CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF DUY NGOC PHAM

[2025] SACC 14

Inquest Findings of her Honour Coroner Giles

20 May 2025

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a 35-year-old male who experienced a cardiac arrest in the custody of South Australia Police. The inquest examined the medical treatment received in custody as well as the actions of the custody Sergeant after identifying a need for medical treatment at hospital.

Held:

1. Duy Ngoc Pham, aged 35 years of Pooraka, died at the Lyell McEwin Hospital on 27 April 2019 as a result of multiple organ failure due to out-of-hospital circulatory arrest due to perforated duodenum (operated).

2. Circumstances of death as set out in these findings.

Recommendations made.

Counsel Assisting: MR D EVANS

Interested Party: COMMISSIONER OF POLICE
Counsel: MR K LINDNER - Solicitor: CROWN SOLICITOR

Witness: SERGEANT D JAMES
Counsel: MR K LINDNER - Solicitor: CROWN SOLICITOR

Hearing Date/s: 18/03/2025

Inquest No: 47/2024 **File No/s: 0840/2019**

INQUEST INTO THE DEATH OF DUY NGOC PHAM [2025] SACC 14

Introduction and reason for inquest

1 Duy Ngoc Pham was born on 19 June 1983 and died on 27 April 2019 at the age of 35 years.

2 South Australia Police (SAPOL) located Mr Pham on Thursday 18 April 2019 in a semi-conscious state in a vehicle at the Caltex Service Station on Main North Road, Pooraka. Drugs and associated paraphernalia were located near him in the vehicle.

3 SA Ambulance Service (SAAS) transported Mr Pham to the Lyell McEwin Hospital (LMH) where he was diagnosed as suffering from opioid toxicity and experiencing drug withdrawal.

4 After a period of observation, Mr Pham was assessed as being medically fit for police custody. At approximately 3pm on that same day, Mr Pham was arrested and conveyed to the Elizabeth Police Station Cell Complex (ECC). He was charged with trafficking in a controlled drug and dangerous driving to escape police pursuit regarding a previous offence he allegedly committed on 15 April 2019. Mr Pham was refused police bail, which meant that he would potentially remain in police custody until Tuesday 23 April 2019, a period of up to six days, due to the Easter public holiday break.

5 A risk assessment was conducted at the time of charging, wherein Mr Pham was assessed as presenting a high level of risk due to his diagnosed drug withdrawal, and was therefore classified as a 'high need' detainee. As a result of this assessment, he was placed in an observation cell within the ECC, and a care plan was implemented.

6 The following day Mr Pham was examined by a locum and, due to concerns regarding his health, he was transferred back to LMH for further assessment. Following this evaluation, he was deemed fit for discharge and returned to the cells, where he was placed in the same observation cell as before.

7 In the early hours of 21 April 2019 Mr Pham's condition deteriorated, and he was observed to fall twice in his cell. The officer in charge (OIC) determined that Mr Pham should be returned to hospital for reassessment as he appeared to have entered a new phase of withdrawal. The OIC arranged for a police escort and called for an ambulance. Upon the arrival of ambulance personnel Mr Pham was found to be in cardiac arrest, having ceased breathing. He was transported to LMH where he was placed on life support but failed to regain consciousness. He remained on life support for several days before being declared deceased.

8 Mr Pham's death was a death in custody within the meaning of the *Coroners Act 2003*. Therefore, an inquest into his death was mandatory in accordance with Section 21 of that Act.

Cause of death

9 An autopsy was performed by Dr Neil Langlois, consultant forensic pathologist, on 3 May 2019 at Forensic Science South Australia.

10 The cause of death was determined to be 'multiple organ failure due to out-of-hospital circulatory arrest due to perforated duodenum (operated)'.[1] I find that to be the cause of Mr Pham's death.

11 The post-mortem examination report details that the medical records indicated there was a 0.5cm by 0.5cm ulcer of the duodenum. Duodenal ulcer is a condition in which there is loss of the protective layer of mucus, and stomach acid damages the lining cells in the first part of the duodenum allowing gastric acid to further erode the mucosa and muscle layer of the intestine. A duodenal ulcer can be complicated by bleeding (as there is a large artery under this site), perforation (where the ulcer erodes right through the wall of the duodenum releasing gastric contents into the abdominal cavity causing peritonitis) and occasionally obstruction (as a result of inflammatory swelling and fibrosis). The death rate for perforated duodenal ulcer has been estimated at between 5% and 25%, depending on other patient factors.[2] Whilst perforation is usually a dramatic event with sudden onset of severe abdominal and epigastric pain, in Mr Pham's circumstances the pain may have been masked by his drug withdrawal symptoms.[3]

12 Dr Langlois also noted that from the post-mortem examination findings it is not possible to determine how long Mr Pham's ulcer had been present and how long before his collapse the ulcer had perforated. This is due to the interval of six days between his collapse and his death, with intervening surgery having occurred. Furthermore, the cause of the perforation was not established by post-mortem examination.

13 Dr Langlois further noted that although the operation had identified and dealt with the perforation of the duodenum, damage to Mr Pham's organs would have occurred from the period of failure of circulation before reaching hospital.

Evidence at inquest

14 At the Inquest I heard evidence from only one witness, Sergeant Darren James. Sergeant James was the OIC at the ECC on 21 April 2019 at the time of Mr Pham's final deterioration leading to his death. Sergeant James provided two affidavits which were tendered at the inquest, one dated 21 April 2019 (the date of Mr Pham's collapse in custody), and one dated 16 January 2025.[4] Sergeant James was also interviewed by SAPOL Major Crime officers the day following Mr Pham's collapse in the cells. That record of interview was tendered into evidence.[5]

15 In addition to hearing evidence from Sergeant James, the Court received into evidence records from various agencies including SAPOL, the Northern Adelaide Local Health Network (NALHN), and the Department for Correctional Services (DCS), as well as affidavits from a number of witnesses who were not called to give evidence. I will not list them all here due to the sheer number. Due consideration was given to each of those affidavits and records in writing this finding.

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[1] Exhibit C1a
[2] Exhibit C24
[3] Exhibit C24
[4] Exhibits C82, C82a
[5] Exhibit C80w

Expert reports

16 Four expert reports were received into evidence from the following suitably qualified medical professionals:

- Professor Jason White - Professor White is an Adjunct Professor in the School of Pharmacy and Medical Sciences, University of South Australia. He qualified from the University of Adelaide with a BSc (Hons) and a PhD, received post-doctoral training in pharmacology at Emory University and subsequently held academic positions at Monash University, the University of Adelaide and at the University of South Australia from 2010 to 2018 as Professor of Pharmacology and Head of the School of Pharmacy and Medical Sciences. Professor White has published extensively in the pharmacology of addictive drugs and in the treatment of drug and alcohol dependence.

- Dr Peter Joyner OAM - Dr Joyner is a general practitioner with over 50 years of experience. He practised from 1974 to 2024 in rural general practice, primarily in Mannum, South Australia.

- Dr Richard Sarre - Dr Sarre graduated MBBS in 1974 from the University of Adelaide. He is a specialist in general and colorectal surgery. He achieved fellowship of the Royal Australasian College of Surgeons in 1981 and the Royal College of Surgeons of England in 1984. He undertook advanced training in general and colorectal surgery in York, UK and at the Cleveland Clinic, Cleveland Ohio, USA. He was appointed senior visiting specialist in colorectal surgery at the Flinders Medical Centre in 1984 and continued in that role until 2020. During that time, he also conducted a private practice in surgery from 1984 to 2020. He has recently retired from active surgical practice in the specialty of colorectal and general surgery and continues to conduct medico-legal assessments within his area of expertise.

- Professor Anne-Maree Kelly - Professor Kelly is an internationally recognised researcher and teacher in the field of emergency medicine. She is senior emergency physician and academic at Western Health in Melbourne, Professorial Fellow at the University of Melbourne and Adjunct Professor at Queensland University of Technology. Her clinical and research interests are broad with a focus on practical clinical research, improving quality of care in emergency departments, and legal medicine. She has more than 200 publications in refereed journals and is a member of a number of international editorial boards. Professor Kelly also has experience providing medicolegal opinions for cases in jurisdictions including AHPRA, Coroners' Courts and civil litigation matters.

17 In this finding I shall not summarise all the evidence tendered or heard at the inquest but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

18 The standard of proof to be applied in making coronial findings is the civil standard, the balance of probabilities. In considering making findings which imply or express criticism

of individuals, I am guided by the principles enunciated in Briginshaw v Briginshaw[6] and I shall not make such a finding unless the evidence leads me to a comfortable level of satisfaction that the finding should be made.

Mr Pham's background

19 Mr Pham's parents, father Ngoc Than Pham, and mother Thi Ngoc Nguyen, came to Australia after the Vietnam War. They had three children (including Mr Pham), all born in Australia.

20 Mr Pham attended Pooraka Primary School and Ross Smith Secondary School, then transferred to Blackfriars Priory School. Mr Pham finished year 11 at Blackfriars and was in the first term of year 12 when he got in with a 'bad crowd' and started missing school, committing petty crimes, and using illicit substances.

21 In 2014 Mr Pham married Dang Thi Kim Lein Hoang. They lived together until they separated in late 2018.

22 Between 2002 and 2018 Mr Pham spent approximately 80 months incarcerated. Offences Mr Pham was reported or arrested for included armed robbery, larceny, receiving, attempted false pretences, unlawful possession, carrying an offensive weapon, trafficking in a controlled drug, possessing a controlled drug, possessing prescribed medication, possessing equipment to use with controlled drug, failing to stop, driving contrary to defect, failing to exchange personal details, and breach of bail.

