IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002438

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of AYMAN PETER FATHO

Findings of:	AUDREY JAMIESON, Coroner
Delivered on:	10 November 2025
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria 3006
Hearing dates:	10 November 2025
Representation:	None
Counsel assisting the Coroner:	Ms Anna Pejnovic of the Coroners Court of Victoria

I, AUDREY JAMIESON, Coroner, having investigated the death of AYMAN PETER FATHO

AND having held a Summary Inquest in relation to this death on 10 November 2025

at the Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006

find that the identity of the deceased was AYMAN PETER FATHO

born on 4 April 1992

and the death occurred on 8 May 2023

at 6 Vaucluse Boulevard, Taylors Hill, Victoria 3037

from:

1a: GUNSHOT INJURY TO THE CHEST

in the following summary of circumstances:

AYMAN PETER FATHO died at the age of 31 years on 8 May 2023, having been shot by his former friend, Mr G[1]. Ayman had violently confronted Mr G over a perceived betrayal and the circumstances of the shooting suggested that Mr G was acting in self-defence.

BACKGROUND CIRCUMSTANCES

1. Ayman was one of five siblings. He was born in Iraq and moved to Australia with his family in 2002. They initially lived in Queensland, before moving to Victoria. He and his family were close.

2. Ayman had held several jobs including as a stone mason and labourer in landscaping and home renovation but had not worked in the year prior to his death. He regularly used drugs including 'ice' (methylamphetamine) and GHB.

3. Ayman commenced a relationship with Ms T in August 2022, and they moved in together the following month. According to Ms T, Ayman was physically and mentally abusive

[1] The names of other parties in this matter have been deidentified for publication.

towards her and this behaviour escalated over the course of the relationship. The relationship ended on 28 March 2023.

4. Around a month prior to Ayman's death, he formed a belief that Mr G had become romantically involved with Ms T. He believed that Mr G was disrespecting him and his family. There is no evidence of this having occurred, and Ms T denies being involved with Mr G.

5. Between 4 April 2023 and his death, Ayman stalked, threatened and abused Mr G and members of his family. He slashed Mr G's tires, physically assaulted him, and intimidated his partner and children.

6. Between 30 April 2023 and 7 May 2023, Mr G illegally purchased a Pirotte 12-gauge double barrel sawn-off shotgun and ammunition. He stated that he did so due to fear for his life, due to Ayman's behaviour. He kept the shotgun in his car.

7. At the time of Ayman's death, Mr G had moved out of his family home and into a hotel as he was fearful for his safety and that of his family.

8. According to Ms T, Ayman was paranoid, and his reputation was such that everyone feared him, as *"he won't stop until he gets what he wants."*

THE CORONIAL INVESTIGATION

Jurisdiction

9. Ayman'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.

10. The Act recognises that it is in the public interest to hold a public hearing when a person causes the death of another: it is mandatory for the coroner to hold an inquest if the death

occurred in Victoria, the coroner suspects the death was the result of homicide, and no person or persons have been charged with an indictable offence in respect of the death.[2]

11. Having considered the available evidence, I determined that this matter would be appropriately finalised by way of a Summary Inquest and Form 37 *Finding into Death with Inquest*. Interested parties were informed of my determination by way of a formal notice for a Summary Inquest to be held on 10 November 2025.

Purpose of a coronial investigation

12. The purpose of a coronial investigation of a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[3]

13. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which death occurred refer to the context or background and surrounding circumstances but are confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[4]

14. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the prevention role.[5]

15. Coroners are empowered to report to the Attorney-General in relation to a death; 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 to make recommendations to any Minister or public statutory authority on any matter connected with the death, including

[2] Section 52(2)(a); section 52(3)(b) of the Act.
[3] Section 67(1) of the Act.
[4] This is the effect of the authorities – see for example, *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).
[5] The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as "implicit".

public health or safety or the administration of justice.[6] These powers are effectively the vehicles by which the Coroner's prevention role can be advanced.[7]

16. The Coroners Court of Victoria is an inquisitorial jurisdiction.[8] Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[9]

Sources of evidence

17. This Finding is based on the totality of the material produced by the coronial investigation into the death of Ayman Peter Fatho. That is, the Court File and Coronial Brief of Evidence compiled by Detective Leading Senior Constable Daniel Ruggiero.

