IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 1579

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**DAN (SELINA) LIN**
Date of birth:	10 November 1990
Date of death:	3 May 2012
Cause of death:	Blunt force trauma to the head
Place of death:	Darebin Creek, Bundoora, Victoria

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HER HONOUR:

BACKGROUND

1. Dan Lin (**Ms Lin**), also known as Selina Lin, was a 21-year-old woman who lived with her husband and young son at Bundoora at the time of her death. Ms Lin was born in China and had migrated to Australia in 2008 for education purposes.

2. In February 2010, Ms Lin married Rong Ping Zhuang (**Mr Zhuang**), also known as Peter, and they had a son, Alfred, in May 2010.

3. On 3 May 2012, Ms Lin's mother-in-law, Huajiao Zhuang (**Mrs Zhuang**), killed her by striking her to the head with a hammer over thirty times. Mrs Zhuang then disposed of Ms Lin's body in the Darebin Creek.

4. Mrs Zhuang had lived with Mr Zhuang and Ms Lin for a period of time at the end of Ms Lin's pregnancy and the first month after Alfred was born. Approximately one month after Alfred's birth, the relationship between Ms Lin and Mrs Zhuang deteriorated due to differences between their attitudes to culture and tradition and Ms Lin's decisions regarding their family in Australia. Ms Lin reportedly resented Mrs Zhuang's interference in her family's life and tried to distance them from Mrs Zhuang.

5. Mrs Zhuang held strong, hostile feelings toward Ms Lin and had physically assaulted her on two occasions in 2011. In July 2011, Mrs Zhuang hit Ms Lin to the face and cut her hair. On another occasion, Ms Lin reported to a friend that Mrs Zhuang had assaulted her.

THE PURPOSE OF A CORONIAL INVESTIGATION

6. Ms Lin's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was the result of an injury.[1]

7. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3]

8. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[4] It is not

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[1] Section 4 *Coroners Act 2008.*
[2] Section 89(4) *Coroners Act 2008.*
[3] See Preamble and s 67, *Coroners Act 2008.*
[4] *Keown v Khan* (1999) 1 VR 69.

the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

9. The expression '*cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

10. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all of the circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate to be considered relevant to the death.

11. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the '*prevention*' role.

12. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

13. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[5] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

14. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

[5] (1938) 60 CLR 336.

MATTERS IN RELATION TO WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

15. On 6 May 2012, Ms Lin was visually identified by her friend, James Li, as being Selina Lin, born 10 November 1990.

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

Medical cause of death, pursuant to section 67(1)(b) of the Act

17. Dr Malcolm Dodd, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy on Ms Lin's body and provided a written report, dated 1 August 2012. In that report, Dr Dodd concluded that a reasonable cause of death was '*Blunt force trauma to the head*'.

18. Dr Dodd noted that the likely mechanism of death was one of acute blood loss, caused by the blunt force trauma.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

19. On 3 May 2012, Mrs Zhuang asked her daughter, May, to drive her to Mr Zhuang and Ms Lin's home to visit Alfred.

20. In the middle of the afternoon, an argument developed between Mrs Zhuang and Ms Lin regarding Alfred's care. In the course of that argument, Mrs Zhuang took hold of a hammer and struck Ms Lin more than thirty times on the face and head. Ms Lin attempted to defend herself and also received a number of defensive injuries to her arms and hands. Ms Lin died as a result of that beating.

21. Mrs Zhuang then concealed Ms Lin's body in a nylon zip-up bag, cleaned the house of the blood and placed the nylon bag containing Ms Lin's body into a wheelie bin belonging to a neighbour, which she then returned to its position outside the neighbour's house.

22. Mrs Zhuang then left the house, leaving Alfred alone and unattended, and arranged for May to collect her from a nearby shopping centre.

23. At approximately 2.00am on 4 May 2012, Mrs Zhuang woke her other daughter, Suki, with whom she was staying. Mrs Zhuang asked Suki to take her to Mr Zhuang's home. On arrival there, Mrs Zhuang took the wheelie bin to nearby Darebin Creek, tipped the nylon bag into

the creek and hid the wheelie bin in some bushes before returning to Suki's vehicle and back to Suki's home in Coburg.

24. Later that same morning, Mrs Zhuang admitted to killing Ms Lin. Mrs Zhuang was questioned by police and was subsequently charged with Ms Lin's murder.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Criminal proceedings

25. On 13 August 2014, Mrs Zhuang was sentenced to 18 years' imprisonment, with a non-parole period of 13 years and six months. On 13 May 2015, following an appeal against the sentence on the grounds of manifest inadequacy, Mrs Zhuang was resentenced to 22 years' imprisonment with a non-parole period of 17 years.

Family violence

26. I requested that the Coroners Prevention Unit (**CPU**)[6] examine the circumstances of Ms Lin's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[7]

27. Both Ms Lin and Mrs Zhuang were from the Fujian Province in China, and therefore from a similar cultural and linguistic background. Despite their similar background, Ms Lin and Mrs Zhuang appear to have differed in their beliefs about family roles and childrearing.