23 Mr Pham had become somewhat estranged from his parents in the years preceding his death. However, his family attended the entirety of the inquest, and it was clear to me the profound impact that the loss of Mr Pham had on them.

Circumstances leading to incarceration on 18 April 2019

24 At about 6am on Thursday 18 April 2019 Ms Darlene Jordan parked her car at the Caltex on Main North Road at Pooraka where she worked. She noticed that there was a car nearby which was parked in an unusual manner. There was a person in the driver's seat. At about 7:30am, having noticed that the car had not moved for the last hour and a half, Ms Jordan asked someone who worked in the same complex if they could check on the driver. That person reported back to Ms Jordan that the occupant was slouched over in the driver's seat with drugs on his lap. Ms Jordan called police.

25 Probationary Constable Travis Black and Constable Matthew Stepcich arrived approximately 15 minutes later and located Mr Pham in the vehicle. Mr Pham had a glass 'ice' pipe on his lap and an aluminium container with eight bags of methylamphetamine, heroin and other substances.[7] Mr Pham was falling in and out of sleep. His speech was 'very slow, soft and a bit slurred'.[8] He said he was tired.[9] Police called for an ambulance.

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[6] Briginshaw v Briginshaw (1938) **60 CLR 336**
[7] Exhibit C28
[8] Exhibit C29
[9] Exhibit C29

26 Mr Pham told paramedics that he had taken methylamphetamine and that he had not slept for five days.[10] He said he had also taken heroin in previous days. He was able to walk to the barouche unassisted[11] and was transported to the LMH where he arrived at approximately 8:18am.

Assessment at the LMH on 18 April 2019

27 At approximately 8:30am Mr Pham was assessed by Dr Mohamed Musawir, an Emergency Department doctor at the LMH.

28 Blood tests were performed, all of which returned normal results, except for a slightly raised carbon dioxide level. Dr Musawir stated this was in keeping with Mr Pham having been found in a slumped position in his car which may have caused a period of non-effective breathing. Blood levels of ethanol and paracetamol were negative. Vital signs and observations were all within normal limits. There were no signs of infection, his chest was clear, and his abdomen was soft and non-tender.

29 Mr Pham informed Dr Musawir that he had taken methylamphetamine on the previous night and that he inhaled the drug heroin on a daily basis. Dr Musawir reviewed Mr Pham's previous presentations to the LMH and noted that Mr Pham had previously presented for drug related reasons.[12]

30 Dr Musawir diagnosed Mr Pham with 'sedative hypnotic or opioid toxicity', since he was more sedated than highly aroused. His plan was to monitor Mr Pham's recovery from whatever drug he had taken, however, no intervention as such was required.

31 At 3:20pm, after having had a period of observation of some hours, Dr Musawir noted that Mr Pham's levels were within normal limits.[13] There were no signs of sepsis. Mr Pham said that he was comfortable but wanted to sleep. Dr Musawir considered that Mr Pham was stable enough to be discharged and accordingly signed a 'fit for custody' form at 3:23pm.

32 According to Dr Sarre, the treatment provided to Mr Pham during his assessment at the LMH on this date was reasonable, and there was no indication of a duodenal ulcer at the time of presentation. Dr Sarre's only concern was that a blood or urine screen for opiates and other potential drugs of abuse was not conducted, which would have been prudent in the circumstances. Dr Musawir explained in his affidavit that as Mr Pham had admitted to him that took heroin on a daily basis and had used methylamphetamine recently, there was no need to request a blood or urine screen for drugs of abuse as the results were unlikely to change his care plan.

33 Dr Sarre opined that the decision to discharge him into police custody was reasonable under the circumstances and the diagnosis of a drug overdose was likely correct. Whilst Dr Sarre has opined that it is plausible that Mr Pham may have had an undiagnosed duodenal ulcer at this time, the ulcer may have subsequently been exacerbated by narcotic withdrawal, as he struggled with oral intake and was physically stressed and dehydrated.

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[10] Exhibit C5
[11] Exhibit C28
[12] Exhibit C6
[13] Exhibit C6

The normal blood tests on 18 April 2019 do not support the presence of a perforated ulcer. Accordingly, I find that the assessment of Mr Pham at the LMH and the decision to release him into police custody were appropriate at that time.

34 Constable Sarah Gavini had been present at LMH with Mr Pham from approximately 2:30pm in the afternoon (having taken over from officers who had earlier remained at the hospital in anticipation of him being fit for custody). Constable Gavini arrested Mr Pham and advised him that he was charged with trafficking in a controlled drug. This charge related to the quantity of drugs that were located in his vehicle earlier that day. Constable Gavini stated that Mr Pham was very drowsy but was able to put his shoes on and 'shuffle his way through the hospital' slowly.[14] Constable Gavini placed Mr Pham in the police vehicle and transported him to the ECC.

Elizabeth Cells Complex

35 Before I turn to the events in custody, I need to make some general observations about the ECC and the management of detainees.

36 The ECC is within the Elizabeth Police Station, 17-19 Frobisher Road, Elizabeth, South Australia.

37 The OIC Cells Complex (OICCC) of the ECC and their staff operate from an office area within the cell complex referred to as 'The Bridge'.

38 High need detainees can be monitored by custody staff from within The Bridge. Not all cells are under direct observation, however Mr Pham's, Cell E2, in which he remained for the entirety of his time while in custody at ECC, was.

39 Cell E2 is approximately 2.5m x 2.5m in dimension. At the furthest point (back wall - north) it is approximately 5m from The Bridge. At its closest point (cell door/wall - south) it is approximately 2m from The Bridge.

40 As well as being able to observe activity in Cell E2 from The Bridge by simply looking across and into Cell E2, staff can also observe a detainee in Cell E2 via CCTV. Monitors within The Bridge provide custody staff with real-time images of the movement and behaviour of detainees. A control panel allows for switching between cameras. All CCTV imagery is recorded.

41 All cells are fitted with an intercom that allows detainees to contact custody staff within The Bridge. The intercom for Cell E2 is located in the northwest corner above the sink. On 21 April 2019, following the deterioration of Mr Pham in custody and subsequent transfer to the LMH, the intercom was tested and found to be in working order.[15]

[14] Exhibit C30
[15] Exhibit C80

SAPOL General Order, Custody Management (GOCM)

42 General Orders provide an employee of SAPOL with instructions to ensure to effectively perform their duties and ensure that organisational standards are maintained consistent with SAPOL's vision.

43 SAPOL is responsible for safely and securely managing all detainees in police custody from the time of their arrest until they are released or transferred to an external agency. The GOCM is the overarching guideline for the management of detainees in police custody.

44 In accordance with the GOCM, all detainees taken into police custody must be subject to an initial risk assessment and, if remaining in custody, be subject to ongoing assessment. The GOCM provides a risk analysis process that assists the OICCC in developing and implementing a suitable care plan strategy. Both the assessment and care plan are managed in Shield.[16] Categories of risk include medical and health concerns, risk to self and risk to others. The level of risk associated with each of the categories is either no risk identified, or low, medium or high risk identified.

45 The GOCM dictates that the high-risk rating must be used when there are risks that are imminent or if there is significant recent or historical evidence suggesting that such a rating is required. Detainees who are seriously affected by drugs and/or alcohol that do not require medical attention must be rated at this level.

46 The GOCM also defines 'high need detainees' which is a risk rating given to a detainee who poses a high risk to themselves, others, or who requires a higher level of care and management due to risk of self-harm (or attempt), or other known medical or health reason. It provides that high need detainees require more frequent checks and closer monitoring compared to a detainee who has been assessed at a lower risk. Further, it provides that a continuous risk assessment must be conducted on each detainee to identify and determine treatment options to mitigate identifiable risks.

47 The GOCM provides that detainees and their cells must be physically checked at intervals of not greater than 15 minutes during the first two hours of the initial care plan developed by the OICCC. At the completion of the first two hours, the OICCC must conduct a care plan review to determine the suitability of placing the detainee on minimum hourly or more frequent physical checks.

48 Cell guard duties with regard to detainee checks are described in the GOCM as follows:

> 'When a cell guard is responsible for undertaking detainee checks and observations they must:
>
> - be appropriately briefed about the detainee's situation, risk assessment, care plan and particular needs
> - conduct detainee checks as directed by the O/C cells and displayed in the 'Obs' column of the cell white board

[16] SAPOL's integrated operational police records system

- record detainee checks in the detention log of the Shield Custody record as soon as reasonable (sic) practical after the check was conducted. Where a detainee check is overdue a reason must be recorded in the detention log.'

49 The GOCM contains directions in relation to the carrying out of 'physical detainee checks'. Under this heading it is stipulated that 'when detainee checks are being conducted, a member must ensure they adhere to the following procedures for awake or sleeping detainees'. There are then set out certain requirements in relation to both awake and sleeping prisoners. In respect of the sleeping patient, it is stipulated as follows:

> 'When a detainee is asleep, a physical check requires a member to be close enough to be able to see that the detainee has a regular breathing pattern, is lying in a safe position and is otherwise not at risk. Where there are concerns for a detainee's mental or physical wellbeing they must be woken up and further assessed.'

