IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000177

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Paul Lawrie
Deceased:	Thi Thu Nguyen
Date of birth:	21 March 1962
Date of death:	9 January 2024
Cause of death:	1(a) COMPLICATIONS OF PULMONARY THROMBOEMBOLISM 1(b) DEEP VEIN THROMBOSIS
Place of death:	Sunshine Hospital, 176 Furlong Road, St Albans Victoria 3021
Keywords:	Involuntary mental health admission; natural causes; death in care

INTRODUCTION

1. On 9 January 2024, Thi Thu Nguyen was 61 years old when she passed away at Western Health Sunshine Hospital after collapsing outside her room in the Sunshine Mental Health and Wellbeing Centre (**SMHWC**), the mental health unit attached to Sunshine Hospital.

2. Four days earlier, Ms Nguyen had been admitted to SMHWC as a voluntary patient. On 6 January 2024, because of ongoing suicidal behaviour, she was placed on an Assessment Order under the *Mental Health and Wellbeing Act 2022* and thus became an involuntary patient.

3. Ms Nguyen was born in Vietnam and arrived in Melbourne in March 2020 to live with her adult daughter. In February 2023, Ms Nguyen married Mohamad Kassar and moved into his home in Broadmeadows.

4. In May 2023, Ms Nguyen applied for a temporary spousal visa to remain in Australia, but her application was rejected in December 2023

5. Ms Nguyen had a limited medical history and did not appear to be suffering from any major medical conditions prior to her hospitalisation in January 2024. At the time of her death, Ms Nguyen lived with her daughter in Deer Park, Victoria.

THE CORONIAL INVESTIGATION

6. Ms Nguyen's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the coroner, even if the death appears to have been from natural causes. Ms Nguyen was a "person placed in custody or care" within the meaning of section 4 of the Act, as she was an involuntary patient and subject to a Temporary Treatment Order under s.180 of the *Mental Health and Wellbeing Act* at the time of her death.

7. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

8. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

9. Senior Constable (SC) Emma Reale acted as the Coronial Investigator for the investigation of Ms Nguyen's death. SC Reale conducted inquiries on my behalf and compiled a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Thi Thu Nguyen including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Circumstances in which the death occurred

11. On 2 January 2024, Ms Nguyen and her daughter met with an immigration lawyer to discuss issues regarding her visa and residency status. Ms Nguyen's daughter recalled that her mother appeared sad because of funding difficulties for legal assistance but despite this, also seemed optimistic about remaining in Australia.

12. On 3 January 2024, police attended an alleged family violence incident between Ms Nguyen and her husband, where Ms Nguyen was identified as the perpetrator. The incident involved an allegation that Ms Nguyen had set fire to a bed. She had sustained burns to her feet and hands and was transported to the Alfred Hospital for assessment and treatment. After blood tests and CT scans (and review by an Ear, Nose and Throat registrar), it was determined that Ms Nguyen's injuries did not require treatment in hospital. She was also assessed by the emergency psychiatric service clinician and cleared for discharge into police custody.

13. That afternoon, police conveyed Ms Nguyen to Broadmeadows Police Station where they interviewed her in relation to an alleged assault on her husband. At 9.10pm Ms Nguyen was released from police custody, pending further enquiries. She then stayed with her daughter at her home in Deer Park.

[1] 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.

14. On the evening of 4 January 2024, Ms Nguyen's daughter discovered that her mother had just attempted to hang herself in a nearby park and she called Broadmeadows Police Station. Victoria Police members and paramedics attended and conveyed Ms Nguyen to Sunshine Hospital for assessment under section 232 of the *Mental Health and Wellbeing Act*. Once assessed at Sunshine Hospital Emergency Department, Ms Nguyen was admitted to the Medium Care Area of the Sunshine Mental Health and Wellbeing Centre as a voluntary patient.

