IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 2149

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Deceased:	**CHIEN DIU HOANG**
Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Delivered on:	31 August 2016
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	31 August 2016
Counsel assisting the Coroner:	Ms Jodie Burns, Senior Legal Counsel.
Catchwords	Homicide; no person charged with indictable offence; mandatory inquest.

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HER HONOUR:

BACKGROUND

1 Chien Diu Hoang (**Mr Hoang**), was born on 16 May 1982, in Vietnam and was a citizen of the Socialist Republic of Vietnam.

2 Mr Hoang finished High School in 1998, before enrolling at a university in Vietnam, where he completed a Bachelor of Business Management in 2002.

3 In 2009, Mr Hoang obtained a student visa for a post graduate course in Business Management at Holmes College in Melbourne. He arrived in Australia in May 2009. During his time in Australia, Mr Hoang was in regular contact with his family in Vietnam.

4 While in Australia, Mr Hoang commenced a relationship with Sharon Ho (**Ms Ho**) and for the year leading up to his death they lived together in Maidstone.

5 In early June 2011, Mr Hoang formed the belief that Ms Ho had an inappropriate relationship with Minh Thao Nguyen (**Mr Nguyen**). Consequently, Mr Hoang and Mr Nguyen did not like each other.

6 Mr Hoang had no recorded criminal convictions.

THE PURPOSE OF A CORONIAL INVESTIGATION

7 Mr Hoang's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as his death occurred in Victoria, and was both violent and not from natural causes.[1]

8 The jurisdiction of the Coroners Court of Victoria is inquisitorial[2]. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

9 It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

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

11 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

[1] Section 4 *Coroners Act 2008.*
[2] Section 89(4) *Coroners Act 2008.*
[3] *Keown v Khan* (1999) 1 VR 69.

all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

12 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.

13 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.

14 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*.[4] 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.

15 Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide, or the deceased was immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

16 While Mr Hoang's identity was not in dispute and he was not a person placed in "*custody or care*" as defined by section 3 of the Act, his death is considered to be a homicide. Therefore, it is mandatory to conduct an inquest into the circumstances of his death.

VICTORIA POLICE HOMICIDE INVESTIGATION

17 Immediately after Mr Hoang's death, Victoria Police commenced a criminal investigation because the death was considered to be a homicide.

[4] (1938) 60 CLR 336.

18 Despite an extensive homicide investigation, no person or persons have been charged with indictable offences in connection with Mr Hoang's death. However, I note that two males were charged with the offence of 'affray.'[5]

19 The purpose of a coronial investigation (including an inquest) is not to investigate possible criminal conduct and/or to compile a brief of evidence in preparation for a future criminal trial. Further, the Act expressly prohibits a coroner from making any statement in a finding or comment that a person is or may be guilty of an offence.[6] However, I note the observations of the Victorian Court of Appeal in *Priest v West*,[7] where it was stated:

> "*If, in the course of the investigation of a death it appears that a person may have caused the death, then the Coroner must undertake such investigations as may lead to the identification of that person. Otherwise the required investigation into the cause of the death and the circumstances in which it occurred will be incomplete; and the obligation to find, if possible, that cause and those circumstances will not have been discharged*."

20 Consistent with this judgment, and mindful that the Act mandates that I must conduct an inquest, one of the purposes of the inquest is to investigate any evidence that may lead to the identification of the person (or persons) who may have caused the death, bearing in mind that I am required to make findings of fact and not express any judgment or evaluation of the legal effect of those findings.[8]

21 Section 7 of the Act specifically states that a coroner should avoid unnecessary duplication of inquiries and investigations, by liaising with other investigative authorities, official bodies or statutory officers. The rationale behind this provision is to allow for consideration of public interest principles that weigh against the potential benefits of any further investigation, such as further cost to the community. It also acknowledges that although a number of authorities or organisations may have the mandate to investigate, some are more appropriately placed than others to do so in any given circumstance.

22 In this case, I acknowledge that the Victoria Police Homicide Squad has conducted an extremely thorough investigation in this matter.

23 The confidential nature of the ongoing criminal investigation prevents me from reciting each and every matter which has been established by the Homicide Squad. However, based on the evidence of Acting Sergeant Simon Hunt, the Coroner's Investigator in this case, the following important matters have been established and are able to be disclosed:

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[5] On 21 December 2011, at the Melbourne Magistrate' Court, one charge of affray, against Huan Le Dang, was struck out because he had left Australia. On 12 September 2012, at the Melbourne Magistrates' Court, Dung Vu pleaded guilty to one charge of Affray and the matter was adjourned, without conviction, to 11 September 2013 and he was ordered to pay $400 to court fund.

[6] Section 69(1) of the Act.

[7] (2012) VSCA 327.

[8] *Perre v Chivell* (2000) 77 SASR 282.

(a) the Homicide Squad investigation has obtained a number of statements, including evidence from independent eye witnesses who have identified Mr Nguyen from identification photograph boards as being the person who caused Mr Hoang's injuries that resulted in his death;

(b) due to Mr Nguyen leaving the jurisdiction, no charges have been laid against Mr Nguyen;

(c) Victoria Police has sought advice about whether to have Mr Nguyen extradited from Vietnam to face a charge of murder in relation to Mr Hoang's death. However, it is inappropriate, for my purposes, to explore this issue any further as I am able to discharge my statutory obligations and make the relevant findings pursuant to section 67 of the *Coroners Act 2008*. I do not consider it appropriate to test that evidence in a coronial inquest as it may prejudice any future criminal trial that may eventuate if Mr Nguyen is charged with criminal offences in relation to the death.

