed into the ambulance for transfer to the Princess Alexandra hospital (the PAH). Shortly afterwards he stopped breathing.

One of the officers commenced manual intermittent positive pressure ventilation with 100 per cent oxygen administered by bag valve mask. He also

inserted an oropharyngeal airway to maintain an open airway and preventing the tongue from (either partially or completely) covering the epiglottis, which could prevent the patient from breathing.

Mr Nguyen is taken to Princess Alexandra Hospital

At 12:45am, after another short delay caused by security, the ambulance carrying Mr Nguyen departed for Princess Alexandra Hospital.

At 1:14am the ambulance arrived at the hospital and was met by the triage nurse and resuscitation team. Mr Nguyen had not regained consciousness during the journey.

At 1:17am Mr Nguyen was admitted to the Emergency Department.

Intensive Care Staff Specialist Dr Gordon Laurie states that on arrival Mr Nguyen was GCS 3, exhibiting decorticate positioning - an abnormal posturing that involves rigidity, flexion of the arms, clenched fists, and extended legs. Mr Nguyen was spontaneously breathing. Dr Laurie reports that he was bradycardic.

A CT scan was conducted of the head of Mr Nguyen. It revealed a Grade 4 subarachnoid haemorrhage with extensive intraparenchymal and intraventricular blood. Subarachnoid haemorrhage is the leaking of a blood vessel over the surface of the brain. Nontraumatic intraparenchymal haemorrhage most commonly results from hypertensive damage to blood vessel walls which may be caused by hypertension or drug abuse.

The CT scan also revealed an aneurysm in the right anterior communicating artery. Dr Laurie considered that this was most likely a mycotic aneurysm secondary to intravenous drug use. A mycotic aneurysm is a localized, irreversible dilatation of an artery to at least one and one-half times its normal diameter due to destruction of the vessel wall by infection. It is a serious clinical condition with significant morbidity and mortality. Mycotic aneurysms are rare and are caused by bacteria.

Dr Robert Campbell of the Neurological team reviewed the condition of Mr Nguyen. He concluded that his outlook was poor and that surgical intervention was not an option.

Mr Nguyen's neurological state continued to deteriorate and treatment was withdrawn due to futility.

At 2:00pm the life support equipment was turned off and the endotracheal and nasogastric tube (passing through the nose and into the stomach, for instilling liquids or other substances, or for withdrawing gastric contents) were removed.

At 3:00pm Detective Sergeant Wild of the Corrective Services Investigation Unit contacted Ms Kaylin Tran Bui, the de facto wife of Mr Nguyen, to make arrangements for her to attend upon Mr Nguyen at the hospital.

At 4:20pm Mr Nguyen died.

At 4:45pm Mr Nguyen ’s mother, Ms Tran Bui, and his de facto wife, Ms Kaylin Tran Bui arrived at the hospital.

At 5:00pm the mother and the de facto attended the room where the body of Mr Nguyen lay. They identified the body to Detective Sergeant Wild. They also requested that no internal autopsy be performed as they believed that it was invasive and unnecessary.

At 6:00pm Detective Sergeant Wild of the Corrective Services Investigation Unit and Constable Antony Schmidt attended at the bedside of Mr Nguyen. Constable Schmidt and Constable Bastijanic arranged for scenes of crime officers to attend and photograph the body of Mr Nguyen and arranged for the body to be taken to the John Tonge Centre.

At 9:00pm Constable Schmidt took possession of the body of Mr Nguyen and accompanied it from the Princess Alexandra Hospital to the John Tonge Centre.

Autopsy results

On 7 March the Deputy State Coroner made an order for an external examination only and for a review of the medical notes.

At 8:40am on 7 March 2008 Dr Alex Olumbe conducted an external post mortem examination of the body of Mr Nguyen. There were no signs of trauma or any indication of any violence having been done to him.

Samples of femoral blood and urine were taken for toxicology analysis. On 23 June 2008 the Forensic Toxicology Laboratory was only able to detect paracetamol less than 10 mg/kg and phenytoin approximately 12mg/kg. No other drugs were detected.