50 Of note, at the time Mr Pham was in custody, a specific definition for what amounted to a 'physical' check did not exist within the GOCM. It follows that, whilst the custody record for Mr Pham records the 'physical' checks that occurred at the requisite intervals, it is not indicative of occasions that staff physically presented at Mr Pham's cell. In fact, the evidence suggested that the overwhelming majority of detainee checks recorded for Mr Pham were conducted via observations from The Bridge or the CCTV monitor.

51 The ECC has an independent supervisor, that is, a supervisor not attached to the ECC, to conduct an audit on the ECC on each day, afternoon, and night shift. The role of the independent supervisor is to ensure the OICCC is complying with the GOCM and to review the custody record of detainees. Any non-compliance is then to be corrected through the OICCC.

52 The ECC also has a local Standing Order[17] to guide certain practices, in addition to the GOCM.

Admission into custody at ECC on 18 April 2019

53 Following his discharge from the LMH and his arrest, Mr Pham was presented to the charge counter at the ECC by Constable Gavini.[18] The 'fit for custody' form signed by Dr Musawir was provided to Senior Constable Masters, OICCC at this time.[19] The form instructed SAPOL to 'monitor for deep sedation/unconsciousness and seek appropriate help'.

54 Senior Constable Masters authorised the detention of Mr Pham. Mr Pham was refused bail for reasons including his criminal history, warrant history and history of breaching bail.

55 Due to the Easter weekend approaching (18 April 2019 was the Thursday before Good Friday), the next available court date was 23 April 2019, which meant Mr Pham would be in custody for six days.

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[17] Exhibit C80ba
[18] Exhibit C36
[19] Exhibit C33

56 At 5:01 pm Senior Constable Masters made an entry in Mr Pham's custody record, rating him as 'high' risk in relating to medical and health concerns, and noting that the hospital 'fit for custody' form stated to keep him under observation and note any change in behaviour and monitor for deep sedation/unconsciousness.

57 At 5:11pm Senior Constable Masters completed the risk assessment for Mr Pham, recording the following information in Mr Pham's custody record:

- In response to the question 'Is the detainee apparently suffering from any physical or mental condition?' answer 'Yes' and commented 'Located drug affected and unconscious from drug use (methylamphetamine/heroin). Treatment at LMH until fit for release'.
- In response to the question 'Does the detainee appear to be under the influence of alcohol or drugs?' answer 'Yes', and comment 'Alert and conscious after being released fit for custody LMH after located unconscious drug use'.
- In relation to the question 'Does the detainee appear to be suffering alcohol or drug withdrawal?' answer 'Yes' with the comment 'Nil at present but addicted to meth and heroin and likely to show signs of withdrawal over next 6 days in custody'.
- In relation to the question 'Based on the responses above, does the detainee need immediate medical treatment?' answer 'Yes' and comment 'Released fit for custody and to be kept under observation and note any change in behaviour and monitor for deep sedation unconsciousness'.

58 During the risk assessment process, Mr Pham told Senior Constable Masters he was addicted to methylamphetamine and heroin and that he gets withdrawals which include aches and pains.[20]

59 As Mr Pham was determined to be a 'high need detainee' he was placed into Cell E2 to allow for direct observation from The Bridge.

60 Records show that Mr Pham was then checked every 15 minutes for his first four hours in custody. On each occasion he was noted to be asleep but regularly breathing. The majority of these checks were conducted via CCTV or from The Bridge, as opposed to being checks where an officer attended upon Mr Pham's cell.

61 Mr Pham was then moved to hourly checks while remaining classified as high need. At 9:57pm and 11pm, he was sleeping but noted breathing regularly.[21]

62 Shift change of ECC staff occurs at 11pm. Important details about Mr Pham, his condition, and his potential to deteriorate were handed over to the oncoming night shift staff. Sergeant Elise Twiggs, the incoming OICCC nightshift, stated that following the handover, she made a note on the 'cells whiteboard' in Shield, which read '*** TO BE MONITORED FOR WITHDRAWALS ***'.[22] Brevet Sergeant Jessie McCallum, who was the second in charge during the night shift commencing at 11pm, stated that during

[20] Exhibit C33
[21] Exhibit C35
[22] Exhibit C40

handover the night shift were told that medical advice had been given that Mr Pham would begin experiencing withdrawal symptoms[23] and officers anticipated that he would likely need to return to hospital when that occurred.

The events of 19 April 2019

63 During the night shift (from 11pm on Thursday 18 April 2019 to 7:30am on Friday 19 April 2019), custody records indicated that a detainee check was conducted on ten occasions.

64 CCTV examined during the night shift period captured Mr Pham drinking on three occasions and vomiting twice. For the majority of this shift, he remained on the bed. No staff were observed to have had physical interaction with Mr Pham during the shift which suggests that the ten recorded checks were conducted via The Bridge or CCTV rather than physically attending at Mr Pham's cell.

65 Handover to day shift occurred at 7am. At handover Sergeant Twiggs advised the oncoming OICCC Sergeant Courtney Jaensch that Mr Pham would likely progress to withdrawal symptoms during the day and need to be taken to hospital.[24]

66 Sergeant Jaensch spoke to Mr Pham shortly after 7am[25] and observed that he '…appeared to be in pain; he was restless and writhing, however he was attempting to sleep'. At shortly after 8:30am, Sergeant Jaensch contacted a locum and requested that they attend the ECC to examine Mr Pham.[26]

67 Probationary Constable Black attended the cells at about 9am to enquire about interviewing Mr Pham but was advised that he was not in an adequate physical state to be interviewed in relation to the charges.[27]

68 At approximately 9:40am, Senior Constable Keir entered Mr Pham's cell to bring him a meal. Mr Pham acknowledged his presence by slightly nodding his head and grunting. Senior Constable Keir left the meal at the end of the bed. Senior Constable Keir recalls an unpleasant smell in the cell, in the nature of vomit, although he did not see any vomit.[28] He formally checked on Mr Pham again at 10:38am. He stated that Mr Pham could be easily checked without entering his cell, as due to his restlessness, it was simple to establish that he was alive because of his constant movement.[29]

Visit by locum

69 Dr Spiro Doukakis is a general practitioner who was at the time working with the 13SICK National Home Doctor Service. At the time of consulting with Mr Pham he had been with the service for approximately 27 years and had been a general practitioner for over 30 years.

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[23] Exhibit C39
[24] Exhibit C40
[25] Exhibit C32
[26] Exhibit C32
[27] Exhibit C28
[28] Exhibit C34
[29] Exhibit C34

70 A phone call was received by 13SICK from the ECC at 8:37am on 19 April 2019 to book a call for Mr Pham who was complaining of nausea and pain. Dr Doukakis received the booking and attended that day at approximately 11:30am.

71 In his affidavit[30] Dr Doukakis described that, according to his notes and his recollection, Mr Pham was lying down in his cell, he looked more or less passed out and looked quite pale. He looked underweight and unkempt. He was very drowsy and difficult to rouse. Dr Doukakis described that when he tried to speak to Mr Pham his response was soft and almost incomprehensible. Complaints of abdominal pain and vomiting came from Mr Pham as well as police reporting those complaints of Mr Pham to Dr Doukakis.

72 Dr Doukakis examined Mr Pham and became concerned due to his appearance that he may have septicaemia and delirium. His advice to the OICCC was to refer him straight to the ED via ambulance. I concur with the opinion of Dr Sarre that Dr Doukakis' assessment in the circumstances was appropriate, as he recognised that Mr Pham was quite unwell and arranged for the transfer to the LMH to occur. That was the most appropriate course of action at that point in time.

73 Sergeant Durbidge called an ambulance[31] at 11:38am, and paramedics Heidi Bradtke and Brenton Fennell arrived at 11:46am. The paramedics were told that Mr Pham had been witnessed vomiting multiple times that day. The paramedics were able to rouse Mr Pham. Dr Doukakis was still present and observed Mr Pham sitting up talking with the paramedics.[32] Mr Pham's observations were in the normal range. He reported nausea and abdominal pain. He was offered an antiemetic medication, and he refused it. While en route to hospital, Mr Pham told paramedics 'I am withdrawing from drugs because I haven't used for over 24 hours. This is how I am when I'm withdrawing'.[33]

Assessment at LMH

74 At approximately 12:06pm Mr Pham was transported to LMH, and his care was transferred from ambulance staff to hospital staff at 12:23pm.[34]

75 Dr Evelyn Timpani was on duty in the ED as a resident medical officer (RMO), having completed her internship at the end of January 2019. Dr Timpani first examined Mr Pham at approximately 3:15pm. She described in her affidavit[35] that when she first saw Mr Pham he was sleeping but was easily rousable. On questioning he said he had abdominal cramps, nausea, vomiting and diarrhoea which the doctor understood had been present for one to two days. Dr Timpani had noted when checking his records shortly prior to consulting with him, that he had presented to the ED the day before with an altered conscious state but was later discharged. He indicated that he was a regular user of heroin and amphetamine but had recently stopped them as he had been in custody for a few days. On questioning he claimed that his current symptoms were quite similar to his previous opioid withdrawals. Dr Timpani stated that Mr Pham did not have any significant past medical history that he told her, or that was obvious from the medical records available to her.

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[30] Exhibit C7
[31] Exhibit C46
[32] Exhibit C7
[33] Exhibit C8
[34] Exhibit C8
[35] Exhibit C9

76 On examination Mr Pham's observations were all within normal limits. Dr Timpani indicated that Mr Pham showed signs of opioid withdrawal including lacrimation and piloerection of the skin (goose bumps) and he was also yawning. His chest was clear, his abdomen was generally tender, but was not rigid, and there was no pain on coughing or moving around in the bed. These findings suggested to Dr Timpani that he did not have an acute surgical abdomen.[36]

77 Blood tests were ordered including electrolyte levels, a blood picture including white cell count, and C-reactive protein (both indicating an active infective or inflammatory process if they are elevated). Both these levels were normal.

