IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2767

FINDING INTO DEATH FOLLOWING INQUEST

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

Inquest into the death of Abdullahi Bashir

Findings of:	Judge John Cain, State Coroner
Delivered on:	18 April 2023
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	18 April 2023
Assisting the Coroner:	Abigail Smith, Senior Coroner's Solicitor to the State Coroner
Keywords:	Suspected homicide; uncharged homicide; reportable death, mandatory inquest; head injury

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BACKGROUND

1. On 12 June 2017, Abdullahi Bashir (**Mr Bashir**) was 27 years old when he died of a head injury at the Royal Melbourne Hospital in Parkville.

2. Mr Bashir was born on 10 April 1990 and was of Somalian background. There is limited available information about Mr Bashir's personal circumstances including his upbringing prior to coming to Australia.

3. Mr Bashir was described as an intellectual person and completed a Bachelor of Commerce majoring in Accounting and Economics at La Trobe University. After completing his degree, he worked in various roles for Serco Immigration Services including in a contractual capacity at the immigration detention centre on Christmas Island.

4. Mr Bashir was also involved in a community organisation called 'ONLYF' which raises awareness about the persecution of Somalian people. He frequently assisted with organising events and fundraising.[1] Mr Bashir was described as a true humanitarian.

5. In March 2017, Mr Bashir returned to Australia after the conclusion of his assignment in Christmas Island. The following month, he took up temporary accommodation at the Stay Inn Motel, which is located at 844-846 Sydney Road in Coburg North.[2]

6. Mr Bashir made periodic bookings at the Stay Inn Motel until he was evicted on 8 May 2017 for owing monies for accommodation. After this time, he continued to reside at the Stay Inn Motel in the rooms of his associates.

7. Whilst he resided at the Stay Inn Motel, Mr Bashir became acquainted with Mr Firas Ali, Mr Nathan Ilsley and Mr George Beainy. According to Mr Beainy, Mr Bashir was using drugs, namely methylamphetamine with Mr Ali and Mr Ilsley.[3]

8. On 4 May 2017, members of Victoria Police attended the Stay Inn Motel to make enquiries regarding a stolen motorcycle.[4] Police subsequently arrested Mr Bashir, Mr Ilsley and Mr Ibrahim Aydemir in relation to the stolen motorcycle as well as other stolen property and a small bag containing amphetamines. They were transported to the Fawkner Police Station and interviewed.

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[1] Statement of Farah Aden dated 30/8/2017, paragraph 11, p 3.
[2] Statement of Philip Alexander dated 2/8/17. See also Booking Slips at Stay Inn Motel Exhibit 47.
[3] Statement of George Beainy dated 21/2/18, paragraphs 2-8, pp 1-2
[4] Statement of S/C Tippett dated 25/7/17, p 1.

9. Following the interviews, Mr Bashir was released pending further enquiries whilst Mr Ilsley was charged and remanded in custody until 17 May 2017. Mr Aydemir was charged and released on bail.[5]

10. On 7 June 2017, Mr Bashir was involved in an alleged altercation with Mr Ilsley near the BP service station on Sydney Road in Coburg. It is alleged that during the altercation, Mr Ilsley punched Mr Bashir causing him to fall backwards onto the road, hitting his head.

11. Later that evening, whilst in the company of his associates, Mr Bashir started having seizures. Emergency services were contacted, and he was conveyed to Royal Melbourne Hospital (**RMH**) where he remained until his death on 12 June 2017.

THE PURPOSE OF A CORONIAL INVESTIGATION

12. Mr Bashir's death constitutes a *reportable death* under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria,[6] was unexpected and as a result of an injury.[7]

13. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the death occurred in Victoria and a coroner suspects the death was as a result of homicide and no person or persons have been charged with an indictable offence in respect of the death.

14. 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 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*."[8]

15. 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.[9]

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[5] Statement of S/C Tippett dated 25/7/17, p 3.
[6] *Coroners Act 2008* (Vic) s 4
[7] *Coroners Act 2008* (Vic) s 4(a).
[8] *Priest v West and Percy* (2012) VSCA 327.
[9] *Perre v Chivell* (2000) 77SASR 282.

16. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[10] 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 death occurred.[11]

17. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[12] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[13] or to determine disciplinary matters.

18. The expression *cause of death* refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

19. For coronial purposes, the phrase *circumstances in which death occurred*,[14] 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.

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

21. Coroners are also empowered:

    a) to report to the Attorney-General on a death;[15]

    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;[16] and

    c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[17] These powers are the vehicles by which the prevention role may be advanced.

22. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[18] In determining these matters, I am guided by the principles enunciated in

[10] *Coroners Act 2008* (Vic) s 89(4).
[11] *Coroners Act 2008* (Vic) preamble and s 67.
[12] *Keown v Khan* (1999) 1 VR 69.
[13] *Coroners Act 2008* (Vic) s 69 (1).
[14] *Coroners Act 2008* (Vic) s 67(1)(c).
[15] *Coroners Act 2008* (Vic) s 72(1).
[16] *Coroners Act 2008* (Vic) s 67(3).
[17] *Coroners Act 2008* (Vic) s 72(2).
[18] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.

Briginshaw v *Briginshaw*.[19] 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.

23. Detective Senior Constable Rebecca Maydom was appointed the Coroner's Investigator and submitted a coronial brief of evidence.

24. This finding draws on the totality of the material which is the product of the coronial investigation into Mr Bashir's death. That is, the investigation and inquest brief and the statements, reports and any documents obtained through the investigation. In writing this finding, I do not purport to summarise all of the evidence but refer only in such detail as appears warranted by its forensic significance and interests of a narrative clarity.

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

25. On 12 June 2017, Ms Ruqiyo Mohamed visually identified her son, Abdullahi Bashir, born 10 April 1990.

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

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

27. On 13 June 2017, Specialist Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Mr Bashir and provided a written report of his findings dated 20 December 2017.

28. On 19 June 2017, Forensic Pathologist Dr Linda Iles of the VIFM conducted a brain examination. Both pathologists provided written reports of their findings.

29. The post-mortem examination revealed significant injuries to the head associated with a left occipital laceration and left occipital fracture. Dr Bedford stated that significant contusions were noted including in both frontal regions and the left cerebellum, in association with brain swelling and a right subdural hematoma. These led to Mr Bashir's death.[20]

30. There were no other significant injuries noted.

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[19] (1938) 60 CLR 336.
[20] Medical Examiner's Report of Dr Paul Bedford dated 20/12/17, p 9.

31. Toxicological analysis of ante-mortem specimens revealed the presence of methylamphetamine, amphetamine and midazolam. The Midazolam was administered in a hospital setting.

32. Dr Bedford determined the cause of death to be *head injury*.

33. I accept Dr Bedford's opinion as to the cause of death.

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

34. In the early hours of 7 June 2017, Mr Firas Ali and his girlfriend, Ms Julie Alimov, attended the Stay Inn Motel where they met Mr Nathan Ilsley, Mr Jamal Hassoun and Mr Bashir.

35. Mr Ilsley, Mr Hassoun and Mr Bashir entered Ms Alimov's vehicle and they drove to the nearby BP Service Station on Sydney Road. The BP Service Station has three separate entry/exit points comprising of two on Sydney Road and one on Spry Street.

36. Whilst in the vehicle, they discussed attending the home of an associate, Mr Lindsay Kendrick in Fawkner. Mr Ilsley also raised the topic of his interview with police regarding the stolen motorcycle on 4 May 2017 with Mr Bashir. [21] After arriving at the BP Service Station, Mr Ali, Mr Bashir and Mr Ilsley excited Ms Alimov's vehicle.[22]

37. Mr Ilsley and Mr Bashir walked to the southern corner of the BP service station near Spry Street. Mr Ali, Mr Ilsley and Mr Bashir spoke to an associate of Mr Ilsley's who was seated in his vehicle which he had parked near the air pump.[23] This person was later identified as Mr Charles Pisani.

38. Mr Pisani stated that Mr Ilsley had contacted him between 11.00pm on 6 June 2017 and 1.00am on 7 June 2017 and asked Mr Pisani to pick him up from the BP service station. Mr Pisani drove his vehicle to the BP Service Station, where he met Mr Ilsley and his associates.[24]

39. At 1.48am, Mr Bashir and Mr Ilsley walked out of the BP service station along Spry Street out of view of Mr Pisani's vehicles.[25] A few minutes later, Ms Alimov drove her vehicle out of the BP service station with Mr Ali and turned right into Spry Street. They drove towards the end of the street, performing a U-turn before driving back along Spry Street towards Sydney Road. She parked her vehicle outside the neighbouring business next to the BP service station.[26]

[21] Statement of Jamal Hassoun dated 1/11/2017, paragraph 7-8.
[22] Statement of Firas Ali dated 25/8/17, paragraphs 39-41.
[23] Statement of Firas Ali dated 25/8/17, paragraph 45.
[24] Statement of Charles Pisani dated 6/6/18 paragraphs 6 – 8.
[25] Statement of Charles Pisani dated 6/6/18, paragraph 17.
[26] Statement of Firas Ali dated 25/7/17, paragraph 46 and Statement of Julie Alimov dated 5/6/18, paragraphs 13-14.

