IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 4684

FINDING INTO DEATH WITH INQUEST

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

Deceased:	**PETER VAN DANH**
Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Hearing date:	22 March 2017
Delivered on:	22 March 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Counsel assisting the Coroner:	Acting Sergeant Paul Collins
Representation	Nil
Catchwords	Homicide, no person charged with an indictable offence in respect of a reportable death, mandatory inquest

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HER HONOUR:

BACKGROUND

1 Peter Van Dahn (**Mr Danh**) was born on 8 July 1978 to Trung Danh and Xuan Tran.

2 At the time of his death, Mr Danh was in a relationship with Kristy Mohamad (**Ms Mohamad**) and they had one child Tamika, who died, full term, shortly after child birth on 23 July 2014.

3 On 3 September 2014, Mr Danh was released from custody. Upon release Mr Danh and Ms Mohamad resided together at 6b Walsh Street, Noble Park (**the House**).

THE PURPOSE OF A CORONIAL INVESTIGATION

4 Mr Danh's death was determined to be a 'reportable death' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was both unexpected and resulted directly from injury.[1]

5 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.

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

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

8 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 and causally relevant to the death.

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

9 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.

10 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.

11 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.

12 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 (and no person or persons have been charged with an indictable offence in respect of the death), or the deceased was immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

13 While Mr Danh'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. The Act provides that an inquest must be conducted into the circumstances of all deaths suspected to be a homicide, if no person has been charged with an indictable offence in respect of the death.

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*

14 The Deceased was identified by fingerprint comparison to be Peter Van Danh, born 8 July 1978.

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[4] (1938) 60 CLR 336.

15 Identity was not disputed and therefore required no investigation.

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

16 On 12 September 2014, Dr Joanna Glengarry (**Dr Glengarry**), Forensic Pathologist with the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr Danh's body and provided a written report, dated 19 December 2014, which concluded that a reasonable cause of death was due to *"Head injuries."*

17 Dr Glengarry commented in her report that:

> *"severe head injuries including multiple and complex fractures of the calvarium and skull base with marked distortion and lacerations of the brain... The pattern of injuries to the head is consistent with a crushing type injury to the head. There was a patterned abrasion and black discolouration of the right side of the face that had appearances suggestive of a tyre tread or similar."*

18 Post-mortem toxicological analysis showed the presence of multiple substances, including:

(a) Methamphetamine and its metabolite amphetamine were detected;

(b) Morphine and codeine were detected;

(c) No 6-MAM was detected[5];

(d) Diazepam[6] was detected;

(e) urinary metabolites of diazepam use including nordiazepam, temazepam and oxazepam;

(f) a metabolite of cannabis was detected in the urine.

19 It is possible that the combinations of the above drugs may have induced drowsiness or fatigue in Mr Danh, however without knowing his drug use history, dosing or times of intake this remains speculative.

Events proximate to the death

10 September 2014

20 On the evening of Wednesday 10 September 2014, Mr Danh and Ms Mohamad had an argument in the driveway of their home. During this argument Mr Danh snatched Ms

[5] It is possible that both the morphine and codeine have arisen from the use of heroin however in the absence of 6-MAM this cannot be confirmed. Occasionally, small amounts of morphine are associated with codeine use as it is a metabolite of codeine.
[6] Diazepam is a sedative/hypnotic drug of the benzodiazepines class.

Mohamad's handbag from her, located a bottle of Valium pills that had been prescribed to Ms Mohamad and consumed approximately 40 pills in her presence.

21 Mr Danh remained outside his home for a number of hours, yelling and causing damage to Ms Mohamad's motor vehicle, a 2003 Ford red sedan. After Mr Danh eventually fell asleep, Ms Mohamad left the home and spent the night with a friend.

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

11 September 2014

22 On 11 September 2014, at approximately 10.00am, Ms Mohamad returned to her home. A number of other persons were present at the home at this time.

23 At approximately 11.30am, Mr Danh attended at the home and appeared to be under the influence of drugs. Mr Danh was refused entry to the house and as a result of that refusal he damaged Ms Mohamad's motor vehicle by smashing the front driver's window.

24 Mr Danh then forced entry to the house via the front door using an iron bar. Upon entry, Mr Danh dragged Ms Mohammad into a bedroom and assaulted her. One of the persons present at the home intervened.