78 Dr Timpani read the letter from the referring locum, but with normal observations and normal blood tests did not feel there was any sign of possible septicaemia, and did not feel there were any grounds to admit Mr Pham. She expressed that if Mr Pham had been unable to tolerate food and water he would have had to remain in the hospital, however he was able to tolerate both food and drink (she provided him with a drink and a sandwich) and did not have any further vomiting or diarrhoea during his stay in ED.

79 During his time in the ED, Mr Pham was administered paracetamol and ibuprofen for pain relief, ondansetron for nausea and Buscopan for abdominal pains.

80 Dr Timpani discussed the case with the ED consultant on duty who also agreed that Mr Pham's symptoms were in keeping with opioid withdrawal. Dr Timpani then contacted the registrar from the Drug and Alcohol Service to discuss his ongoing management.

81 Prior to discharge back into police custody Mr Pham was alert, orientated and cooperative. He was lying down but when asked to sit up, he cooperated.

82 Professor White detailed in his report that opioid withdrawal has typical symptoms of nausea, vomiting, irritability, depressed mood, insomnia, pain, diarrhoea, stomach cramps, fever and headache.[37] Professor White noted that on 19 April 2019 Mr Pham was found unsettled, restless and writhing in pain, and he opined that these are likely symptoms of opioid withdrawal following his cessation of heroin use. Professor White stated that his pain could have been due to stomach cramps that are characteristic of opioid withdrawal. This is consistent with the diagnosis at the hospital.

83 According to Dr Sarre, the assessment and treatment provided by Dr Timpani appeared reasonable. Her final diagnosis of opiate withdrawal seemed correct in Dr Sarre's opinion.

84 Dr Sarre expressed that, in retrospect, it would have been wise to admit Mr Pham to hospital to better manage his developing withdrawal symptoms in the event he became progressively more dehydrated and physiologically compromised at the police cells. He noted there were no trained nursing staff at ECC, though he did express that returning him to the cells in the circumstances was not an inappropriate decision. Put at its highest, this was perhaps a missed opportunity to have provided better supervision of Mr Pham's

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[36] A medical emergency characterised by sudden, severe abdominal pain that often requires immediate surgical intervention
[37] Exhibit C23

drug withdrawal, which was fairly severe, regardless of the impending duodenal perforation. According to Dr Sarre, perforation had not occurred at this time.

85 Bearing in mind Dr Sarre's qualification of that comment as being made in retrospect, and combined with the assessment of Dr Joyner that having had two separate medical assessments at the LMH and on both of those occasions there were no signs of any other clinical condition other than the effects of drug withdrawal, and that the medical assessment, treatment and advice all seemed reasonable, I find that the decision to discharge Mr Pham back to the ECC following this ED presentation was reasonable. Of note, Dr Sarre opined that Dr Timpani's instructions to Mr Pham's custodians were clear.

86 Constable Sarah Price took over guard duties for Mr Pham from Probationary Constable Black and Constable Stepcich (who had acted as escorts for the ambulance to the hospital) at the LMH from 3:20 pm.[38] Constable Price said that Dr Timpani approached her at 5:17pm and advised that she considered Mr Pham was fit for police custody and signed a form to that effect.[39] In the discharge note on the form, Dr Timpani recommended paracetamol and ibuprofen as needed, Buscopan for abdominal cramps, metoclopramide for nausea, and loperamide for diarrhoea. Dr Timpani wrote a prescription for SAPOL to obtain these required medications and emphasised that the police officers should ensure Mr Pham maintained good oral intake and to return if he was unable to tolerate oral fluids. Constable Price advised Dr Timpani that some of the medications prescribed could not be sourced until the pharmacy opened the following morning, and Dr Timpani said that it would be acceptable to obtain them at that time. A supply of metoclopramide had been provided by the hospital. Dr Timpani was unable to provide supplies of any of the other medications, as they are over-the-counter medications not kept by the hospital.

87 I observe that, although Dr Timpani prescribed ibuprofen, it was not administered at any time in the police cells. I simply mention that because, as I have detailed above, chronic use of ibuprofen can cause a duodenal ulcer. However, it would require more than a few tablets to induce a duodenal ulcer.[40]

88 Constable Price stated that Mr Pham was easily roused and walked independently to the police vehicle.[41] She observed that he appeared to be tired and was yawning constantly. His skin appeared yellow. Mr Pham said he was tired and wanted to sleep during the drive.

Return to police cells on the evening of 19 April 2019

89 At 5:48pm Mr Pham was returned to the ECC.

90 The OICCC at the time was Senior Constable Christopher Masters. He was presented with the 'fit for custody' form signed by Dr Timpani who recorded a diagnosis of 'acute opioid withdrawal'.

91 Senior Constable Masters stated that the form instructed that the ongoing medical care included ensuring oral intake, including sips of water frequently if vomiting, to avoid dehydration. He stated that the doctor also prescribed medications to be taken on an 'as

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[38] Exhibit C48
[39] Exhibit C48
[40] Exhibit C24
[41] Exhibit C48

needed' basis, namely paracetamol 1gm up to four doses per day maximum for pain as needed, ibuprofen 400mg up to three times a day for pain as need, Buscopan 10-20mg up to three to four times a day as needed for abdominal cramps and metoclopramide 10mg up to three times a day as needed for nausea. Senior Constable Masters stated that the doctor directed that all medications were to be given on an as needed basis and if not available they are not urgent, but useful for symptomatic relief. The hospital had supplied metoclopramide 10mg tablets and a script to be filled for further anti-nausea medication.

92 At 5:50pm Senior Constable Masters updated Mr Pham's care plan and recorded that the other prescriptions were to be filled when the pharmacy opened on 20 April 2019. Mr Pham was assessed as still being a 'high need detainee'. He was again placed in Cell E2 and quarterly checks were scheduled.[42]

93 Checks were recorded at 6:07pm, 6:22pm, 6:30pm, 6:43pm,6:58pm, 7:27pm, 7:40pm, 8:07pm and 8:21pm. On all of those occasions Mr Pham noted to be was asleep, but regularly breathing.[43] He was then moved back to hourly checks. At 9:26pm and 10:22pm he was noted to be sleeping but breathing regularly.[44]

94 At 11pm Senior Constable Masters finished his shift as OICCC. The incoming night shift OICCC was Sergeant James. Sergeant James was aware that Mr Pham had been in custody since Thursday 18 April 2019. He knew he was a high need detainee and in an observation cell. He was aware that Mr Pham had been to hospital on his arrest and since that time had been examined by a locum doctor and returned to hospital. Sergeant James also knew that Mr Pham had medication for dispensing on a 'needs' basis and that was because Mr Pham was in 'withdrawals'.

95 Second in charge for this shift was Acting Brevet Sergeant Shone. He had had previous contact with Mr Pham on occasions when Mr Pham had been in custody. He stated that on previous occasions in custody Mr Pham had also been to hospital for withdrawal and similar issues.[45]

96 CCTV during the night shift period captured Mr Pham drinking on four occasions and using the toilet three times. He appeared to vomit on three occasions.

97 The custody record indicates that Mr Pham's checks were conducted on ten occasions. CCTV records that only two of those occasions were checks where a staff member was physically present at Mr Pham's cell.

20 April 2019

98 At about 9am the following morning, 20 April 2019, Probationary Constable Black and Constable Stepcich attended the cells, and they were permitted to interview Mr Pham in relation to the drug trafficking charge.[46] The interview lasted for less than two minutes as Mr Pham declined to comment on the allegations. He yawned and his eyes were closed for the majority of the interview.[47] A second interview was then conducted in relation to

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[42] Exhibit C33
[43] Exhibit C35
[44] Exhibit C35
[45] Exhibit C56
[46] Exhibit C28
[47] Exhibit C29

a different matter. Probationary Constable Black recalls Mr Pham's cell having a 'very strong pungent smell' and that he saw black faeces splattered on the rear of the toilet bowl.[48] The officers were in the cell speaking to Mr Pham for approximately six minutes.

99 After completing the interviews, Probationary Constable Black and Constable Stepcich then attended at a pharmacy to fill the prescriptions for Mr Pham, returning the medication to the cells.[49] At 9:51 am Mr Pham was given two Gastro-Soothe tablets at the charge counter.[50] At 10:50am Mr Pham was asked if he wanted to take more Gastro-Soothe, but he declined.[51] He was then given another dose at 11:55am.[52]

100 Senior Constable Keir recalled that sometime during this shift, he observed Mr Pham leaning over his bed and vomiting on the floor of his cell. Senior Constable Keir stated this was in the middle of the day, either late morning or early afternoon. He observed Mr Pham use a cup of water in an attempt to wash the vomit down the drain of the cell.[53]

101 A prisoner who was in Cell E1 and provided an affidavit for the purposes of the inquest, stated that at some time during the afternoon of 20 April 2019, he heard the person in E2 vomiting and say, 'Help, I need help' in a panicked way.[54] It is unclear whether that was the same instance of vomiting described by Senior Constable Keir. CCTV captured Mr Pham vomit four times during this shift.

102 For this day shift period (7am to 3:30pm) the custody record indicated that a check was conducted on Mr Pham on 16 occasions. Staff physically attended the cell seven times. CCTV during this day shift period captured Mr Pham drinking on five occasions and using the toilet four times. He was not seen to eat any food.

