IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000964

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:	Thi Minh Phuong Nguyen
Date of birth:	25 July 1991
Date of death:	20 February 2021
Cause of death:	1(a) Mixed drug toxicity (gamma hydroxybutyrate, methylamphetamine, amphetamine, diazepam, nordiazepam)
Place of death:	[redacted] City Road, Southbank, Victoria, 3006
Keywords:	Family violence; mixed drug toxicity; suicide

INTRODUCTION

1. On 20 February 2021, Thi Minh Phuong (Sophie) Nguyen was 29 years old when she passed away at a hotel in Southbank, Victoria.

2. Thi was born in Kuala Lumpur, Malaysia, and moved to Western Australia in 1994. She was one of eight children. Thi's childhood was marred by family violence, and she allegedly observed her father perpetrate family violence against her mother. She later described this as traumatising for her and her siblings. WA Police responded to several reports of family violence perpetrated by Thi's father against her mother, including physical abuse, threats to kill and property damage. Thi's parents divorced in about 2007, and Thi continued to live with her mother and siblings.

3. The evidence available to the Court suggests that Thi had at least two male partners in WA who perpetrated family violence against her. One partner physically assaulted her whilst she was pregnant with her son. Thi moved to Melbourne in 2015 whilst she was pregnant and gave birth to her son on 25 July 2016.

4. Following her son's birth, Thi experienced post-natal depression (**PND**). She continued to discuss this diagnosis and sought support for same until the time of her passing. Her other mental health diagnoses included depression, bipolar spectrum disorder, borderline personality disorder, and post-traumatic stress disorder (**PTSD**).

5. In March or April 2020, Thi commenced a relationship with a man named Yehia Yehia. It appears that Yehia intermittently lived with Thi from that time and the couple used illicit substances together, namely methylamphetamine and gamma hydroxybutyrate (**GHB**). According to police records, Yehia had an extensive history of family violence and was named as a respondent on intervention orders protecting five other women (not including Thi).

THE CORONIAL INVESTIGATION

6. Thi'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.

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. Victoria Police assigned Detective Senior Constable Emma Skewes to be the Coroner's Investigator for the investigation of Thi'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.

10. This finding draws on the totality of the coronial investigation into the death of Thi Minh Phuong 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

Identity of the deceased

11. On 20 February 2021, Thi Minh Phuong Nguyen, born 25 July 1991, was visually identified by her former brother-in-law, Omar Yehia.

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

Medical cause of death

13. Forensic Pathologist Dr Sarah Parsons, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 26 February 2021 and provided a written report of her findings dated 11 May 2021.

[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. The post-mortem examination revealed evidence of chronic hepatitis. There was no evidence of natural disease that would have caused or contributed to the death.

15. Toxicological analysis of post-mortem samples identified the presence of GHB, methylamphetamine and its metabolite amphetamine, and diazepam and its metabolite nordiazepam.

16. Dr Parsons commented that GHB was detected at levels consistent with excessive use. She noted that the combination of drugs detected above may have caused death in the absence of other contributing factors.

17. Exhibits located at the scene were also tested as follows:

    a) Exhibit 1 – glass cylinder with rubber piping; one glass pipe attached to the top containing a clear liquid

    b) Exhibit 2 – one 89mL plastic bottle containing a clear liquid

    c) Exhibit 3 – one NIPRO 3mL syringe with a plunger

    d) Exhibit 4 – one empty 30mL body wash bottle without lid, containing an unknown clear liquid.

18. Testing of Exhibit 1 detected methylamphetamine, amphetamine, and 1,4 Butanediol. Testing of Exhibits 2, 3, and 4 detected 1,4 Butanediol only.

19. Dr Parsons provided an opinion that the medical cause of death was *mixed drug toxicity (gamma hydroxybutyrate, methylamphetamine, amphetamine, diazepam, nordiazepam).*

20. I accept Dr Parsons' opinion as to the medical cause of death.

Circumstances in which the death occurred

21. In the early hours of 21 August 2020, Thi contacted police from a payphone outside her apartment. Upon police attendance, Thi reported that Yehia allegedly spiked her drink with GHB, then refused to leave her apartment. Police observed Thi was distressed and appeared to be drug-affected. She declined offers of referrals for medical treatment or crisis accommodation and refused to make a statement. Police completed a Family Violence Risk Assessment (**L17 FVR**), which triggered referrals for specialist family services for both Yehia and Thi and made an automatic notification to Child Protection. Police initiated a criminal

investigation and applied for a family violence intervention order (**FVIO**) to protect Thi and her son. The family violence services were unable to contact with Thi and did not contact Yehia as they assessed that this contact could increase the risk posed to Thi.