28. Evidence was submitted to the Royal Commission into Family Violence (**the Royal Commission**), that young persons of Culturally and Linguistically Diverse (**CALD**) background tend to adapt more quickly to the new environment in Australia and may adopt values that differ from their country of origin. This can damage power dynamics and family relationships, which in some cases, may lead to violent behaviour from the senior family member/s.[8]

29. In order to understand the role that cultural expectations may have played in Ms Lin's death, the CPU engaged an expert witness, Ms Junxi Su (**Ms Su**), to:

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[6] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

[7] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition, the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focussed recommendations aimed at reducing the incidence of family violence in the Victorian community.

[8] Royal Commission into Family Violence: Report and Recommendations. Volume II, Chapter 10, '*Children and young people's experience of family violence*', p 114.

(a) provide insight into Chinese cultural family roles and relationships; and

(b) identify whether or not cultural expectations influenced Ms Lin's death.

30. Ms Su outlined Chinese family values as being '*loyalty, responsible parenthood and harmony*'. She advised that the mother-in-law and daughter-in-law relationship should be based on respect and friendliness. By engaging in violence towards her daughter-in-law, Mrs Zhuang was acting contrary to Chinese cultural beliefs and values.

31. Ms Su conceptualised the conflict between Mrs Zhuang and Ms Lin as a "*social and family problem*" influenced by Mrs Zhuang's "*intolerant personality ... demand for total control and never wanting to be disobeyed*".[9]

32. Ms Su believed that Ms Lin being from a CALD background may have influenced her lack of engagement with support or legal services in relation to Mrs Zhuang's prior physical attacks against her. Ms Su opined that Ms Lin may have been unaware of support services that she could access and may have been fearful of losing her legal status to remain in Australia, and of therefore losing her son, if she engaged with the legal system. Ms Su stated that as a child born under the 'One Child Policy' and living away from her parents, Ms Lin may not have had the knowledge, maturity and ability to cope with her challenging mother-in-law.

Assessment of Adequacy of Service Contact/Response

33. Victoria Police had contact with Ms Lin and Mrs Zhuang on 20 July 2011, after a bystander contacted police when Ms Lin sought refuge on her property following an argument with Mrs Zhuang. Ms Lin informed the bystander that her mother-in-law had attacked her with scissors in the car, cutting her hair and allegedly stabbing her in the neck.

34. When police attended, Ms Lin, her husband and Mrs Zhuang were all unwilling to provide information about the incident. Police observed shortened sections of hair and a cut on Ms Lin's lip. Ms Lin stated that her mother-in law did not like her and had cut her hair, but refused to elaborate further or to allow police to check her for injuries.

35. Due to language barriers, police asked Mr Zhuang to interpret for his mother and she reportedly denied any knowledge or involvement. Mr Zhaung informed police that his mother and wife had a verbal argument and he denied that any violence had occurred.

[9] Report to the Coroners Court of Victoria, Ms Junxi Su, p 2-3.

36. Ms Lin and her husband left the location together. One of the attending police officers reported that Mrs Zhuang appeared to be yelling abuse at Ms Lin as she left, but police were unable to understand what was said.

37. The attending police officers stated that they completed a family violence report and made referrals to Berry Street Northern Region Family Violence Service (**Berry Street**) for follow-up. However, Berry Street records management had no record of this referral, or of any action that would usually have been taken by the service if such a referral was received.

38. The failure to record or follow-up the Berry Street referral may have been a missed opportunity for specialist family violence services to attempt to engage with Ms Lin or Mrs Zhuang, to reduce risks of further or escalating violence. Furthermore, the missing referral suggests that there may have been an issue with the information-exchange practices between police and family violence services at that time.

39. No other service contact was identified, with either health or family violence services.

40. Since Ms Lin's death in 2012, Victoria Police have updated their Code of Practice for the Investigation of Family Violence. In 2015, the Department of Health & Human Services and Victoria Police introduced a joint '*Family Violence Referral Protocol*' (**the Protocol**). The intent of the Protocol is to improve information exchange between police and family violence services and to enhance follow-up practices.

41. The InTouch Multicultural Centre Against Family Violence and the Ethnic Communities Council of Victoria emphasised the importance of providing culturally sensitive family violence training to Victoria Police, in order to:

    (a) help them to understand barriers that CALD women (particularly) face in accessing support; and

    (b) increase awareness of the need for police officers to engage independent, professional interpreters as soon as possible.

42. The Royal Commission made a number of recommendations relating to use of interpreters, in line with the above comments.

43. The Royal Commission also made recommendations to the Victorian Government and Victoria Police to enhance culturally sensitive responses to family violence. I support the

Royal Commission's recommendations to improve guidance and practice in the use of interpreters when investigating family violence incidents involving CALD families.

44. Other than what is set out above, in the course of my investigation I did not identify any prevention matters arising from the circumstances of Ms Lin's death.

FINDINGS AND CONCLUSION

45. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) *Coroners Act 2008*:

    (a) the identity of the deceased was Dan (Selina) Lin, born 10 November 1990;

    (b) the death occurred on 3 May 2010, at 33 Tasman Drive, Bundoora, Victoria;

    (c) the cause of death was blunt force trauma to the head; and

    (d) the death occurred in the circumstances described above.

46. Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

47. I convey my sincerest sympathy to Ms Lin's family.

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

    (a) Peter Zhuang, senior next of kin.

    (b) Senior Constable Mark Berens, Victoria Police, Coroner's Investigator.

Signature:

JUDGE SARA HINCHEY
STATE CORONER
Date: 12/12/2016