103 At 3pm Constable Masters started his next shift as OICCC.

104 Mr Pham was checked (via The Bridge windows or the CCTV monitor) by Senior Constable Sims at 4:09pm, 4:58pm, 5:57pm and 6:53pm.

105 Senior Constable Richard Elksinits gave Mr Pham dinner at about 7pm when he was lying on the bed. He asked Mr Pham if he wanted food and Mr Pham did not respond. He asked Mr Pham if he wanted the food left and Mr Pham said yes, and a pie and sausage roll were left in the cell.[55]

106 Mr Pham was given 10mg of metoclopramide and 10mg of Gastro-Soothe at 7:48 pm.[56]

107 He was checked again at 8:43pm, 9:31pm and 10:20pm. At each of these checks he was recorded to be asleep but breathing regularly.[57]

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[48] Exhibit C28
[49] Exhibit C29
[50] Exhibit C32
[51] Exhibit C55
[52] Exhibit C34
[53] Exhibit C34
[54] Exhibit C11
[55] Exhibit C51
[56] Exhibit C33
[57] Exhibit C35

108 CCTV footage indicates Mr Pham was clearly experiencing pain during this shift, as he can be seen holding his stomach area, grimacing in pain, and experiencing several instances of diarrhoea and vomiting (including some that appear to be self-induced). Dr Joyner has opined that the symptoms of abdominal cramping pains, vomiting and diarrhoea are well recognised as being typical of withdrawal, and it is not possible to say whether any particular pains suffered by Mr Pham were due to drug withdrawal or an acute duodenal ulcer.[58] Whilst it should have been obvious to anyone monitoring Mr Pham during this shift that he was experiencing pain, his symptoms were consistent with the diagnosis at the hospital the previous day of opioid withdrawal, and Mr Pham had at this time been assessed by three doctors in the past two days. Dr Sarre expressed in his report that in the absence of any formal medical or first aid experience, it is understandable that those observing Mr Pham assumed he was undergoing narcotic withdrawal, as they would not necessarily recognise the risks of progressive dehydration and electrolyte disturbance leading to collapse and cardiac arrest, or to recognise a perforated duodenal ulcer.[59]

109 The custody records indicate that Mr Pham was checked 11 times during this shift. Three of those checks were checks where a staff member presented at Mr Pham's cell – once for observation, once to deliver medication, and once to deliver a meal.

110 Probationary Constable Weepers stated she spoke to Mr Pham over the intercom system near the end of her shift (which was ending at 11pm).[60] She said that Mr Pham asked to speak to someone about his charges and she told him that would occur on Tuesday when his matter was in court.

Evening shift from 11pm on 20 April 2019

111 Sergeant Darren James came on shift again as the OICCC at 11pm on 20 April 2019. Other officers on duty were Acting Brevet Sergeant Graham Shone as second in charge, Senior Constable Russell Carter, and Constable Ben Riddle.

112 Custody records indicate that for the night shift period (11pm-7:30am) the ECC fluctuated between having 14-16 detainees, with three high need detainees (including Mr Pham) for the duration of this shift.

113 Sergeant James stated that at the start of his shift at about 11pm, Mr Pham was howling and guarding his stomach.[61] He said that while the howling stopped over time, Mr Pham remained guarding his stomach and was using the toilet a lot. He said that his condition appeared to be getting worse. Sergeant James stated that:

> '…at no time did he knock on the, on the glass and say, "I need my medication", or, or use the intercom and say "can I have my meds now"'.[62]

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[58] Exhibit C22
[59] Exhibit C24
[60] Exhibit C36
[61] Exhibit C70
[62] Exhibit C70

He said:

> '…had he done it I would've, I would've given it to him.' [63]

114 Sergeant James stated that during this shift Mr Pham was up and down using the toilet quite a lot overnight, as he had diarrhoea.[64] He said that his understanding was that part of the withdrawal symptoms was to have 'black and hard' stools.

115 Acting Brevet Sergeant Shone said that he recalls being informed, at shift handover, that Mr Pham had been moaning and groaning for some time.[65] Acting Brevet Sergeant Shone then conducted a walkthrough inspection with Inspector Kevin Brown at about 11:45pm.[66] He said that he observed Mr Pham rolling around on his bed quite a lot and moaning and groaning a little.[67]

116 Sergeant Sando attended for the purposes of the cells audit at approximately 1:10am on Sunday, 21 April 2019. Sergeant Sando said that his practice is not to wake up detainees who are sleeping, as his visits are always at night, but that he does check for signs of breathing and/or moving. He said that this may require entry into the cell and may actually require waking the detainee. Sergeant Sando checked Cell E2 at 1:20am and saw that it was Mr Pham whom he had also seen on 20 April 2019 during his routine checks. Mr Pham was lying on his bed and was breathing. He stated he had no concerns about his welfare at this time. Sergeant Sando then sat in The Bridge and had a coffee with cell staff. During this time he saw Mr Pham get up to use the toilet in the cell before returning to bed.[68]

117 CCTV from this night shift indicates that staff physically attended the cell four times for observation (albeit brief observation, in the order of seconds) prior to Mr Pham being observed by Sergeant James to fall backwards at about 4:19am.

118 Mr Musolino, the detainee in Cell E1 which adjoined Mr Pham's, was in that cell during this shift, along with a Mr Herbert. Mr Musolino provided an affidavit in which he stated he recalls the person in the cell next to him saying at some point, 'I'm having a heart attack, I need help, I need help, I need help' and gasping for air.[69] Mr Musolino does not know what time he heard this. At no time did Mr Musolino contact cell staff to report what he allegedly heard, nor did he attempt to gain assistance for Mr Pham after allegedly hearing this.

119 Mr Herbert stated that during this shift he heard sounds coming from the cell next door which sounded like vomiting. He heard someone sound like they were gasping for air. He then heard someone say, 'he had fallen over'. Mr Herbert stated he discussed with Mr Musolino what was happening, and Mr Musolino stated, 'the bloke next door said he is having a heart attack'.[70] Mr Herbert said he went back to sleep and when he woke up there were two ambulance officers and two police officers standing by Mr Pham's cell.

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[63] Exhibit C70
[64] Exhibit C70, CCTV during the night shift period captured Mr Pham using the toilet a minimum of 13 times
[65] Exhibit C56
[66] Exhibit C56
[67] Exhibit C56
[68] Exhibit C54
[69] Exhibit C11
[70] Exhibit C10

Mr Herbert does not mention in his affidavit hearing Mr Pham call out 'help' or that he is having a heart attack at any time. Sergeant James' evidence was that Mr Pham did not mention chest pains, which, in his mind, would have necessitated him contacting an ambulance immediately.[71] I am satisfied that, if Mr Pham did call out that he was having a heart attack at some point, that was not heard by Sergeant James. Sergeant James conveyed in his evidence that he appreciated the urgency of ambulance attendance in cases of reported chest pain. None of the other officers in the cell present that night report hearing Mr Pham complain of chest pain or having a heart attack, nor does Mr Herbert.

120 CCTV footage captures the events leading up to Mr Pham's collapse. The footage depicts that in the hours leading up to his collapse, Mr Pham was very unsettled. He was observed to move to the toilet frequently (at 2:31am, 3:53am, 4:09am, 4:12am and 4:15am).

121 At 4:19am Mr Pham sat on the edge of the bed before standing up. He walked to the sink and grabbed his cup. He was unsteady on his feet and then leant his head on the wall in front of him. He then put his arm up and stumbled backward. He fell backwards and appeared to hit his back on the corner of the bed and put his arms out to stop himself from falling further. He then sat upright on the floor and leant his back against the bed. He did not appear to lose consciousness. About 17 seconds later, Sergeant James opened the door of the cell. Acting Brevet Sergeant Shone appeared shortly after, placing gloves on as he approached. Sergeant James appeared to talk to Mr Pham for several seconds before Mr Pham helped himself up and back onto the bed. He then lay down facing away from Officers James and Shone. The cell door was closed, and the officers left the area. Sergeant James' evidence was that during this conversation Mr Pham reported to him that he felt dizzy.[72] Sergeant James' evidence was that this fall:

> '... did concern me because I legitimately thought that he'd fallen and hit his head, that was my biggest worry. When I went and had a look there was no blood on the floor, there was no blood on the back of his head and he just said he felt dizzy. So, I'm assuming when he fell he didn't fall on his head.' [73]

122 Sergeant James' evidence was that, after seeing Mr Pham fall at this time, he had a discussion with Acting Brevet Sergeant Shone where they agreed Mr Pham needed to return to hospital. Sergeant James was concerned that Mr Pham was more than likely in withdrawal from heroin. Acting Brevet Sergeant Shone was also concerned that Mr Pham was withdrawing.

123 At 4:21am Mr Pham can be seen on the cell bed, facing towards the cell wall with the blanket pulled up between his legs. His breathing appears rapid, and he appears uncomfortable.

124 At 4:23am Mr Pham can be seen getting up from the bed and moving to the toilet. He initially steadied himself while on the toilet with a hand on the adjacent wall and by holding the sides of the bowl. At approximately 4:25am Mr Pham fell forward, off of the toilet, landing on the floor. Mr Pham then rocked back and forward for about ten seconds. He then pulled up his pants, lifted himself onto his hands and knees and crawled onto the

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[71] Transcript, page 48
[72] Transcript, page 50
[73] Transcript, page 56

bed. He struggled, but climbed back on to the bed, partially at first and then all the way. He lay back down.