25 A short while later Ms Mohamad attempted to drive her car away from the premises. Another altercation then occurred between her and Mr Danh, whereby Mr Danh assaulted Ms Mohamad by pulling her hair while she was seated in the front driver's seat of her car.

26 At the same time Mr Danh forcibly removed the keys from the ignition hurting Ms Mohamad's hand in the process. At this point, two other persons present at the home intervened and stopped the assault.

27 Mr Danh and a friend, Mr Lopez, then left on foot and travelled to Noble Park Railway Station. They caught a train to Springvale Railway Station and then walked to the Springvale Centrelink Office, arriving at 2.50pm.

28 At the Centrelink office Mr Danh attempted to obtain emergency funds. While at the Centrelink office staff observed Mr Danh to be jittery, sleepy and slurring his words and appeared to be under the influence of drugs. Mr Danh was not able to access funds and an appointment was made with him to return at 9.00am the following day. Mr Danh and his companion left the Centrelink office at 4.35 pm. They walked back towards Springvale Railway Station along

Springvale Road. Outside Safeway in Springvale Road, Mr Danh told Mr Lopez that he had something to do and would meet him at the Springvale Railway Station.

29 Mr Lopez waited at the Springvale Railway Station, however, Mr Danh did not meet him there.

30 Between 5.00pm and 6.00pm, Mr Danh was observed walking along Joy Parade towards Corrigan Road, Noble Park. Mr Danh was observed to look tired.

31 Shortly thereafter, Mr Danh, returned to his home. Present at this address were Ms Mohamad, Julie Mohamad, Stacey Mohamad, Ronald Terrick and Amanda Brierely.

32 Mr Terrick and Ms Brierely had arrived at the Home earlier in the day and gone with Ms Mohamad to a motor vehicle wreckers to purchase a replacement drivers side window for her vehicle. At the time Mr Danh arrived Mr Terrick was in the process of fitting the replacement window.

33 Mr Danh demanded entry into the house and requested to see Ms Mohamad. Entry was refused.

34 Mr Danh then demanded the keys to Ms Mohamad's motor vehicle, Mr Terrick refused this request. Mr Danh, using a small axe handle or similar item, smashed the rear passenger taillight of Mr Mohamad's motor vehicle. Mr Danh then appeared to calm down and sat down in a chair near the front door. Mr Terrick and Ms Breierely departed in Ms Mohamad's motor vehicle a short while later, and Mr Danh left on foot sometime after that.

35 A short time after 8.00pm, Jenny Le attended the Home and parked her Toyota Tarago van near the side gates of the premises. When she arrived Mr Danh was not present. Approximately one hour later Mr Danh returned and demanded entry to the house, banging on the front door, screaming and swearing and damaging items outside the house.

36 Mr Danh smashed Ms Le's windows of her Toyota Tarago van. Mr Danh remained outside the Home for approximately one hour and then left on foot.

37 A CCTV camera situated at 6 Prior Road Noble Park, captured footage of the area of Prior Road directly in front of 6 Prior Road and a portion of the intersection of Prior Road and Percy Street.

38 At 10.04pm, CCTV vision depicts a person to walk west from Percy Street and turn South into Prior Road, the image is indistinct and is visible only when watching the footage in motion. Police officer investigating the circumstances of Mr Danh's death believed this person to be Mr

Danh because it is consistent with the most practicable route he would have walked from Walsh Street to his parents' home address of 38 Martin Street, Springvale South.

39 At 10.08pm, Pheap Uk was driving a Suzuki Alton sedan. Also in her vehicle was her three children. She turned from Noble Street into Prior Road and noticed a male now known to be Mr Danh sitting down in the middle of Prior Road, just after the intersection with Percy Street.

40 Ms Uk observed Mr Danh in a crouched down position sitting on his bottom with his arms around his legs which were bent up in front of him. Mr Danh's legs were facing the west side of Prior Road and his bottom was closest to the middle of the road. A satchel type bag was beside him.

41 Mr Danh responded to the headlights of Ms Uk's car by turning his head to face the headlights, however, he did not move other than to turn his head. Ms Uk drove around him to avoid hitting him.

42 At 10.15pm, CCTV depicts an unidentified vehicle travelling North past 6 Prior Road, coming from the direction where Mr Danh was located. Approximately 38 seconds later the same unknown vehicle is depicted on the CCTV to travel South past 6 Prior Road, back towards where Mr Danh was located.

