

IN THE CORONERS COURT OF VICTORIA AT MELBOURNE COR 2015 001474

# FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1) Section 67 of the Coroners Act 2008

# Inquest into the death of Dung Pham

| Findings of:           | Judge John Cain, State Coroner   |
|------------------------|--|
| Delivered on:          | 28 June 2023   |
| Delivered at:          | Coroners Court of Victoria<br>65 Kavanagh Street Southbank   |
| Hearing dates:         | 28 June 2023   |
| Assisting the Coroner: | Ms Abigail Smith, Senior Coroner's Solicitor to<br>the State Coroner   |
| Keywords:              | Homicide; uncharged homicide; reportable death;<br>mandatory inquest; drug dealer; stab wound to<br>neck; vehicle fire |

### **INTRODUCTION**

- 1. On 27 March 2015, Dung Pham was 40 years old when he was found deceased in his burnout vehicle in Olive Road Reserve, Frawley Street in Eumemmerring.
- 2. Mr Pham was born in Vietnam in 1974 and migrated to Australia with his family in 1983. At the time of his death, Mr Pham resided at 7/85 Frawley Road in Eumemerring<sup>1</sup> which he had purchased in 2012.<sup>2</sup> He resided alone, was not in a relationship and did not have any children or dependents.
- 3. Mr Pham had an extensive criminal history dating back to 1993 and had served a number of prison sentences for Heroin Trafficking and related offences.<sup>3</sup>
- 4. Mr Pham was a major drug trafficker in the Dandenong region and was known by the alias "The Phantom". He ran a drug trafficking business with an estimated turnover of between \$40,000 and \$60,000 per week.
- 5. Mr Pham's sister stated that despite the differences between Mr Pham and his family he was a loyal and kind-hearted person.

## THE PURPOSE OF A CORONIAL INVESTIGATION

- Mr Pham's death constitutes a "reportable death" under the Coroners Act 2008 (Vic) (the Act), as Mr Pham ordinarily resided in Victoria<sup>4</sup> and the death appears to have been unexpected and violent.<sup>5</sup>
- 7. Pursuant to section 52(2) of the Act, it is mandatory for the coroner to hold an inquest if the death occurred in Victoria and the coroner suspects the death was due to a homicide and no person or persons have been charged and convicted with an indictable offence in respect of the death.
- 8. I note the observations of the Victorian Court of Appeal in *Priest v West*, 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

<sup>&</sup>lt;sup>1</sup> Statement of Lan Pham dated 26 April 2015 at Coronial Brief ('CB'), p 32.

<sup>&</sup>lt;sup>2</sup> Exhibit 13 - Property title for 7/85 Frawley Road.

<sup>&</sup>lt;sup>3</sup> Exhibit 15 - Criminal History of Dung Pham.

<sup>&</sup>lt;sup>4</sup> Coroners Act 2008 (Vic) s 4.

<sup>&</sup>lt;sup>5</sup> Coroners Act 2008 (Vic) s 4(2)(a).

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."<sup>6</sup>

- 9. 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.<sup>7</sup>
- 10. The jurisdiction of the Coroners Court of Victoria is inquisitorial.<sup>8</sup> 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 the death occurred.<sup>9</sup>
- 11. It is not the role of the coroner to lay or apportion blame, but to establish the facts.<sup>10</sup> It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,<sup>11</sup> or to determine disciplinary matters.
- 12. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.
- 13. For coronial purposes, the phrase "*circumstances in which death occurred*",<sup>12</sup> refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of 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.
- 14. 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

<sup>&</sup>lt;sup>6</sup> Priest v West and Percy (2012) VSCA 327.

<sup>&</sup>lt;sup>7</sup> Perre v Chivell (2000) 77SASR 282.

<sup>&</sup>lt;sup>8</sup> Coroners Act 2008 (Vic) s 89(4).

<sup>&</sup>lt;sup>9</sup> Coroners Act 2008 (Vic) preamble and s 67.

<sup>&</sup>lt;sup>10</sup> Keown v Khan (1999) 1 VR 69.

<sup>&</sup>lt;sup>11</sup> Coroners Act 2008 (Vic) s 89(4).

<sup>&</sup>lt;sup>12</sup> Coroners Act 2008 (Vic) s 89(4).

the making of recommendations by coroners. This is generally referred to as the Court's "prevention" role.