125 Sergeant James observed this second fall. He stated, 'when he fell off the toilet it wasn't that far to fall and I didn't really have any concerns when he fell off the toilet the second - or the second fall'.[74]

126 At 4:27am Mr Pham is on the bed facing the cell wall. He is clutching the blanket, moving around appearing to try and get comfortable. His eyes and mouth are open with his legs half curled, tucked up towards his torso. His breathing appears to remain rapid and shallow.

127 At 4:31am Mr Pham appears noticeably uncomfortable, constantly shifting positions on the bed from left to right and onto his back. He continually clutches the blanket and at times places his hands on his head. His breathing remains rapid and shallow.

128 At 4:37am Mr Pham lies on his back with his arms across his chest, hands meeting in the middle. His hands and fingers are curled/contorted. His head faces towards the ceiling. He does not blink. He appears to be swallowing heavily. His legs are curled up.

129 At 4:38am Sergeant James calls for an ambulance for Mr Pham.[75] He reported the following information to the call taker during this call:

- There is a prisoner who is in withdrawals from heroin;
- He has fallen over twice, is dizzy, doubling over in pain, moaning, 'that kind of thing';
- He is conscious, breathing;
- His breathing is completely normal;
- He is completely alert;
- He is grey in colour;
- He is under observation.

130 At 4:40am Mr Pham remains on his back with his left leg outstretched. His right leg is drawn up and begins to shake for about a minute and then stops.

131 At 4:41am paramedics Lauren Grigg and Georgie Mittiga were tasked to attend at the Northern Cells for a priority 2 case.[76]

132 Also at 4:41am, Mr Pham commences a series of swallowing actions. His breathing appears to become even more laboured.

133 At 4:50am Mr Pham appears to swallow twice.

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[74] Transcript, page 56
[75] Exhibit C80bv
[76] Exhibit C13

134 CCTV records Sergeant James going into the sally port area to greet and brief the SAAS paramedics at 4:52am.[77]

135 At 4:56am paramedics and Sergeant James are seen to enter the ECC charge area with a barouche.

136 The paramedics then return to the sally port area, before returning to the ECC charge area at 4:58am.

137 At 5am four police and two paramedics enter Mr Pham's cell. Constable Riddle opened the door and spoke to Mr Pham, who did not answer back.[78]

138 Sergeant James said that when the paramedics arrived at the cell he was in The Bridge, and he saw that Mr Pham was lying on his back on the bed and that he was breathing.[79]

139 Upon entry to the cell, Ms Mittiga approached Mr Pham, held his right hand and looked at his face, getting no apparent response. She checked Mr Pham's pulse and advised Ms Grigg that she could not find a pulse and that Mr Pham's pupils were fixed.

140 Paramedics commenced CPR at approximately 5:01am. A shockable rhythm was detected, and a shock was delivered. Mr Pham was moved to an open area and Ms Mittiga and Ms Grigg called for backup.

141 Police officers took over compressions while an endotracheal tube and intravenous line were inserted by the paramedics.

142 At 5:06am Intensive Care Paramedic Simon Walter was dispatched to attend. Mr Walter stated in an affidavit provided to the Court that paramedics Mittiga and Grigg had instigated care within the SA Ambulance Clinical Practice Guidelines for Cardiac Arrest.[80] He then assumed the clinical lead in Mr Pham's resuscitation. He stated that at that time Mr Pham was showing no signs of life, had no respiratory effort and no signs of circulation. An ECG showed some signs of organised activity with no corresponding cardiac output or pulse.

143 At 5:30am, after approximately 26 minutes of CPR, there was a return of spontaneous circulation.[81] Mr Pham had a respiratory rate of three breaths per minute, oxygen saturation of 63%, no measurable blood pressure and a heart rate of 160 beats per minute. He was kept on intermittent positive pressure ventilation because he had no respiratory effort.[82]

144 Mr Pham was taken to the LMH.

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[77] Exhibit C70
[78] Exhibit C53
[79] Exhibit C70
[80] Exhibit C14
[81] Exhibit C13
[82] Exhibit C14

The events between the first fall at 4:19am and CPR commencing at 5:01am

145 Sergeant James' evidence was that the decision to call an ambulance was made shortly after Mr Pham's first observed fall at 4:19am. He and Acting Brevet Sergeant Shone both agreed an ambulance should be called. Despite that, the call to SAAS was not made until 4:39am, and the paramedics did not present to Mr Pham's cell until 5am when it was immediately apparent that Mr Pham required CPR. This raises the question of what occurred during that 41 minute timeframe.

146 It is not clear what was occurring between 4:19am and 4:38am. Sergeant James' evidence was that at approximately 4:30am he contacted Salisbury Police Station to arrange an escort to the hospital. This was consistent with the evidence of Sergeant Sando. As for what else Sergeant James was doing in the time period between 4:19am and 4:38am other than arranging for the escort, there is no evidence. Sergeant James was unable to recall his actions or movements during this time period.[83] He posited that there could have been other people who asked his opinion about a matter, there could have been something else that he needed to do, though he agreed with the proposition that if there had been some other major incident that had diverted his attention from calling an ambulance within this time period, he would have mentioned that in the statement he provided to police in the hours that followed Mr Pham's demise and transport to hospital.[84]

147 Sergeant James was questioned in Court about why he called to arrange a police escort before calling for an ambulance. His evidence was that he was of the understanding that the GOCM required police escorts to be used when a SAPOL detainee with medical issues is being moved elsewhere. He was also mindful that, because Mr Pham was being held in custody on serious drug charges, sufficient police officers would be required to effectively guard him once transferred to the hospital. He considered that there were 12 other detainees in the cells, including two pending newly arrested detainees. Sergeant James stated in his affidavit that he did not want to put one of the cells' staff in the ambulance with Mr Pham because if he did that, he would exceed the prisoner to cell guard ratio for the remaining prisoners. The Standard Operating Procedure: Custody Management dictated that the cell guard ratio of 7:1 should not be exceeded. He stated that he was also alert to the fact that cell guards do not have the operational equipment that a patrol officer carries when out in public.

148 There were two documents that offered direction to Sergeant James about what should occur when a detainee needed to be transferred to hospital: the GOCM, and the ECC Standing Order.

149 On the issue of detainees requiring medical attention, the ECC Standing Order stated:

> 'If the Officer in Charge of the cells has a prisoner that requires urgent medical treatment (life threatening etc.) then they are to call for an ambulance as per normal protocols for transport to the Lyell McEwin Hospital.'

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[83] Transcript, page 55
[84] Transcript, page 55

In addition:

> 'If a prisoner is presented or is in custody and requires treatment for other non-emergency medical issues (e.g. drug withdrawal, cuts and abrasions and headaches, prisoner care plans) the locum service can be utilised.'

150 In relation to his interpretation of this document and his obligations in the situation, Sergeant James' evidence was:

> 'It said "life-threatening". At the time I did not believe that his injuries were life-threatening. If he had suffered a heart attack or something measurable or observable, or obvious that it was life-threatening, then yes, it would have definitely guided how I did it. But at the time all I was aware, that he was potentially drug withdrawal, he was dizzy and had stomach cramps. The training that I had, the first-aid certificate that I had didn't allude to those symptoms being life-threatening, but I do now.'

151 The GOCM at the relevant time stated that the OIC cells or cell guard must ensure a person in custody, including a person detained under the *Public Intoxication Act 1984*, is treated as a medical emergency and an ambulance is called **immediately** when that person has been rated as a high need detainee and requires medical assessment.

152 Counsel Assisting cross-examined Sergeant James about this portion of the GOCM. It was suggested to Sergeant James that this portion of the GOCM required him to call an ambulance immediately upon making the decision with Acting Brevet Sergeant Shone that that should occur, as Mr Pham classified as a high need detainee.

153 Although Sergeant James conceded that this portion of the orders was potentially applicable, and that he did not call an ambulance 'immediately',[85] it is of some relevance that Sergeant James was aware that Mr Pham had recently been medically assessed on at least two occasions, diagnosed with drug withdrawal and been assessed as being 'fit for custody'. He believed (on what Dr Sarre opined as being a reasonable basis) that Mr Pham's symptoms were a continuation of his already medically diagnosed drug withdrawal. The Commissioner of Police submitted that it was reasonable for Sergeant James to consider that this portion of the GOCM was not applicable in the circumstances.

154 In my view, the wording of this particular portion of the GOCM is quite clear when read in isolation. It requires two preconditions to be satisfied. That is; that a detainee is rated as high need, and that they require a medical assessment. Both of those preconditions were satisfied here.

155 I accept that, when read in the context of the GOCM as a whole, there does appear to be some potential for confusion, given the mention of an escort being required for transfers on the page preceding this instruction, yet no explicit instruction about whether an escort should be disregarded in the case of a high need detainee requiring medical assessment. Of course, ambulance attendance at the cells does not of itself necessitate the attendance of an escort - an escort would only be required if and when a patient is to be transported from the ECC. Accordingly, it is appropriate that in the case of a high need detainee that requires medical assessment, the ambulance should be contacted first to avoid any delays in medical attention being provided to the detainee.

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[85] Transcript, pages 62-63

156 I find that SAAS should have been contacted earlier than 4:38am; SAAS should have been contacted shortly after 4:19am when Sergeant James and Acting Brevet Sergeant Shone agreed that Mr Pham required medical attention. I accept the lack of immediacy on Sergeant James' part was influenced by the knowledge that Mr Pham had received medical attention on multiple prior occasions, and that he viewed this to be a continuation of the medical complaint for which he had previously received that medical attention. Yet this instruction of GOCM does not distinguish between medical assessment for a new condition or medical assessment for a continuing condition, nor does it look beyond the immediate issue of arranging for ambulance attendance (for example, to arrangements for transport to hospital).