18. The Brief will remain on the Court File, together with the Inquest transcript.[10] In writing this Finding, I do not purport to summarise all the material and evidence but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

Standard of proof

19. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*[11]. These principles state that in

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[6] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations, respectively.
[7] See also sections 73(1) and 72(5), which requires publication of coronial findings, comments and recommendations and responses respectively; sections 72(3) and 72(4), which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.
[8] Section 89(4) of the Act.
[9] Section 69(1) of the Act. However, a Coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1) of the Act.
[10] From the commencement of the Act, that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.
[11] *Briginshaw v Briginshaw (1938)* 60 C.L.R. 336 esp. at 362-363: *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters, "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…".*

deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

- the nature and consequence of the facts to be proved;
- the seriousness of any allegations made;
- the inherent unlikelihood of the occurrence alleged;
- the gravity of the consequences flowing from an adverse finding; and
- if the allegation involves conduct of a criminal nature, weight must be given to
    - the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

IMMEDIATE CIRCUMSTANCES

20. At 4:06pm on 7 May 2023, Ayman's friend, Mr W, sent Mr G a text message requesting to purchase methylamphetamine from him. Mr G agreed, and they arranged to meet at the West Waters Hotel in Caroline Springs. Mr W called Ayman and advised him of the arrangement. Ayman then called his friend, Mr H, and they arranged to confront Mr G.

21. Mr H and Ayman drove to the West Waters Hotel in a stolen black BMW and parked outside. At this time, Mr G was parked in the level one carpark, with his friend Mr J in the passenger seat.

22. At around 11:15pm, Ayman located Mr G's vehicle. He attempted to open the driver's side door and when he could not do so, began kicking and punching the car. Mr G drove away.

23. Ayman ran back to the stolen vehicle, got in the passenger seat, and told Mr H to follow Mr G's vehicle. A 15-minute pursuit through Caroline Springs and Taylors Hill ensued, with Mr H intentionally colliding with Mr G's vehicle several times. During the pursuit, an occupant

in the stolen vehicle fired a Winchester .22 calibre firearm at Mr G's vehicle, which impacted the boot and ricocheted into the rear windscreen.[12]

24. Mr G drove onto Johnston Way in Taylors Hill where his vehicle collided with a concrete bollard. The stolen vehicle stopped behind Mr G's vehicle, and Mr G could hear Ayman yelling at him.

25. Mr G, who stated he was in fear for his life, took the shotgun from the back seat, exited his vehicle and fired one shot at the stolen vehicle. The projectiles from the shotgun went through the windscreen and impacted Ayman in the head and chest. Mr G and Mr J left the scene.

26. Mr H drove approximately 750 metres to Vaucluse Boulevard, where he knocked on the door of a nearby house and asked for assistance. He called Triple Zero at 11:36pm and reported that his friend had been shot. He then left the scene.

27. At 11:41pm, police and paramedics attended and located Ayman in the passenger seat of the stolen vehicle. Despite medical intervention, he died at 12:09am on 8 May 2023.

INVESTIGATION PRECEDING THE INQUEST

Identification

28. On 9 May 2023, the right thumb print of the deceased was positively compared with the corresponding print on file for Ayman Fatho.

29. On the same date, Coroner David Ryan considered the available evidence and determined that the cogency and consistency of all evidence relevant to the identification of the deceased supported a finding that the deceased was Ayman Peter Fatho, born 4 April 1992. Accordingly, he signed a Determination by Coroner of Identity of Deceased (Form 8).

[12] It is unknown whether Ayman or Mr H fired the gun.