43 At 10.19pm, Volkan Yildiz (**Mr Yildiz**) was driving an Audi sedan. At that time he turned into Prior Road from Noble Street and drove South. He noticed an object on the road and slowed down. About two metres from the object he recognised it to be a person lying on the road, with blood coming from his head. That person was identified as Mr Danh.

44 Mr Yildiz did not approach Mr Danh, but called '000' immediately requesting an ambulance.

45 At 10.23pm, Jaswant Singh was driving a Ford sedan with his friend Nirmal Singh as front seat passenger and their respective wives as rear seat passengers. At that time he turned into Prior Road from Noble Street and drove South. He saw that Mr Yildiz's vehicle was blocking his path, he stopped behind Mr Yildiz's vehicle and alighted from his vehicle with Nirmal Singh. They saw the body of Mr Danh lying on the road and had a short conversation with Mr Yildiz before returning to their vehicle and reversing North of Prior Road away from the collision scene.

46 At 10.25pm, Stevin Toner, riding a skateboard, travelled south into Prior Road from Noble Street. At the request of an ambulance call taker via Mr Yildiz, Mr Toner approached Mr Danh and checked for signs of life and found none.

47 Ambulance and Police officer arrived shortly afterwards and Mr Danh was declared to be deceased.

48 Police officers established a crime scene and the Major Collision Unit Investigators attended and examined the scene.

49 No sign of vehicle debris could be found and accounts of residents from nearby houses reported hearing the sound of a fight in the street.

50 Initially, police officers formed the opinion that Mr Danh's death was due to an intentional act. However, further investigation by police officers identified the drivers of the vehicles seen in Prior Road at 10.08pm, 10:19pm and 10.23pm, established that Mr Danh was still alive and conscious at 10.08 pm.

51 Police officers considered that the account from neighbours hearing yelling in the street was attributed to the noise from the occupants of Mr Singh's vehicle.

COMMENTS PURSUANT TO SECTION 67(3) OF THE *CORONERS ACT 2008*

52 The unexpected death of a person is a devastating event for their family and loved ones. This is particularly difficult for family and loved ones when a person dies and the circumstances leading to their death is not precisely known.

Victoria Police Criminal Investigation

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

54 Victoria Police obtained information from the autopsy performed upon Mr Danh's body that there was a patterned abrasion and black discolouration to the right side of his face consistent with a tyre tread or similar.

55 Mr Danh's death was investigated by police officers from the Major Collision Investigation Unit. Despite this investigation, no person or persons have been charged with indictable offences in connection with Mr Danh's death.

56 Police officers from the Major Collisions Investigation Unit have conducted extensive investigations into Mr Danh's death and, to date, the driver and vehicle that is believed to have that struck and killed Mr Danh have not been identified.

57 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."*

58 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]

59 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.

60 In this case, I acknowledge that the Victoria Police, through the Major Collision Investigation Unit, has conducted an extremely thorough investigation in this matter.

61 In making this Finding, I have been careful not to compromise any potential criminal prosecution in the course of my investigation, mindful that Mr Danh's death is an unsolved homicide case which Victoria Police continues to investigate.

FINDINGS AND CONCLUSION

62 Having investigated the death of Peter Van Danh and having held an Inquest in relation to his death on 22 March 2017, at Melbourne, make the following findings, pursuant to section 67(1) of the Act:

(a) that the identity of the deceased was Peter Van Danh, born 8 July 1978;

(b) that Peter Van Danh died on 11 September 2014, in the vicinity of 10 Prior Road, Noble Park from head injuries;

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[7] (2012) VSCA 327.
[8] *Perre v Chivell* (2000) 77 SASR 282.

(c) that the death occurred in the circumstances set out above; and

(d) that despite an extensive criminal investigation conducted by Victoria Police, no person or persons have been identified, to date, as being responsible for causing Mr Danh's death. On that basis, I am satisfied that no investigation which I am empowered to undertake, would be likely to result in the identification of the person or persons who caused Mr Danh's death.

63 I note that in the future, if new facts and circumstances become available, section 77 of the Act 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.

64 I convey my sincerest sympathy to Mr Danh's family and friends.

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

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

(a) Mr Danh's family.

(b) Detective Sergeant Andrew Kilpatrick, Coroner's Investigator.

(c) Officer-in-Charge, Major Collision Investigation Unit (Brunswick), Victoria Police.

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

Signature:

JUDGE SARA HINCHEY
STATE CORONER
Date: 22 March 2017