15. On 6 January 2024, clinicians assessed Ms Nguyen and concluded that she was at high risk for suicide or self-harm and therefore required continuous, one-on-one specialised nursing support. Nursing staff also noted Ms Nguyen was experiencing auditory and visual hallucinations.

16. That afternoon, Ms Nguyen attempted self-strangulation, and as a result, she was transferred to the intensive care area of the SMHWC and placed on an Assessment Order[2] at 1:38pm. From that point Ms Nguyen was an involuntary patient, and a person "in care" within the meaning of s.4(2)(c) of the *Coroners Act*.

17. Whilst in the intensive care area, clinicians observed Ms Nguyen's physical health to be relatively stable but noted that she continued to express suicidal ideation. Her rapid mental deterioration was believed to have been exacerbated by her precarious social situation, her fears of deportation, visa refusal and the prospect of criminal charges. Despite her mental state, clinicians noted that she was compliant with nursing interventions and her medication regime.

18. On 7 January 2024, at 1:50pm, Ms Nguyen was placed on a Temporary Treatment Order[3] and remained in the SMHWC.

19. On 9 January 2024, at approximately 8:10am, Ms Nguyen was washing her hands at a basin outside her room with a nurse standing beside her. She suddenly collapsed and staff immediately activated a "Code Blue". Ms Nguyen had no palpable pulse and staff quickly transferred her to the emergency department. Whilst enroute, Ms Nguyen suffered a seizure, followed by cardiac arrest.[4] The transferring team began cardiopulmonary resuscitation, which was continued by emergency department staff.

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[2] *Mental Health & Wellbeing Act 2022* – s.144
[3] *Mental Health & Wellbeing Act 2022* – s.180
[4] Specifically, a PEA or Pulseless Electrical Activity arrest.

20. Ms Nguyen received maximum support in the Intensive Care Unit but remained haemodynamically unstable. Imaging revealed multiple bilateral pulmonary emboli, and clinicians commenced systemic thrombolysis. Despite aggressive treatment, Ms Nguyen's condition continued to deteriorate, and she passed away at 9.32pm on 9 January 2024.

Identity of the deceased

21. On 9 January 2024, Thi Thu Nguyen, born 21 March 1962, was visually identified by her daughter.

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

Medical cause of death

23. Forensic Pathologist Dr Judith Fronczek, from the Victorian Institute of Forensic Medicine conducted an examination on 10 January 2024 and provided a written report of her findings dated 19 January 2024.

24. A post-mortem computed tomography (CT) scan showed bilateral lung consolidation and anterolateral rib and sternal fractures in keeping with cardiopulmonary resuscitation. There was no acute intracranial pathology. In short, the post-mortem examinations produced findings in keeping with the described circumstances.

25. Dr Fronczek provided an opinion that the medical cause of death was 1(a) Complications of pulmonary thromboembolism secondary to 1(b) Deep vein thrombosis. Dr Fronczek opined that the death was due to natural causes.

26. I accept Dr Fronczek's opinion.

FINDINGS AND CONCLUSION

27. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Thi Thu Nguyen, born 21 March 1962;

    b) the death occurred on 9 January 2024 at Sunshine Hospital, 176 Furlong Road, St Albans Victoria 3021, from complications of pulmonary thromboembolism secondary to deep vein thrombosis; and

c) the death occurred in the circumstances described above.

28. Having considered all the circumstances, I am satisfied that Ms Nguyen's death was due to natural causes. There is nothing to suggest that the medical care Ms Nguyen received at Sunshine Hospital (including the Sunshine Mental Health and Wellbeing Centre) was anything other than appropriate.

I convey my sincere condolences to Ms Nguyen's family for their loss.

I thank the Coronial Investigator and those assisting for their work in this investigation.

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:

Thi Thu Ha Nguyen, Senior Next of Kin

Western Health

Senior Constable Emma Reale, Coronial Investigator

Signature:

Coroner Paul LawrieDate: 17 September 2025

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.