IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 005189

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Ngoc Bao Vy Tran
Date of birth:	7 September 1995
Date of death:	30 September 2021
Cause of death:	1(a) Stabs wounds to the abdomen and back
Place of death:	Dandenong Hospital 135 David Street, Dandenong, Victoria, 3175
Keywords:	Family violence; intimate partner homicide

INTRODUCTION

1. On 30 September 2021, Ngoc Bao Vy Tran was stabbed multiple times by her partner, Stephen Nguyen. Despite receiving medical treatment, Ms Tran died at Dandenong Hospital later the same day. At the time of her death Ms Tran was 26 years and lived at an address in Noble Park.

2. Ms Tran was born in Vietnam and completed tertiary studies before moving to Australia in April 2016.

3. Mr Nguyen was born in Vietnam on 13 June 1984 and moved to Australia when he was approximately 13 years old.

4. Ms Tran and Mr Nguyen met on Facebook in 2019 and were in an off and on relationship from that time until Ms Tran's death.

5. The couple lived together for approximately one year during 2020. However, they stopped living together in early 2021. Mr Nguyen moved into an apartment and Ms Tran moved into a house in Noble Park with a female friend.

6. Although they no longer lived together, Ms Tran and Mr Nguyen continued their relationship.

THE CORONIAL INVESTIGATION

7. Ms Tran'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.

8. 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.

9. 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.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Tran's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of Ms Tran 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

12. On 29 September 2021, the available evidence suggests that Mr Nguyen reportedly began feeling strange and experiencing paranoid thoughts.

13. In the afternoon, Mr Nguyen picked Ms Tran up after work and took her to his residence, where they planned for her to stay the night.

14. Ms Tran and Mr Nguyen had dinner together, before going to bed. At some point in the evening Mr Nguyen got out of bed and retrieved a knife from the kitchen.

15. Mr Nguyen returned to the bedroom and stabbed Ms Tran six times. He also inflicted stab wounds upon himself, in his chest.[2] He later reported to police that he had intended to murder Ms Tran and then suicide.[3]

16. At 2.12am on 30 September 2021, Mr Nguyen contacted emergency services seeking medical help for Ms Tran.[4] Mr Nguyen stated to the emergency call taker, police at scene, and during his post-arrest interview that he had stabbed Ms Tran and then himself.

17. Ambulance paramedics arrived on scene at 2.33am and commenced resuscitation procedures before transporting Ms Tran to the Dandenong Hospital at 3.22am. Ms Tran was pronounced deceased at approximately 4.14am.[5]

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[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.
[2] Coronial Brief, record of interview, 211, 215.
[3] Ibid 213.
[4] Coronial Brief, Transcript – Triple Zero recordings, 157.
[5] Coronial Brief, Statement of First Constable A. King dated 2 October 2021, 61.

18. Mr Nguyen was arrested on scene on 30 September 2021 and charged with Ms Tran's murder. On 16 November 2022, in the Supreme Court of Victoria, Mr Nguyen was found not guilty of murder due to mental impairment.

Identity of the deceased

19. On 1 October 2021, Ngoc Bao Vy Tran, born 7 September 1995, was identified via fingerprint identification.

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

Medical cause of death

21. Specialist Forensic Pathologist, Dr Joanna Glengarry, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 30 September 2021 and provided a written report of her findings on 17 February 2022.

22. The post-mortem examination revealed:

    a) Multiple sharp force injuries (that is, injuries inflicted by a blade or sharp implement, such as a knife), numbering six in total. These comprise both stab wounds and incised wounds (cuts). Of these:

        i. There was a stab wound of the chest that entered the upper abdomen in the midline that was 18-20cm deep directed from front to back, to the right and downwards. The wound track was associated with injury to the musculature of the anterior abdominal wall, the falciform ligament, perforation of the liver, perforation of the inferior vena cava, transection of the right adrenal and penetrating injury of the right kidney. The wound track was associated with 2250mL of blood within the abdominal cavity and bleeding around the right kidney.

        ii. There was a stab wound of the left back that was 5-10cm deep and directed forwards, horizontally and not to the left or right. The wound track was associated with penetration of the trapezius muscle and an intercostal muscle, entering the left chest cavity between the third and fourth ribs and associated with air and blood (haemopneumothorax) in the left chest cavity and a penetrating injury of the left lung upper lobe.

iii. Both of these wounds were considered lethal, with the first the more severe of the two.

iv. There was a stab wound beneath the left eye that was associated with injury to the soft tissues beneath the eye and haemorrhage into the fat surrounding the left eye causing displacement of the eye towards the nose. There was no injury to the eye itself. This wound track was up to 3cm deep and directed from front to back and slightly upwards. This stab wound was significant but not lethal.

v. There were incised wounds ("cuts") that penetrated only the skin of the right lower chest and right back. There was an incised wound that penetrated both the skin and subcutis of the right upper chest.

b) There were no sharp force injuries to the arms or hands (often referred to as "defense-type injuries").

c) There was a cluster of abrasions on the chin but no facial or skull fractures and no brain injury.

d) No significant natural disease was identified by the autopsy examination.

e) Medical resuscitation efforts were associated with a minor complication secondary to dislodgment of the intraosseous cannula of the right arm (cannula that is designed to enter the bone barrow cavity to infuse blood and fluids). This had become dislodged out of the bone and as a result, blood and fluids had extravasated into the soft tissues and muscles of the right upper arm. In Dr Glengarry's opinion, this did not contribute to Ms Tran's death.