157 At 4:38am Sergeant James completed a medical examination of detainee entry on Mr Pham's custody record. The GOCM dictated that on each occasion a detainee in custody is to be medically or psychiatrically examined by a health care practitioner, a medical examination of detainee form must be completed by the OICCC. Sergeant James recorded on the report that 'this detainee has already been to hospital twice and appears to now be in drug withdrawal'. It also recorded that:

> 'Police have seen this detainee is unable to stand and has fallen over twice. He appears to have stomach cramps and is doubled over when laying down and guarding his stomach area. He has been constantly on the toilet and his stools are black. He has been taking fluids occasionally; Last medication given was on the 20th of April at 1948 hours. This patient WILL be in custody until Tuesday and may not last that long without further medical treatment that only a hospital can give, as opposed to a Police custodial facility.'

I note that the GOCM dictated that report should be provided to the senior escorting member when a detainee is conveyed to a medical facility for treatment, clearly contemplating both that an escort will be arranged, and that the medical examination of detainee form will be ready for the escort when it is time to depart the cells.

158 Sergeant James made the call to SAAS at 4:39am. He called what he referred to as the 'non-urgent' line. His rationale for contacting this number (rather than 000) was as follows:

> 'Based on what I could see and what I knew, I spoke to him in the cell and he told me that he felt dizzy. I knew that he had stomach cramps and he did not - he looked off color. So there was no indication to me at that point in time that it was a life and death emergency. I knew that 000 is for emergencies only, so I rang the medical - ambulance attendance line so that I wouldn't tie up the 000 number. It, as I said, did not appear to me to be urgent at that time, based on what I knew. If I had the ability to have 20/20 vision hindsight about this whole incident and how serious it was, then, yes, I would have rang 000 at the beginning of my shift. But it did not warrant ringing 000 for a person that felt dizzy.'[86]

159 I do observe that between 4:19am after Sergeant James and Acting Brevet Sergeant Shone closed the door, to 5am when paramedics enter - a period of some 41 minutes - no person entered the cell to conduct a physical check on Mr Pham. The officers relied on CCTV observations and their observations from The Bridge to monitor Mr Pham's welfare.[87] No

[86] Transcript, page 48
[87] Transcript, page 78

person was tasked to remain with Mr Pham after his first fall to provide closer monitoring while awaiting the arrival of the ambulance.

160 I also observe that the GOCM was somewhat unclear as to whether it was a requirement that Sergeant James arranged for an officer to be physically present awaiting ambulance arrival. Although it stated, 'The O/C cells must also ensure a member is physically present with the detainee where possible while waiting for the ambulance and where practicable, the incident is monitored by CCTV', it is unclear whether this related to all detainees for whom an ambulance is called, or only semiconscious or unconscious persons (noting the bold text preceding this which stated, 'Where possible never leave a semiconscious or unconscious person alone and always place them in the recover position'). There is potentially some ambiguity around the term 'physically present', which that may be interpreted to mean physically observing, but not from the inside of the cell, given that appeared to be how the term 'physical check' was interpreted.

161 The decision to monitor via The Bridge and CCTV was not adequate in the situation. However, I accept that that the ECC staff at the time did not appreciate the gravity of Mr Pham's condition and the level of urgency required. This decision was made in the context of a clear lack of appreciation of how critically unwell Mr Pham was, due to a lack of medical expertise. On that issue, Sergeant James gave the following evidence:

> 'The only medical training I have received is for my first aid certificate. I had no idea of the relevance of Mr Pham's black excrement in his cell, and I was unaware that his internal organs were already in the process of shutting down. All I could see after Mr Pham's two falls on the morning of Sunday 21 April 2019 was that he was conscious and breathing.'

162 I accept that, viewing Mr Pham from The Bridge and/or the CCTV monitor, it likely appeared to officers that he was breathing for the duration of this period of time between the first fall and the arrival of the ambulance.

163 However, the failure to have an officer physically present in the cell with Mr Pham immediately following the decision that an ambulance should be called, and until the ambulance arrived, was a lost opportunity for Mr Pham's deterioration to have been recognised sooner. Closer monitoring of Mr Pham after the first fall, or even the second, may have led to a recognition of the urgency of the situation, potentially resulting in earlier medical intervention. I do observe that the ambulance call taker did specifically query if Sergeant James was 'with him now' and Sergeant James responded 'yeah, we've got him under observations' and advised that his breathing was completely normal. Had Sergeant James advised that the observations were taking place from outside of Mr Pham's cell, that is from The Bridge and/or CCTV as they were, the call taker may have advised Sergeant James of the importance of the physical presence of an officer.

164 The absence of recognised urgency significantly delayed the commencement of CPR. As demonstrated by the timeline I have detailed above, paramedics were on-site for approximately eight minutes before entering Mr Pham's cell. Critical time was lost while the SAAS crew remained in the sally port and donned PPE. The apparent failure to prioritise immediate access to Mr Pham to provide urgent intervention reflected the underestimation of the urgency on the part of the ECC staff.

Footage of Mr Pham between 4:19am and 5:01am

165 The footage of Mr Pham in Cell E2 during this critical 41 minute time period was of assistance in ascertaining how his condition deteriorated during this time. The footage was sent to Professor Anne-Maree Kelly for an assessment on the progression of his situation during this time.

166 Professor Kelly expressed that it can be very difficult to tell from video footage (especially when it is taken from a distance) exactly when all respiratory effort ceases. Often breathing does not stop abruptly but becomes increasingly shallow and/or slow (and potentially ineffective) before ceasing. Professor Kelly also pointed out that it should be noted that she was able to pause and rewind the video footage. This possibility was not available to the ECC staff viewing the footage in real time. I accept that and bear that fact in mind.

167 Professor Kelly expressed her view that Mr Pham, more likely than not, had a significant period of hypotension preceding his cardiac arrest and that the cardiac arrest was due to compromise in heart function, due to low blood flow to the heart muscle, hypoxia and potentially electrolyte abnormalities. Her rationale of this conclusion was that when Mr Pham stood, he became unsteady and fell backwards. Mr Pham also fell while trying to stand up after using the toilet. After the fall, he was unable to stand and had to crawl back to bed. This is consistent with low blood pressure.

168 Professor Kelly expressed her opinion that all respiratory effort ceased shortly after the paramedics had entered the cell. This is the point at which mouth movements suggestive of attempts to breathe ceased. However, Professor Kelly explained that there is a difference between effective breathing, ineffective breathing and agonal breathing. Agonal breathing is when a person takes short, gasping breaths that are not normal. These breaths are shallow and often irregular. Agonal breathing is common among cardiac arrest patients. It can be observed in about 40%-60% of cardiac arrest patients within the first few minutes. Agonal breathing can last seconds to many minutes.

169 In Professor Kelly's opinion, Mr Pham's breathing became increasingly ineffective over the time of the video footage. In her opinion he was clearly breathing, albeit shallowly, until about 4:55am. For about the next two minutes there are probably some very small breaths which she would expect to be ineffective. Her rationale is that she cannot see Mr Pham's chest moving at all. In her opinion, thereafter, which is from about 4:57am, breathing is agonal and ineffective.

170 I accept that, viewing from The Bridge and the CCTV monitors, officers observing Mr Pham would not have been in a position to make a proper assessment of the effectiveness of any breathing. That is why the absence of a staff member, either continuously present in Mr Pham's cell or conducting regular physical checks while awaiting the ambulance, may have contributed to the failure to recognise his deterioration. Whilst an officer might not have identified the clinical significance of a change in his breathing, consistent physical presence could have increased the likelihood of noticing signs of decline. The failure to recognise Mr Pham's deterioration during this critical 41 minute period clearly contributed to the delay in Mr Pham receiving timely medical attention.

Admission to LMH on 21 April 2019

171 Mr Pham was admitted to the LMH at 6am on 21 April 2019.

172 At the time of his arrival in the ED he was found posture in keeping with hypoxic brain injury. His pupils were dilated but not fixed. On admission to the ICU an ECG, troponin, blood and liver and kidney function tests were performed. At that time, Mr Pham's blood results were in keeping with ischaemic hepatitis and kidney impairment, findings consistent with a patient who suffered an out-of-hospital cardiac arrest.

173 A CT or MRI was performed on Mr Pham's brain, but the results were inconclusive.[88] At the time there was concern that Mr Pham would not recover from the cerebral compromise during the cardiac arrest episode, but the medical opinion was to treat all other causes of Mr Pham's condition first to see whether he would improve.

174 The CT scan of the abdomen showed free gas within the peritoneal cavity which suggested a gastrointestinal perforation.[89]

The surgical plan was to perform a laparotomy, which is an incision over the abdominal wall, to gain access to the peritoneal cavity, allowing for identification of the site of perforation and subsequent repair.

175 Mr Pham was taken to surgery at 9:09 am on 22 April 2019. The surgeon, Dr Rebecca Thomas, found a 0.5cm by 0.5cm perforated ulcer at the junction between Mr Pham's stomach and duodenum.[90] The surgical team reported that Mr Pham's liver, spleen and bowel were displaying significant changes consistent with oxygen deprivation. These findings were attributed to Mr Pham's out-of-hospital cardiac arrest.[91]

176 Following surgery Mr Pham's surgical incision was not closed. This allowed for further inspection of the organs after noradrenaline, a vasoconstrictor used during surgery, had been ceased. A review surgery was planned for 24 to 48 hours later. Mr Pham was prescribed pantoprazole.