- 15. Coroners are empowered:
  - a) to report to the Attorney-General on the death;<sup>13</sup>
  - 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;<sup>14</sup> and
  - c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety of the administration of justice.<sup>15</sup>
- 16. These powers are the vehicles by which the prevention role may be advanced.
- 17. This finding draws on the totality of the material obtained in the coronial investigation of Mr Pham's death. That is, the court file and the coronial brief prepared by Detective Senior Constable Michael Cashman.
- 18. In writing this finding, I do not purport to summarise all the material evidence 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.
- 19. All coronial findings must be based on proof of relevant facts on the balance of probabilities.<sup>16</sup> In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.<sup>17</sup> 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.

<sup>&</sup>lt;sup>13</sup> Coroners Act 2008 (Vic) s 72(1).

<sup>&</sup>lt;sup>14</sup> Coroners Act 2008 (Vic) s 67(3).

<sup>&</sup>lt;sup>15</sup> Coroners Act 2008 (Vic) s 72(2).

<sup>&</sup>lt;sup>16</sup> Re State Coroner; ex parte Minister for Health (2009) 261 ALR 152.

<sup>&</sup>lt;sup>17</sup> Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

20. 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.

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

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

- 21. On 30 March 2015, Dung Tri Pham was identified by fingerprint identification at the Victorian Institute of Forensic Medicine (**VIFM**).
- 22. Identity is not in dispute and requires no further investigation.

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

- 23. On 27 March 2015, Forensic Pathologist Dr Stephen Cordner from the VIFM, conducted an autopsy and provided a written report of his findings dated 19 December 2015.
- 24. The autopsy showed that Mr Pham had cirrhosis of the liver, but there were no natural diseases to cause or contribute to his death.
- 25. Dr Cordner did not find any evidence to suggest that Mr Pham was alive during the vehicle fire. There was no soot located in Mr Pham's airways, and there was no detectable carbon monoxide in the blood.
- 26. Dr Cordner stated that while there was a subdural smearing of blood, there was no evident or visible scalp bruising and no skull fracturing. On this basis, Dr Cordner was unable to conclude that Mr Pham had sustained a serious head injury.
- 27. There was found to be bruising to Mr Pham's left forearm and back of the left hand, as well as a second incised defect to the left side of the neck. There were no obvious incised or stabbed defects seen to the arms or hands.
- 28. Mr Pham was found to have a stab injury to his neck which occurred whilst he was alive. There was evidence of inhalation of blood and there was also considerable blood in the stomach indicating some of the blood had been swallowed. The stab wound involved the major blood vessels on the right side of the neck, as well as dividing the larynx and also entering the spine and partly dividing the spinal cord. The stab wound terminated at the upper left neck. Dr Cordner opined that the haemorrhage from the stab wound, has resulted in death.

- 29. Toxicological analysis of post mortem samples identified the presence of heroin metabolites, methylamphetamine, amphetamine, diazepam, temazepam and oxazepam.
- 30. Dr Cordner provided an opinion that the medical cause of death was:

### (1)(a) Haemorrhage and inhalation of blood

- (1)(b) Stab wound to the neck
- 31. I accept Dr Cordner's opinion as to the cause of death.

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

- 32. On 26 March 2015, Mr Pham spent most of the day at the Crown Casino in Southbank. At around 6:26pm, Mr Pham left the Crown Casino in his red Holden Commodore and drove along the Monash Freeway to his residence on Frawley Road in Eumemmerring.
- 33. Mr Pham's phone records indicate that after he left the Crown Casino, he made a series of calls and sent text messages to his associates including, Mr O'Brien (Mr Pham's drug runner), Ms Anna Dalla Bona (Mr Pham's personal friend), as well as some of his customers. Those that he spoke to on the phone stated that Mr Pham sounded drug affected.
- 34. Mr O'Brien recalled that earlier in the day, Mr Pham had told him '*I've fucked up, I've got to do something and then I'll come and see ya*'. Mr O'Brien and Mr Pham arranged to meet at 10:00pm that evening to balance the daily takings and to re-supply Mr O'Brien for the following day.<sup>18</sup>
- 35. At 8:32pm, Mr O'Brien spoke to Mr Pham for the last time and recalled that Mr Pham stated, *'sorry Scotty, I'm still coming I've just got something to do'*. There is no evidence that the 10:00pm meeting took place.<sup>19</sup>
- 36. At 8:51pm, Mr Pham received a telephone call from an associate, Mr Roddy Burton who was seeking to purchase drugs. Mr Pham told Mr Burton to await a telephone call to arrange the deal, but Mr Pham never followed through .<sup>20</sup> This was the last known contact with Mr Pham.
- At 11:18pm, Mr Pham drove his vehicle to the Olive Road Reserve in Eumemmerring (the Reserve) and parked behind a small stadium building adjacent to a series of netball courts.