23. Toxicological analysis of ante and post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

24. Dr Glengarry provided an opinion that the medical cause of death was 1 (a) Stab wounds to the abdomen and back.

FURTHER INVESTIGATIONS AND CPU REVIEW

25. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by an intimate partner is particularly shocking, given that all persons have a right to safety, respect and trust in their most intimate relationships.

26. The relationship between Ms Tran and Mr Nguyen met the definition of *'family member'* as described by the *Family Violence Protection Act 2008* (Vic) (**FVPA**).[6] Moreover, Mr Nguyen's actions towards Ms Tran during and after their relationship, including his fatal assault of Ms Tran, constituted *'family violence'*.[7]

27. In light of Ms Tran's death occurring in circumstances of family violence, I requested that the Coroners Prevention Unit (**CPU**)[8] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[9]

History of family violence in the relationship

28. Ms Tran and Mr Nguyen lived together for approximately one year. During this time, Ms Tran reported to her friend that Mr Nguyen was verbally abusive and threw things around when he was angry. Ms Tran's friend described Mr Nguyen as a jealous person with a hot temper who demonstrated controlling and jealous behaviour. She stated that he would message Ms Tran every day to ask who she was with, and would reportedly *'go crazy'*[10] if he saw a message on Ms Tran's phone from a male, finding out who the person was so he could message them.

29. Ms Tran's friend described an incident where Ms Tran was at a work party. Mr Nguyen repeatedly sent Ms Tran messages and became upset when she did not immediately reply. He asked her to take photos of the party to prove where she was.

30. Neighbours of Mr Nguyen reported hearing loud arguments from his residence, and one reported intervening in an incident where Mr Nguyen was having a loud argument with a woman matching Ms Tran's description. During this argument Mr Nguyen reportedly punched the window of his vehicle several times.

31. In early 2020, Ms Tran commenced a new relationship and began seeing another man. The new partner stated that he believed that he and Ms Tran were heading towards formally

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[6] *Family Violence Protection Act 2008* (Vic), s 8.
[7] *Family Violence Protection Act 2008* (Vic), s 5.
[8] The CPU 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.
[9] The VSRFVD provides assistance to 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.
[10] Coronial Brief, Statement of Lan Nguyen, 122.

commencing a relationship in the months preceding Ms Tran's death. He reported that Ms Tran appeared *'scared and sad'*[11] in the weeks preceding her death.

32. In the beginning of 2021, Ms Tran and Mr Nguyen stopped living together because, according to Mr Nguyen, the relationship was not working out the way that he and Ms Tran wanted.[12] Ms Tran moved to Lan's home[13] and Mr Nguyen moved to the apartment he lived in at the time of the fatal incident.[14] According to Lan, although Ms Tran moved in with her because she reportedly had had enough of Mr Nguyen and needed time to think clearly on her own, Ms Tran continued to see Mr Nguyen.[15]

33. The available evidence suggests that Ms Tran and Mr Nguyen were in an on and off relationship in the two month period leading to the fatal incident.

COMMENTS

34. Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

35. The available evidence suggests that friends of Ms Tran were aware of or suspected that Mr Nguyen was perpetrating violence against Ms Tran prior to her death, but it does not appear that any relevant support services were contacted in relation to this violence.

36. There have been many family violence homicides examined by this court where third parties were aware of or suspected that family violence was occurring in a relationship prior to a family violence related death but no services were contacted in relation to this family violence. This is consistent with research which indicates that victims of family violence are more likely to talk to family and friends about their experiences of violence than contact a family violence support services or the police.[16]

37. In recent studies, '*coercive control*' was a commonly reported theme, regardless of whether the homicide was preceded by intimate partner physical violence, most often in the form of

[11] Coronial Brief, Statement of Lan Nguyen, 125.
[12] Coronial Brief, Transcript – record of interview, 206.
[13] Coronial Brief, Statement of Lan Nguyen, 122.
[14] Coronial Brief, Transcript – record of interview, 206.
[15] Coronial Brief, Statement of Lan Nguyen, 122-123.
[16] Glennys Parker and Christina Lee, 'Violence and abuse: An assessment of mid-aged Australian women's experiences' (2002) 37(2) Australian Psychologist 142-148; Jenny Mouzos and Toni Makkai, 'Women's Experiences of Male Violence: Findings from the Australian Component of the International Violence Against Women Survey (IVAWS)' (Research and Policy Series No 56, Australian Institute of Criminology, 2004) 101; Janet Fanslow and Elizabeth Robinson, 'Help-seeking behaviors and reasons for help seeking reported by a representative sample of women victims of intimate partner violence in New Zealand.' (2010) 25(5) J Interpers Violence 929-951.