22. Later that morning, police completed a welfare check on Thi's son, at the request of Child Protection. Police observed Thi's son was home alone with access to medications, lighters and a half-filled bathtub. When Thi returned home, police noted that she appeared to be substance affected. She told police that she left home to go for a walk and accidentally locked herself outside. Child Protection placed Thi's son in foster care at this time, and he remained there until the date of his mother's passing. His removal reportedly devastated Thi, and her mental health suffered significantly following his removal.

23. On 31 August 2020, Thi contacted police again in relation to conflict with Yehia. When police arrived, Yehia had already left the scene. Thi reported that Yehia attended the apartment and that they argued, as Yehia believed Thi was cheating on him. Thi did not disclose any further issues, so police completed another L17, which triggered new specialist family violence referrals. Family violence services were again unable to contact Thi and again did not contact Yehia as police did not get consent for the referral.

24. Following the two incidents in August 2020, police placed Yehia on a family violence high-risk management plan. This involved regular contact with Thi by phone to monitor risk and to offer referrals, and provision of details for The Orange Door. Police closed the plan on 1 December 20020, after receiving no further reports of Yehia committing family violence in a three-month period. Yehia was arrested by police on 9 September 2020 for non-family violence related offences, and he remained in custody until late-December 2020, which would explain the lack of further offending.

25. The Melbourne Magistrates' Court issued an interim FVIO on 18 September 2020, to protect Thi and her son. The FVIO prohibited Yehia from having contact with Thi or her son, however evidence available to the Court suggests that Yehia intermittently continued to live with and have contact with Thi.

26. On 1 October 2020, Thi told her general practitioner (**GP**) that she was sleeping in her car and was unable to sleep in her bed, due to "*PTSD from DV with flashbacks*". From October to November 2020, Thi attended four private alcohol and other drugs (**AOD**) counselling sessions. She disclosed using methylamphetamine every day, but wanted to stop so that she could regain custody of her son.

27. On 18 December 2020, Thi informed Child Protection that she was feeling low, and did not get out of bed most days. She also stated that she would not be completing urine drug screens (**UDS**), as requested by Child Protection.

28. On 6 January 2021, Thi attended an appointment with her GP, and they referred her to The Melbourne Clinic for treatment of her PTSD, bipolar affective disorder and "*domestic violence issues*". She consulted with a different GP on 13 January 2021, as her usual GP was unavailable, and they referred her to Delmont Private Hospital (**DPH**).

29. Thi contacted Chid Protection on 20 January 2021 and reported that her mental health and substance misuse had deteriorated, and that she planned to voluntarily admit herself to a mental health inpatient unit. Two days later, Thi was admitted to DPH "*for symptoms including anger, irritability, mood dysregulation, short temper, anxiety agitation, sleep deprivation*". Whilst in hospital, Thi was noted to be teary when discussing the topic of her son. Unfortunately, Thi self-discharged from DPH on 24 January 2021 against medical advice. Yehia collected Thi from DPH, however it does not appear that DPH were aware of the FVIO in place preventing his contact with Thi.

30. On 2 February 2021, the Melbourne Magistrates' Court issued a final FVIO in protection of Thi and her son, however this was not served on Yehia prior to Thi's passing. The interim FVIO remained in place. On the same day, Thi attended her GP reporting symptoms of PTSD, bipolar disorder and depression. The GP completed referral to Albert Road Clinic for management of PND and anxiety.

31. On 10 February 2021, Thi sent an email to Yehia in which she evinced her intention to end her life. She asked Yehia to ensure that her son was placed in his grandmother's care. That same day, Thi moved to a two-bedroom apartment in a hotel in Southbank, which was booked until July 2021. Yehia also moved into this apartment.

32. On 14 February 2021, Thi asked staff at the hotel for the CCTV footage outside her room, as she had broken up with Yehia and was concerned that he had broken into her room whilst she was out.

33. CCTV footage from the hotel depicts both Thi and Yehia entering and exiting the hotel room frequently between 18 and 20 February 2021.

34. In the early hours of 20 February 2021, Thi and Yehia returned to the apartment. Prior to entering the apartment, Thi reportedly purchased 20mL of GHB and that when they returned

to the apartment, she consumed some of the GHB. Yehia later observed that the bottle was empty and was surprised because Thi normally only consumed 3 or 4mL of GHB at a time and thought she may have tipped out some of the contents. Yehia reported that Thi fell asleep on the floor, and he monitored her for about an hour, before he also went to sleep.