<sup>&</sup>lt;sup>18</sup> Statement of Mr Scott O'Brien dated 22 April 2015 at CB, p 100.

<sup>&</sup>lt;sup>19</sup> Ibid.

<sup>&</sup>lt;sup>20</sup> Summary of circumstances from Victoria Police.

- 38. The Reserve is located east of Eumemmerring Park and Eumemmerring Creek in Doveton. It is accessible by vehicle from Frawley Road to the north with an eastern and western driveway, and by foot from Olive Road to the south. The Reserve has a number of outdoor netball courts, car parks and stadium building.
- 39. At approximately 11:26pm, an unidentified person left the Reserve on foot and discarded an item in a storm water drain before running west of Frawley Road. An unknown vehicle then entered the Reserve at speed before exiting the Reserve approximately 5 minutes later.
- 40. At around 11:46pm, local residents heard bangs coming from within the Reserve and observed a vehicle to be on fire. They contacted emergency services to report the incident.
- At 11:50pm, a local police unit travelling along Frawley Road noticed the fire in the Reserve.
  The Country Fire Authority arrived on scene shortly thereafter.
- 42. The fire was extinguished, and a badly burnt body (later identified as Mr Pham) was located covered in debris, lying across the back seat of the vehicle with the head pointing towards the passenger side door.
- 43. A quantity of blood had been pooled on the ground beneath the rear passenger door of the vehicle which was consistent with the position that Mr Pham was found in the vehicle. As debris was removed from the vehicle, the handle of a large knife was observed protruding from the right side of Mr Pham's neck. An accelerant appeared to have been used to cause the fire. A crime scene was established.

#### HOMICIDE INVESTIGATION BY VICTORIA POLICE

- 44. The Victoria Police Homicide Squad assumed carriage of the investigation into Mr Pham's death and commenced an extensive criminal investigation which included a crime scene investigation and obtaining CCTV footage, as well as canvassing and statements from more than thirty-five witnesses and associates of Mr Pham.
- 45. Ms Karen Ireland a Fire Examination Expert from the Victoria Police Forensic Services Centre examined the scene and provided a written report of her findings dated 24 April 2015.<sup>21</sup>
- 46. Ms Ireland concluded that the fire started by the ignition of the driver's seat, aided by the presence of petrol inside the passenger compartment and likely over Mr Pham's body. There

<sup>&</sup>lt;sup>21</sup> Report of Karen Ireland dated 24 April 2015 at CB, p 78.

were no fuel containers located amongst the debris, although a small plastic container may have melted/been consumed during the fire. Ms Ireland found that in the circumstances, the probable source of ignition was a match or cigarette lighter.<sup>22</sup>

- 47. Police searched the general area of the Reserve for any items of interest and canvassed the surrounding area. Whilst no items of interest were located, CCTV footage was obtained from a residence on Frawley Road.
- 48. During the course of my investigation, I reviewed the CCTV footage obtained by police. Notwithstanding the poor quality of the footage, it is seen to depict the following:
  - at 11:18pm, a vehicle (presumed to be the deceased's) travels along Frawley Road from the west and enters the Reserve;
  - at 11:19pm, that vehicle then circles the Reserve and parks behind a small building;
  - at 11:26pm, an unidentified person leaves the Reserve on foot, stops and bends down at a storm water drain before running west along Frawley Road;
  - at 11:40pm, an unidentified vehicle travels along Frawley Road entering the Reserve at speed from the west. It then circles the rear of the Reserve to arrive in the vicinity of the deceased's vehicle; and
  - at around 11:43pm, the unidentified vehicle leaves the vicinity of the deceased's vehicle and exits the Reserve west onto Frawley Road at speed. The deceased's vehicle is then seen to ignite.
- 49. Due to the delay in police obtaining the CCTV footage, a search of the stormwater drain was not conducted until 6 May 2015. To date, police have been unable to locate the item that was discarded in the storm water drain outside the Reserve or identity of the person seen leaving the Reserve on the night of Mr Pham's death.

## Additional investigations

<sup>&</sup>lt;sup>22</sup> Report of Karen Ireland dated 24 April 2015 at CB, p 81.