Paracetamol is an analgesic and antipyretic drug. It is used for the relief of mild to moderate pain and fever. Phenytoin is an anticonvulsant drug which can be useful in the treatment of epilepsy and acts to suppress the abnormal brain activity seen in seizure by reducing electrical conductance among brain cells by stabilizing the inactive state of voltage gated sodium channels.

Dr Olumbe observed that the final report of the CT scan of the head revealed an extensive subarachnoid haemorrhage and intraventicular haemorrhage, with a 4cm x 2cm intraparenchymal haematoma in the genu of the corpus callosum extending in to the white matter of both frontal lobes. The right anterior cerebral artery A3 segments demonstrate a fusiform aneurismal dilation to 9mm. The aneurysm had a corkscrew configuration. The mastoid air cells and temperarte cavaties were normally aerated with no skull fracture evident. Paranasal sinuses were normally aerated with no evidence of facial bone fracture.

Considering the circumstances of the death, a review of the medical charts from the PAH, in particular the CT scan final report, and the letter of Dr

Gordon Laurie, and a review of the medical records at the AGCC, Dr Olumbe and Dr Ansford found the cause of death was subarachnoid haemorrhage, due to or as a consequence of a ruptured large fusiform cerebral aneurysm with other contributory factors of chronic intravenous drug use.

Was the death preventable?

There were no indications that Mr Nguyen was ill until he collapsed in his cell after lock down.

Mr Nguyen did not receive any medial attention for 15 to 20 minutes after Mr Tran found him fitting, probably because Mr Tran failed to effectively activate the intercom.

Dr Laurie considers this delay in commencing treatment for Mr Nguyen did not contribute to his death because the subarachnoid haemorrhage was so extensive it could not have been addressed even had he been brought to hospital earlier.

Dr Laurie did not think that this death was preventable. He considered that Mr Nguyen developed a mycotic aneurysm in his brain, related to a transient bacterial infection in his blood stream related to his previous intravenous drug use. Had Mr Nguyen sought medical attention when the transient bacterial infection arose a course of antibiotics might have prevented a mycoctic aneurysm forming. However, these infections routinely lead to minimal or non-specific symptomatology and no immediate medical attention is sought. Dr Laurie considered it impossible to predict when aneurysms developed.

Dr Jeremy Hayllar an expert in opiate dependence, treatment and withdrawal reviewed all of the medical records in this death and concluded that Mr Nguyen was not suffering from acute withdrawal at the time of his death and it is unlikely that the provision of opioid maintenance therapy would have influenced the outcome of this case.

Conclusions

I am persuaded Mr Nguyen died from natural causes and that no other person played any part in his death. There are no suspicious circumstances surrounding the death. I am also satisfied that while in custody he received medical care of an appropriate standard and that no failure of care caused or contributed to his death. There were no indications that Mr Nguyen was ill until he collapsed in his cell after lock down. By that stage there was no treatment that could have saved him. The brain injury which caused the death was spontaneous and was not able to be prevented, predicted or treated.

Findings required by s45

I am required to find, as far as is possible, the identity of the deceased person, how, where and when he died and what caused the death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings:-

Identity of the deceased-	The deceased was Luong Bang Nguyen
How he died –	Mr Nguyen died of natural causes, most probably precipitated by illicit drug use. At the time of his death he was a sentenced prisoner.
Place of death –	He died at the Princess Alexandra Hospital, Brisbane Queensland.
Date of death –	He died on 6 March 2008
Cause of death –	Mr Nguyen died from a subarachnoid haemorrhage, due to or as a consequence of a ruptured large fusiform cerebral aneurysm with other contributory factors of chronic intravenous drug use.

Comments and recommendations

Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

I have found that Mr Nguyen died suddenly of natural causes and that the response to his collapse was timely and appropriate. The health care that he had received while in custody in the days before being taken to and at the hospital was also appropriate. His death was not foreseeable or preventable.

In those circumstances, there are no preventative recommendations I could usefully make in this case.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
16 April 2010