35. Later that afternoon, Yehia awoke and observed that Thi appeared to be blue and cold to touch. Yehia contacted his brother, told him that Thi had consumed 20mL of GHB and asked him to call an ambulance. Yehia then left the hotel and attempted to conceal his identity from CCTV cameras.

36. Yehia's brother, Omar, attended the hotel and hotel staff contacted 000. Paramedics attended the scene and confirmed Thi had passed away. Police also attended the scene and investigated the circumstances of Thi's passing. Police located handwritten notes from Thi which referred to Yehia accusing her of "*slutting around*", his treatment of her causing her to be "*mentally unwell*", Yehia allegedly throwing and breaking Thi's property and Yehia borrowing money from Thi and not paying it back unless she repeatedly asked for it. Police did not identify any suspicious circumstances or signs of third-party intervention in connection with Thi's death.

CPU REVIEW

37. As Thi's death occurred in circumstances where there was a reported history of family violence, I requested that the Coroner's Prevention Unit (**CPU**)[2] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRDFVD**).[3] I requested the CPU consider Thi's contact with family violence and other services proximate to her passing.

Health services

38. Whilst Thi disclosed indicators of family violence risk to GPs and mental health practitioners, it did not appear that any further action was taken by those clinicians in response to her concerns. However, the CPU noted that as police provided Thi with details of The Orange

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[3] The VSRFVD provides assistance to Victorian 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-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community.

Door in the months prior to her passing, and because she did not engage with specialist family violence services following the referrals on 21 and 31 August 2020, any further actions taken by her clinicians may not have had a preventative impact in this case.

Child Protection

39. I note that although Thi's son came to the attention of Child Protection due to the risks associated with family violence, Child Protection did not complete a family violence risk assessment or management plan with Thi. In addition, Child Protection's work towards reunifying Thi and her son appeared to focus largely on encouraging Thi to complete Urine Drug Screening (**UDS**). At the relevant time, Child Protection was prescribed under Victoria's Multi-Agency Risk Assessment and Management framework (**MARAM**), and therefore should have taken these actions.

40. During the recent inquest into the deaths of four children who were known to Child Protection, Child Protection advised the Court that in November 2021,[4] their Client Relationship Information Management System (**CRIS**) was redeveloped to reflect the MARAM framework. As a result of these changes, practitioners are now prompted to consider elements of the MARAM when entering information into CRIS and are automatically alerted when mandatory assessments are required. There are now also some determinations made by practitioners that must be endorsed before cases can progress through the system.

41. In those circumstances, I am satisfied that Child Protection practitioners are appropriately reminded of their obligations under the MARAM and that no further recommendations or changes can be made in this matter.

Victoria Police

42. I note that there was a five-week delay to serve the interim FVIO on Yehia, however this occurred when he was incarcerated. Service of FVIOs and other documents upon people on remand, particularly during the COVID-19 lockdowns in affect at the time, was challenging. I am satisfied that there are no issues relating to the contact Victoria Police had with Thi and Yehia in this case.

Gendered violence and primary prevention

[4] CCoV Child Protection Cluster Inquest, Oral evidence of Ms Lomas, Inquest transcript of evidence for 20 April 2023, 162-163.

43. The CPU noted that in Australia, violence against women is 'staggeringly common', and is overwhelmingly perpetrated by men.[5] Although attitudes regarding violence against women are slowly improving, problematic attitudes in relation to gender equality and violence against women, including attitudes which reinforce rigid gender roles, persist for a concerning minority of Australians.[6] To address gender-based violence, more must be done to challenge dominant forms of masculinity, and the harm they do to people of all genders at an individual, group and society level.[7]

44. Primary prevention aims "*to change the underlying social conditions that produce and drive violence against women*" to prevent it from occurring in the first place.[8] This involves working on actions to address the gendered drivers of violence against women to create generational, cultural and attitudinal change.[9]

45. In recent years, Victoria has made progress in building an effective primary prevention system. Respect Victoria was established in 2018 in response to a recommendation by the Royal Commission into Family Violence, becoming the first agency dedicated to the primary prevention of family violence and all forms of violence against women in Victoria.[10] The Victorian Government is currently developing the *Family Violence Reform Rolling Action Plan 2024 – 2026*, which will be released in late 2024, and will set out the Government's priorities in addressing family and sexual violence and abuse.

46. The CPU suggested that I make the following recommendations:

    a) That the Victorian Government urgently increase the total quantum of primary prevention funding and prioritise longer term funding across the primary prevention system, including multi-year funding for organisations leading prevention activities, and stable, ongoing funding for Respect Victoria.