verbal and emotional abuse.[17] But "*few of the victims equated the controlling behaviour with domestic violence or risk of serious harm*."[18]

38. Canadian researchers have indicated that data from studies of intimate partner homicides between 1991 and 2000 evidences a link between withdrawal of commitment and an increased use of violence in an attempt to re-establish control and, if the loss is perceived as irretrievable, motivation or decision to kill.[19]

39. I confirm that previous coronial findings into the deaths of Mrs FS,[20] Mrs K[21], Mrs VT,[22] John Reed,[23] and Mrs ZT[24] recommended that the Victorian Government and Family Safety Victoria develop a research-based strategy, in consultation with victim survivors, informal supporters, priority communities and specialist family violence services, to provide targeted services to informal supporters assisting persons affected by family violence.

40. On 11 November 2021 Family Safety Victoria (**FSV**) responded to this recommendation and confirmed that they accepted the recommendation in full. They also noted that they are '*undertaking work across several areas to aid informal supporters assisting persons affected by family violence, as well as priority communities*.'[25]

41. FSV advised that in March 2020 the Victorian Government released a '*Family Violence Support During COVID-19 Practice Note*'[26] which gives '*informal supporters guidance on what to do if they are concerned someone they know needs help, including safe communication, safe accommodation and the contact number for Safe Steps*.'[27] They also noted that the Orange Door website contains information and advice for people who may be worried about someone they know experiencing or perpetrating family violence.[28]

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[17] Ibid 5.
[18] 'Women's Experiences of Male Violence: Findings from the Australian Component of the International Violence Against Women Survey (IVAWS)' (Research and Policy Series No 56, Australian Institute of Criminology, 2004), 61.
[19] Johnson, Holly & Hotton, Tina. (2003). Losing Control. Homicide Studies - HOMICIDE STUD. 7. 58-84
[20] COR 2017 2423.
[21] COR 2017 1889.
[22] COR 2016 1879.
[23] COR 2015 3624.
[24] COR 2016 2733.
[25] Family Safety Victoria, Response to recommendations made in COR 2016 1876, COR 2017 1889, COR 2017 2423, COR 2015 3624, COR 2016 2733, dated 11 November 2021, 1.
[26] https://www.vic.gov.au/sites/default/files/2020-05/Family%20violence%20support%20during%20COVID-19_0.docx
[27] Family Safety Victoria, above n 12, 2.
[28] Ibid 2.

42. FSV also outlined a range of initiatives, strategies and prevention projects targeted towards strengthening and expanding bystander programs within mainstream and priority community services. This includes funding for prevention work within multicultural and faith communities which enables them to 'implement and test innovative and culturally appropriate prevention initiatives and strengthen their capacity to identify and respond to family violence.[29] They also referenced Active Bystander Action and Intervention training sessions run by organisations such as Gender Equity Victoria, No To Violence and Women's Health in the North, noting that organisations that are trained in bystander action have then included it in family violence awareness workshops they have provided to their communities.

43. The Victorian Government have subsequently released the Victorian Family Violence Research Agenda 2021-2024. This research agenda identifies the primary prevention of family violence and violence against women as a research priority and notes that '*further research, alongside monitoring and evaluation, is required to better understand 'what works' in the primary prevention of family violence.*'[30] It suggests that '*research into critical elements of primary prevention work may include topics such as…the role of bystanders.*'[31]

44. Safe and Equal,[32] the peak body for specialist family violence services that provide support to victim survivors in Victoria, has recently undertaken work to improve family violence awareness and resources for third parties who are assisting persons experiencing family violence. On 10 May 2022 they launched the inaugural '*Are you safe at home*?' day which aims to raise awareness about family violence and encourages members of the community to '*start a conversation that could end family violence by asking someone, 'Are you safe at home?*'. They also launched a new website which provides information and resources for the community to assist them in helping someone who may be unsafe at home.[33] This website includes information about how to approach the conversation with a potential victim/survivor or perpetrator, questions they can ask, identifying family violence and where to seek help. This information is also available in 15 community languages as well as easy English.

[29] Ibid 3.
[30] https://www.vic.gov.au/victorian-family-violence-research-agenda-2021-2024/research-priorities/primary-prevention-family-violence-violence-against-women
[31] Ibid.
[32] Safe and Equal is the peak body for specialist family violence services that provide support to victim survivors in Victoria. This service is an amalgamation of two previous statewide services – Domestic Violence Victoria and Domestic Violence Resource Centre Victoria.
[33] https://areyousafeathome.org.au/

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Ngoc Bao Vy Tran, born 7 September 1995;

    b) the death occurred on 30 September 2021 at Dandenong Hospital 135 David Street, Dandenong, Victoria, 3175, from stab wounds to the abdomen and back; and

    c) the death occurred in the circumstances described above.

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

47. 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:

Tan Tran, Senior Next of Kin

Thi Tran, Senior Next of Kin

Kate Macdermid, Monash Health

Detective Senior Constable Lee Horsley, Coroner's Investigator

Signature:

Judge John Cain
STATE CORONER
Date : 14 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.