- 50. On 28 March 2015, police undertook a search of Mr Pham's resident on Frawley Road in Eumemmerring. A large quantity of cash was located and seized on the suspicion of being the proceeds of crime from drug trafficking. Police also located a receipt from the Crown Casino issued at 4:35pm which confirmed that Mr Pham had returned home at some stage that evening prior to his death.<sup>23</sup>
- 51. The property was otherwise found to be unremarkable with no signs of struggle or assault having taken place. There was no evidence to suggest that Mr Pham was stabbed inside the property or that there was any attempt to conceal a crime scene.<sup>24</sup>
- 52. Police also conducted a door knock of the surrounding apartments. The residents were unable to provide any additional information to investigators, however, they did confirm that Mr Pham was known by an alias 'John Arkadon'. The residents did not notice anything unusual on the night of Mr Pham's death. There was no CCTV footage available at the property.
- 53. Mr Pham's mobile phone was not located by police. However, an analysis of his Vodafone phone records showed that his mobile phone was registered in the name of 'Hung Nguyen' of 33 Tarata Drive, Doveton. The police investigation confirmed that this was another alias used by Mr Pham and that he had previously resided at Tarata Drive address.
- 54. The additional investigations undertaken by police confirmed that Mr Pham had substantial financial assets at the time of his death. This included his apartment, two vehicles and bank accounts holding varying amounts of money.
- 55. Police established that in the lead up to his death, Mr Pham had employed the services of two associates to deliver drugs and collect payment from clients. The associates resided at an address on Heatherton Road, Dandenong North. Approximately two weeks before Mr Pham's death, there was a break-in at the Heatherton Road property and a quantity of drugs and cash had been stolen.<sup>25</sup> Mr Pham subsequently severed ties with those associates and began using the services of Mr Scott O'Brien and his wife Wendy O'Brien.<sup>26</sup>
- 56. Police were unable to identify the person or persons that the deceased was purchasing heroin from in order to conduct his business. There was also no evidence or intelligence to suggest a

<sup>&</sup>lt;sup>23</sup> See Body Worn Camera footage from search of 7/85 Frawley Street.

<sup>&</sup>lt;sup>24</sup> Ibid.

<sup>&</sup>lt;sup>25</sup> See statements of Craig Heffernan and Callum Galbraith at CB, pp 107 – 118.

<sup>&</sup>lt;sup>26</sup> Statement of Mr Scott O'Brien dated 22 April 2015 at CB, p 97.

falling out, any bad debts or trouble with a competitor which might have brought about his death.

- 57. Police were also unable to establish who, if anyone, the deceased had arranged to meet on the evening of 26 March 2015 prior to his death. It is the opinion of investigating police that on that night, Mr Pham left home and met with an unidentified person or persons on the pretence of a drug transaction which turned violent. Mr Pham was then fatally stabbed in the neck and his vehicle was then set alight in the Reserve.
- 58. Despite a thorough and extensive investigation, police have been unable to establish how Mr Pham's death occurred and the surrounding circumstances. To date, no person or persons have been charged with an indictable offence in connection with Mr Pham's death. In light of this extensive investigation, 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 Pham's death.
- 59. It is important to note that it is not the purpose of a coronial investigation to investigate possible criminal conduct to compile a brief of evidence in preparation for a future criminal trial. Section 69 of the Act expressly prohibits a coroner from including a finding or a comment, any statement that a person is or may be guilty of an offence.
- 60. Being mindful of section 7 of the Act which makes clear that a coroner should "avoid unnecessary duplication of inquiries and investigations" and having reviewed the available evidence in depth, I am satisfied that no further investigation of the circumstances surrounding the death of Mr Pham is required.
- 61. I have been careful not to compromise any potential future prosecution in the course of my investigation, being mindful that Mr Pham's death may be the result of a homicide.
- 62. I note that if new facts or circumstances become available in the future, section 77 of the Act allows any person to apply to the Court for an order that some or all of the findings be set aside. Any such application would be assessed on its merits at the time.

#### FINDINGS AND CONCLUSION

63. Having investigated the death of Dung Tri Pham and having held an inquest in relation to his death on 28 June 2023 at Melbourne, I make the following findings, pursuant to section 67(1) of the Act, I make the following findings:

- a) the identity of the deceased was Dung Tri Pham born 14 July 1974;
- b) the death occurred between 11:19pm and 11:30pm on 26 March 2015; and
- c) the death of Dung Tri Pham was violent, and from injuries sustained as a result of the actions of a person or persons unknown. The precise circumstances leading to Mr Pham's death are also unknown.

I convey my sincere condolences to Mr Pham's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Hung Pham, Senior Next of Kin

## Leading Senior Constable Michael Cashman, Coroner's Investigator

Signature:

In I am



JUDGE JOHN CAIN STATE CORONER

Date: 28 June 2023

NOTE: Under section 83 of the *Coroners Act 2008* ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.