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[5] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 12; Australian Bureau of Statistics, Personal Safety Survey – Physical Violence (2023) < Physical violence, 2021-22 financial year | Australian Bureau of Statistics (abs.gov.au)>; Australian Bureau of Statistics, Personal Safety Survey – Partner Violence (2023).

[6] Christine Coumarelos et al, ANROWS, Attitudes Matter: The 2021 National Community Attitudes Towards Violence against Women Survey (NCAS) Findings for Australia (Report, 2023) 22-4.

[7] Respect Victoria, Progress on Preventing Family Violence and Violence Against Women in Victoria: First Three-Yearly Report to Parliament (Report, September 2022) 113.

[8] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 12.

[9] Victorian Government, Free from Violence: Victoria's Strategy to Prevent Family Violence and all Forms of Violence Against Women - Second Action 2022-2025 (December 2021) 4.

[10] Respect Victoria, Progress on Preventing Family Violence and Violence Against Women in Victoria: First Three-Yearly Report to Parliament (Report, September 2022) 6, 114.

b) That the Federal Government commit to long term funding for the development and maintenance of critical infrastructure for the primary prevention of violence against women and family violence as well as for those agencies that play a key role in influencing the quality, reach, impact and coordination of prevention activities at a national level, as outlined by Our Watch[11] in *Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia*.[12] These include:

i. Our Watch (to provide independent national leadership on primary prevention)

ii. Australia's National Research Organisation for Women's Safety (ANROWS) (to deliver the National Community Attitudes towards Violence against Women Survey and the prevention elements of the national research agenda)

iii. Australian Bureau of Statistics (to deliver the Personal Safety Survey)

iv. Workplace Gender Equality Agency.

47. I see significant merit in the above recommendations, in order to ensure that research and support for primary prevention strategies are appropriately funded. I therefore intend to adopt these recommendations.

Family violence, mental illness and substance abuse

48. I note that Thi's experiences of family violence from Yehia and other people intersected with and contributed to other key stressors in her life, proximate to the fatal incident.

49. The CPU explained that women who experience a perpetrator's pattern of coercive and controlling behaviour over time are "*six times more likely to use substances*" and may do so "*as a way of coping with a managing the impact of trauma*".[13] Substance misuse and family violence also directly contributed to the removal of Thi's son. The CPU also noted that women who experience a perpetrator's pattern of coercive and controlling behaviour over time are also likely to experience mental health issues as a result.[14] In particular, research has

[11] Our Watch is the national leader in the primary prevention of violence against women and their children in Australia.
[12] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 100-6.
[13] Family Safety Victoria, MARAM Practice Guides: Foundation Knowledge Guide –Guidance for Professionals Working with Child or Adult Victim Survivors, and Adults Using Family Violence (February 2021), 60.
[14] Family Safety Victoria, MARAM Practice Guides: Foundation Knowledge Guide –Guidance for Professionals Working with Child or Adult Victim Survivors, and Adults Using Family Violence (February 2021), 60.

demonstrated a link between depression, anxiety, PND, and PTSD, all of which Thi experienced in the context of family violence.[15]

50. In the United Kingdom, coroners are increasingly acknowledging the link between family violence and suicide, with one inquest concluding that a victim of intimate partner violence had been subject to unlawful killing by her partner after she suicided in the context of his abuse.[16]

51. A recent investigation by Ombudsman Western Australia, Investigation into Family and Domestic Violence and Suicide, found that between 1 January 2017 and 31 December 2017,124 women and children died by suicide and that of them, 68 were known to have experienced family violence.[17] The report contained a systemic review of available research which found a strong link between intimate partner violence and suicidality, and noted intimate partner abuse as a significant risk factor for suicidal thoughts and behaviours. The report acknowledged however that the link between family violence and suicide is under-researched.[18]

52. The report of the Rapid Review of Prevention Approaches published in August 2024 notes that Australia has yet to include suicide related to Domestic, Family and Sexual Violence (**DFSV**) victimisation in homicide data despite evidence suggesting that suicides related to DFSV victimisation potentially account for at least three times the number of female homicide deaths.[19] The report notes the potential to prevent further suicide through DFSV-victimisation is deserving of further investigation.[20] In line with this, the rapid review made the following recommendation:

> *The Commonwealth and state and territory governments to develop a consistent approach to death review processes and improve knowledge on the relationship between DFSV and suicide. This should include:*