Medical cause of death

30. On 8 May 2023, Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Ayman Fatho and provided a written report of his findings dated 14 July 2023. At the time of compiling his report, Dr de Boer had available to him the following materials:

- Victoria Police Report of Death (Form 83)
- VIFM contact log
- Victoria Police Section 27: Request for Immediate Autopsy
- Post mortem computed tomography (**CT**) scan

31. The autopsy identified a ballistic injury to the right side of the chest which terminated in a deformed projectile which was retrieved from the mediastinum. The wound tract included perforation of multiple vital structures, including the right lung, a major blood vessel and the left bronchus. This would have resulted in major blood loss and would have negatively impacted lung function. Dr de Boer considered this injury was sufficient to explain death in the absence of other contributing factors.

32. There was a ballistic injury to the right side of the head, terminating in two deformed projectiles which were recovered in the right temporal muscle. Dr de Boer considered that this injury was of limited relevance for the cause and mechanism of death.

33. There was no post mortem evidence of other substantial injury and no evidence of substantial natural disease.

<u>Toxicology</u>

34. Toxicological analysis of post-mortem samples identified the presence of methylamphetamine, amphetamine and dimethylamphetamine.

Forensic pathology opinion

35. Dr de Boer provided an opinion that the medical cause of death was 1 (a) gunshot injury to the chest.

Victoria Police investigation

36. The Victoria Police Major Crime Scene Unit conducted a forensic examination of the scene.

37. A Winchester .22 calibre firearm was located in the stolen vehicle, as were illicit drugs. 13 shotgun cartridges, methylamphetamine and cannabis were located in Mr G's vehicle, which had damage to the boot and rear windscreen consistent with a .22 calibre round.

38. On 9 May 2023, Mr G presented at Melbourne West Police Station with his legal representative. He was arrested and interviewed, during which he said he was in fear for his life and acted in self-defence when he discharged the shotgun. He said *"I was scared for my life but didn't intentionally try to shoot anyone"* and *"I intended the shot to be a warning shot to give me time to escape."*

39. Mr G told police where he had discarded the shotgun. It was later located at Heysen Parkway in Caroline Springs.

40. Investigating police members submitted a brief of evidence against Mr G in relation to the death of Ayman. Ultimately, murder/manslaughter charges were not authorised to be laid on the basis that Mr G had a legitimate claim of self-defence, and there was no reasonable prospect of a conviction being obtained.

41. Mr G was charged with traffick methylamphetamine, possess cannabis and possess unregistered firearm. He was convicted and received an 18-month Community Corrections Order.

42. Mr H was charged and pleaded guilty to one charge of Reckless Conduct Endangering Life in respect of the theft of the vehicle and his involvement in the incident. Neither Mr J nor Mr W were charged in respect of their involvement.

FINDINGS AND CONCLUSION

Having applied the applicable standard to the available evidence, I make the following Findings pursuant to section 67 of the *Coroners Act 2008* (Vic):

1. I find that Ayman Peter Fatho, born 4 April 1992, died on 8 May 2023 at 6 Vaucluse Boulevard, Taylors Hill, Victoria 3037.

2. I accept and adopt the medical cause of death ascribed by Dr Hans de Boer and I find that Ayman Peter Fatho died from a gunshot injury to the chest.

3. AND, I find that the injury was inflicted by Mr G who discharged a shotgun in the direction of Ayman Peter Fatho, in circumstances where the weight of the evidence supports that he was in fear for his life and acted in self-defence.

PUBLICATION OF FINDING

To enable compliance with section 73(1) of the *Coroners Act 2008 (Vic)*, I direct that the Findings will be published on the internet.

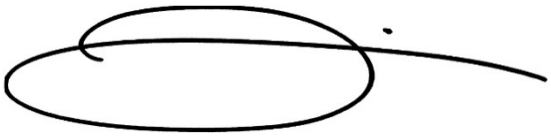
DISTRIBUTION OF FINDING

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

Mr Adris Fatho, Senior Next of Kin

Detective Leading Senior Constable Daniel Ruggiero

Signature:



AUDREY JAMIESON
CORONER

Date: 10 November 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 inquest. 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.