24 In conducting the inquest and writing this Finding, I am mindful that Mr Hoang's death is an unsolved homicide case which Victoria Police continues to investigate. In these circumstances, I have been careful not to compromise any potential criminal prosecution in the course of my investigation.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

25 On 14 June 2011, the Deceased was visually identified by Sharon Ho to be her de facto partner, Chien Diu Hoang, born 16 May 1982.

26 Identity is not in dispute in this matter and therefore required no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

27 On 13 June 2011, Dr Heinrich Bouwer, a forensic pathologist practising at the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on Mr Hoang's body, and provided a written report, dated 30 September 2011, which concluded that a reasonable cause of death was *"stab wound to the neck."*

28 Dr Bouwer identified that Mr Hoang had died as a result of a stab wound to the right side of his neck. He commented that Mr Hoang had sustained three stab wounds:

(a) the fatal stab wound situated on the right base of the neck region, which penetrated and lacerated the right subclavian artery. The direction of the wound entry was front to back, right to left with downwards angulation. This stab injury resulted in cardiorespiratory

arrest, due to massive blood loss, which further compromised blood flow to the brain[9] and resulted in marked brain swelling and irreversible brain injury;

(b) a wound at the level of Mr Hoang's sternal notch and extended front to back, left to right and with downward angulation; and

(c) a wound on Mr Hoang's left lateral side of his abdomen which extended into the rectus muscle but did not penetrate the abdominal cavity.

29 Dr Bouwer did not identify any defensive-type wounds to Mr Hoang's arms or hands.

30 Toxicological analysis of ante mortem specimens obtained from the Royal Melbourne Hospital identified the presence of number of drugs including amphetamine and methamphetamine in Mr Hoang's blood plasma. Alcohol was not detected.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

31 On Saturday, 11 June 2011 at approximately 11.30 pm, Mr Nguyen entered the Bubble nightclub[10] (**the Nightclub)** with a group of friends.

32 On Sunday, 12 June 2011 at 2.33 am, Mr Hoang received a text message from a friend informing him that "*Kelvin*[11] *was going with a group looking for trouble. He asked about you…I am swearing / abusing him.*"

33 At approximately 2.45 am, Mr Hoang attended at the United Service Station in West Melbourne and purchased a screw driver.

34 At 2.56 am, Mr Hoang arrived at the Nightclub and joined the queue to enter.

35 At 3.02 am, Mr Nguyen left the Nightclub with friends.

36 Shortly thereafter, a fight broke out between two groups of Asians. Mr Hoang became involved in the fight during which he slapped a male in the face. Mr Hoang then produced the screw driver and pointed it towards Mr Nguyen and his friend group. Mr Nguyen, armed with a knife and is said to have run towards Mr Hoang and stabbed him to the right neck area.

37 Mr Nguyen then ran away with his friends. Mr Hoang was left holding his neck. Despite Mr Hoang being aided by friends, he collapsed to the ground. Police officers arrived shortly thereafter and attended to Mr Hoang until paramedic officers arrived. Mr Hoang was taken to

[9] Dr Linda Iles, forensic pathologist, VIFM, conducted a neuropathology examination of Mr Hoang's brain and provided a report dated 29 September 2011, which identified that the brain had a global cerebral ischaemic injury.
[10] The Bubble Nightclub is located at 577 Little Collins Street Melbourne, on the south side of Little Collins Street between Spencer and King Streets.
[11] Evidence obtained established that Mr Nguyen uses the anglicised Christian-name of Kelvin.

the Royal Melbourne Hospital where he underwent unsuccessful emergency surgery and he was declared deceased at 2:35 pm, 12 June 2011.

38 The next day, Monday 13 June 2011, about 12.41 pm, Mr Nguyen attended the Sydney International Airport where he met with a female friend who purchased an over-the-counter one way ticket to Vietnam on behalf of Mr Nguyen. At 3.15 pm that same day, Mr Nguyen left Australia on board a Singapore Airlines flight bound for Vietnam. Mr Nguyen has not returned to Australia since this day.

FINDINGS AND CONCLUSION

39 Having investigated Mr Hoang's death and having held an Inquest in relation to his death on 31 August 2016, at Melbourne, make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

(a) that the identity of the deceased was Chien Diu Hoang, born 16 May 1982; and

(b) that Mr Hoang died on 12 June 2011, at the Royal Melbourne Hospital from a stab wound to the neck, likely to have been inflicted by Minh Thao Nguyen, in the circumstances set out above.

40 I note that in the future, if new facts and circumstances become available, section 77 of the *Coroners Act 2008* allows any person to apply to the Court for an order that some or all of these findings be set aside. Any such application would be assessed on its merits at that time.

41 I convey my sincerest sympathy to Mr Hoang's family, partner and friends.

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

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

(a) Mr Hoang's family;

(b) Sharon Ho;

(c) Acting Sergeant Simon Hunt, Coroner's Investigator;

(d) Detective Inspector Michael Hughes, Homicide Squad, Victoria Police.

Signature:

JUDGE SARA HINCHEY

STATE CORONER

Date: 31 August 2016