[15] Ibid; M Campo, Australian Institute of Family Studies, *Domestic and Family Violence in Pregnancy and Early Parenthood: Overview and Emerging Interventions* (2015), 4.
[16] Sophie Naftalin and Vanessa Munro, 'Investigations into Suicides in the Context of Domestic Abuse' (October 2023) Legal Action https://www.lag.org.uk/article/214523/investigations-into-suicides-in-the-context-of-domestic-abuse.
[17] 5 Ombudsman Western Australia, Investigation into Family and Domestic Violence and Suicide: Volume 1, Executive Summary, 41 https://www.ombudsman.wa.gov.au/Publications/Reports/FDV-Suicide-2022-Volume-1-Ombudsman-Foreword-and-Executive-Summary.pdf.
[18] Ibid, 30.
[19] Elena Campbell et al, Unlocking the Prevention Potential: Accelerating action to end domestic, family and sexual violence (Report of the Rapid Review of Prevention Approaches, August 2024), 79.
[20] Ibid 80.

a. *establishing and uplifting death review panels across all jurisdictions, including with First Nations support units and protocols (state and territory governments);*
b. *strengthening national coordination and consistency of DFSV death review processes, and learning and sharing of findings (state and territory governments supported by Commonwealth); and*
c. *initiating an urgent inquiry into the relationship between DFSV victimisation and suicide, with a view to developing a methodology for accurate counting of the DFSV death toll (Commonwealth, state and territory governments).*[21]

53. I support and endorse the above recommendation (Recommendation 21) from the rapid review. I intend to make a recommendation encouraging the Commonwealth and Victorian Governments to work together to implement this recommendation.

54. I also note the above recommendation's call for uplifting death review panels across all jurisdictions and initiating an urgent inquiry into the relationship with DFSV victimisation and suicide. The Coroners Court of Victoria (**CCoV**) made a submission on this issue. The CCoV submitted that in order to ensure that the VSRFVD can fulfill the requirements of this recommendation, it requires resourcing to support:

a) Increased capacity at the CCoV to support coroners' investigations in the circumstances of all family violence related deaths, and to provide in-depth analysis of these circumstances;

b) Enhanced functionality of the CCoV database to provide more comprehensive/multidimensional data on family violence victims and perpetrators, and;

c) Increased capacity at CCoV to code, analyse and disseminate the data to the coroners and relevant stakeholders.[22]

55. I echo and endorse the submission made by the Court to the Parliamentary Inquiry in June 2024.

[21] Ibid 81.
[22] Coroners Court of Victoria, Submission 59 to the Legislative Assembly Legal and Social Issues Committee, *Parliamentary Inquiry into the Data on the Profile and Volume of Perpetrators of Family Violence in Victoria* (14 June 2024) 6.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Thi Minh Phuong Nguyen, born 25 July 1991;

    b) the death occurred on 20 February 2021 at [redacted] City Road, Southbank, Victoria, 3006, from *mixed drug toxicity (gamma hydroxybutyrate, methylamphetamine, amphetamine, diazepam, nordiazepam);* and

    c) the death occurred in the circumstances described above.

57. Having considered all of the circumstances, I am satisfied that Thi intentionally took her own life.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. The **Victorian Government** urgently increase the total quantum of primary prevention funding and prioritise longer term funding across the primary prevention system, including multi-year funding for organisations leading prevention activities, and stable, ongoing funding for Respect Victoria.

2. The **Federal Government** commit to long term funding for the development and maintenance of critical infrastructure for the primary prevention of violence against women and family violence as well as for those agencies that play a key role in influencing the quality, reach, impact and coordination of prevention activities at a national level, as outlined by Our Watch[23] in *Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia*.[24] These include:

    a. Our Watch (to provide independent national leadership on primary prevention)

    b. Australia's National Research Organisation for Women's Safety (ANROWS) (to deliver the National Community Attitudes towards Violence against Women Survey and the prevention elements of the national research agenda)

[23] Our Watch is the national leader in the primary prevention of violence against women and their children in Australia.
[24] Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 100-6.

c. Australian Bureau of Statistics (to deliver the Personal Safety Survey)

d. Workplace Gender Equality Agency.

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

Pursuant to section 73(1A) 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:

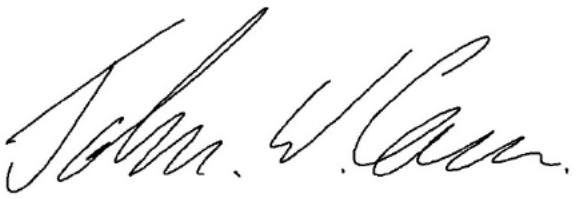
Thi Gai Tran, Senior Next of Kin (C/- Regional Alliance West)

Commonwealth Government

Victorian Government

Detective Senior Constable Emma Skewes, Coroner's Investigator

Signature:



Judge John Cain
State Coroner
Date: 3 December 2024

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.