177 On 24 April 2019 Mr Pham underwent a brain MRI. The scan was reported as compatible with severe oxygen deprivation of the brain and the injury was considered not compatible with life. Dr Sarre opined that the management of Mr Pham at the LMH following his cardiac arrest was appropriate but that '… the damage had already been done by a prolonged episode of cardiac arrest'.[92] I accept that to be the case.

178 In consultation with Mr Pham's family, his care was transitioned to palliation[93] and on 25 April 2019 Mr Pham was extubated.[94]

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[88] Exhibit C15
[89] Exhibit C15
[90] Exhibit C16
[91] Exhibit C18
[92] Exhibit C24
[93] Exhibit C18
[94] Exhibit C19

179 At about 3am on 27 April 2019, Registered Nurse Kirsten Shuttleworth was advised by family members that they believed Mr Pham had died. She checked and found no signs of life.[95]

Was Mr Pham's death preventable?

180 Relevant to the question of preventability is the issue of when the perforation in fact occurred. Dr Sarre has opined that it is likely that Mr Pham had an undiagnosed duodenal ulcer at the time of his arrest. The perforation may have been provoked by his narcotic withdrawal as he was unable to tolerate oral intake and was physically stressed and dehydrated. Dr Sarre was of the opinion that the perforation likely occurred during the evening of 20 April 2019 on a background of an emaciated, dehydrated individual undergoing an opiate withdrawal episode. Dr Joyner stated that it is impossible to be certain about the timing of this perforation, noting that it is not possible to say whether any symptoms suffered by Mr Pham were due to opioid withdrawal or to an acute duodenal ulcer. On the balance of the evidence, I am unable to find precisely when the perforation occurred, other than it was sometime after discharge from the LHM on 19 April 2019 and before his collapse at 4:19am on 21 April 2019.

181 Whilst I accept the evidence of both Drs Sarre and Joyner that the discharges from LMH on both 18 and 19 April 2019 were appropriate in the circumstances, and that Mr Pham was showing no signs of duodenum perforation at that time, Dr Sarre concluded that if Mr Pham had been admitted to hospital on 19 or 20 April 2019, Mr Pham's collapse and cardiac arrest may have been prevented. In saying that, he was not critical of the hospital assessment and discharge of Mr Pham on those occasions, as I have mentioned above.

182 As to whether Mr Pham's death was still preventable as at the time of his collapse in the cell on 21 April 2019, that question is more complex. Dr Joyner expressed that he could not identify a specific time prior to that collapse episode that would have required earlier transfer back to hospital. Nonetheless, Dr Sarre also opined that if Mr Pham had been in hospital, resuscitation would have been better provided with the presence of trained staff and full facilities. Implicit in that is that the resuscitation of Mr Pham may have been more successful had he arrived at the hospital earlier. While an earlier arrival of the ambulance may have resulted in an earlier arrival at hospital, and potentially a more successful resuscitation, it would be speculative to assert that this would have absolutely occurred. Too many variables are involved to draw any firm conclusions about how events might have unfolded had the ambulance been contacted and arrived sooner after Mr Pham's first collapse in the cells.

183 I note that Dr Sarre and Dr Jessen (Director of ICU at LMH)[96] both opined that the resuscitation effort of the attending SAAS members was entirely appropriate, and I so find.

184 I am satisfied that at the time Mr Pham presented to LMH on 21 April 2019, his death was not preventable. His organs had sustained irreversible damage following a prolonged episode of cardiac arrest.

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[95] Exhibit C19
[96] Exhibit C18

Summary of findings

185 Mr Pham was in lawful custody from the time of his arrest.

186 The assessment of Mr Pham at the LMH on 18 April 2019 and the decision to release him into police custody was appropriate at that time.

187 Mr Pham was correctly identified as a high need detainee.

188 On 19 April 2019, locum Dr Spiro Doukakis took appropriate action by arranging for Mr Pham to be transferred back to the LMH via ambulance for assessment.

189 The assessment of Mr Pham at the LMH on 19 April 2019 and the decision to release him into police custody was appropriate at that time.

190 Mr Pham experienced perforation of a duodenal ulcer sometime after his return to custody on 19 April 2019 and before his collapse on 21 April 2019.

191 The exact timing of the perforation is unknown.

192 At the time of his first collapse at approximately 4:19am on 21 April 2019, Mr Pham was critically unwell and required urgent ambulance attendance.

193 There was no specific time prior to that episode that required earlier transfer to hospital (given he had already attended the hospital twice in the previous days).

194 Sergeant James and Acting Brevet Sergeant Shone decided shortly after witnessing Mr Pham's collapse at 4:19am on 21 April 2019 that Mr Pham required medical attention.

195 Due to their lack of medical expertise, they did not appreciate the gravity of the situation.

196 As Mr Pham was a high need detainee requiring medical attention, an ambulance should have been contacted immediately, in compliance with the GOCM.

197 Sergeant James contacted an ambulance approximately 20 minutes after discussing with Acting Brevet Sergeant Shone that an ambulance should be called.

198 That did not amount to 'immediate' contact within the definition of the GOCM.

199 Lack of physical interactions with Mr Pham for the duration of his time in custody, and in particular for the 41 minutes between his first collapse at 4:19am on 21 April 2019 and the arrival of paramedics into the cell, may have contributed to the lack of recognition of his deterioration.

200 Earlier ambulance attendance may have led to a more favourable outcome for Mr Pham.

201 The actions of the paramedics who attended were entirely appropriate.

202 As at the time of his arrival at LMH on 21 April 2019, Mr Pham's death was no longer preventable.

Recommendations

203 Pursuant to section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of events similar to the events which were the subject of the inquest.

204 The Court received into evidence an affidavit from Assistant Commissioner Simon Watkins detailing some relevant changes that have occurred within SAPOL since the time of Mr Pham's death.[97]

205 Firstly, on 11 August 2021, a new definition of 'physical check' was added to the GOCM. A 'physical check' of a detainee is the inspection of a detainee in person by an employee to check on the welfare of a detainee and involves the employee communicating personally with a detainee who is awake or checking for signs of breathing and movement where a detainee is asleep. A physical check requires that the employee conducting the check will be able to open the cell door, and personally interact and respond to the needs of the detainee. Observation of a detainee on closed circuit television (CCTV) or from an office/intercom does not constitute a physical check. I am satisfied that this change negates the need for me to make any further recommendation about how a detainee should be physically checked in accordance with the GOCM.

206 On 26 March 2020, Wellbeing SA[98] formally agreed to supply qualified nurses to work in each of the four SAPOL metropolitan custodial facilities to assist in appropriate screening and management of detainees. Since April 2020, Pop-Up Health Services are contracted to supply nursing services to each of the four metropolitan custodial facilities to assist in the appropriate screening and management of detainees. Pop-Up Health are contracted to work at the City Watch House and Elizabeth custodial facilities 24 hours per day, seven days per week. Nurses at Port Adelaide and Christies Beach custodial facilities work afternoon shift and night shift seven days per week. In addition, a day shift nurse will be on duty at Port Adelaide and Christies Beach custodial facilities every Monday due to the volume of detainees these sites experience over a weekend. Pop-Up Health have access to the SA Virtual Care service provided by SA Health within metropolitan custodial facilities. The service provides an individualised assessment service via video link for urgent patients on-scene with SAAS staff, regional clinicians (including Pop-Up Health) or aged care staff. This is a significant improvement and again I need not make any further recommendations in order to address the predicament that arose by police officers not being sufficiently medically trained to recognise the critical deterioration of Mr Pham.

207 In relation to the failure to have someone present in the cell with Mr Pham while awaiting arrival of the ambulance, it is my view that the GOCM should clearly specify this as a requirement any time a decision is made to contact an ambulance for a detainee. Clearly, in the case of Mr Pham, arrangements were not made to have someone physically present in the cell, which suggested that, regardless of the intention behind the wording of the GOCM in place at that time, physical presence of an officer in the cell was not understood by ECC staff to be a requirement in this situation. Given the potential for any patient to rapidly deteriorate awaiting the arrival of an ambulance, and the need for such a

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[97] Exhibit C81
[98] SA Health

deterioration to be immediately identified, communicated to ambulance and acted upon via means of first aid if required, it should be essential for a detainee awaiting arrival of an ambulance to have an officer in their cell making constant observations for the entirety of the time between the decision to contact the ambulance and the arrival of the ambulance. Accordingly, I recommend that SAPOL update the GOCM to specify the requirement that an officer be physically present in the cell with the detainee at all times while awaiting an ambulance.

208 In relation to the ambulance having not been called 'immediately', and in light of the evidence of Sergeant James about why he arranged for the escort before calling for an ambulance, and in light of the comments I have made about the potential for confusion given the mention of escorts for medical transfers on the page preceding the instruction in relation to high need detainees who require medical assistance, I recommend that the GOCM be reviewed to make it abundantly clear that for a high need detainee requiring medical assessment, an ambulance must be called immediately, and nothing need occur before that (including medical transfer paperwork or the arranging of an escort). I direct these recommendations to the Commissioner of Police.

209 In conclusion, I extend my condolences to the family of Mr Pham for their loss.

Keywords: *Death in Custody; Police Cells; Natural Causes*