40. Ms Alimov stated that she looked up and saw a *commotion* on the road in front of her where she had last seen Mr Bashir and Mr Ilsley standing.[27] She observed Mr Ilsley and Mr Hassoun moving back and forth quickly on the road in a *panicked* motion. Ms Alimov could not see Mr Bashir and told Mr Ali that she thought something was wrong.[28]

41. Mr Ali exited the vehicle and walked towards Mr Hassoun and Mr Ilsley. He observed Mr Bashir on the road. Mr Ilsley was shaking him, attempting to rouse him, and calling his name.[29] Mr Bashir regained consciousness but was initially unable to stand. Mr Ali observed blood around his mouth and asked Mr Ilsley what had occurred. Mr Ilsley stated that they had been arguing.[30]

42. Mr Ali and Mr Ilsley placed Mr Bashir in the back seat of Ms Alimov's vehicle. Discussions were had with respect to taking Mr Bashir to the hospital. Mr Bashir declined and indicated that he wanted to proceed to Mr Kendrick's residence. Ms Alimov and Mr Ali proceeded to Mr Kendrick's residence with Mr Bashir, and left Mr Hassoun and Mr Ilsley on Spry Street.[31]

43. Mr Pisani had remained in his vehicle during this time and was unaware of the incident that had occurred. Mr Ilsley and Mr Hassoun returned to his vehicle and appeared to be discussing something. Mr Pisani asked what had occurred and Mr Ilsley stated that he had *fronted* Mr Bashir and asked him why he had *ratted him in*. He stated that Mr Bashir came towards him, and he punched Mr Bashir, causing him to fall backwards.[32]

44. On arrival at Mr Kendrick's home, Ms Alimov and Mr Ali were assisted by a male resident to bring Mr Bashir into the home. They placed him on the couch in the living room.[33] Mr Kendrick was not home at this time but a friend, Mr Jennifer Greenaway was present.

45. Upon entering the loungeroom, Ms Greenaway observed Ms Alimov and Mr Ali standing in the doorway. Mr Bashir was slumped over on the couch. Ms Alimov stated that Mr Bashir had been *touched up a bit* and to keep an eye on him.[34] Ms Greenaway asked why they had attended the residence, but Ms Alimov did not answer. Ms Greenaway stated that they then left the premises.[35] In their statements to police, Mr Ali stated that they remained at the house for 1.5 hours and Ms Alimov stated that they remained for 40 minutes.[36]

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[27] Statement of Julie Alimov dated 12/6/17, paragraph 38.
[28] Statement of Julie Alimov dated 12/6/17, paragraph 38.
[29] Statement of Firas Ali dated 25/8/17, paragraph 50.
[30] Statement of Firas Ali dated 25/8/17, paragraph 50.
[31] Statement of Firas Ali dated 25/8/17, paragraph 51.
[32] Statement of Charles Pisani dated 6/6/18, paragraphs 18-22.
[33] Statement of Firas Ali dated 25/8/17, paragraphs 53-56.
[34] Statement of Jennifer Greenaway dated 19/6/17.
[35] Statement of Jennifer Greenaway dated 19/6/17, paragraphs 8-10.
[36] Statement of Firas Ali dated 25/8/17, paragraph 55; Statement of Julie Alimov dated 5/6/18, paragraph 25.

46. Ms Greenaway observed Mr Bashir to be disorientated. Shortly after arriving at Mr Kendrick's residence, Mr Bashir began convulsing and had a seizure which lasted approximately three minutes.[37] Ms Greenaway noted that he had a lot of blood on the side of his neck and coming out of his mouth. Approximately five minutes after the first seizure stopped, Mr Bashir began convulsing for a second time. The second seizure lasted for approximately 5 minutes.

47. In his statement to police, Mr Kendrick stated that approximately a week prior, Mr Bashir had experienced an epileptic seizure whilst at his home. He stated that Mr Bashir was o*nly down for a few minutes and when he came to, he told me that he had epilepsy*.[38]

48. At 3.55am, Ms Greenaway contacted emergency services. Following the arrival of paramedics, Mr Bashir suffered another seizure.[39] He was subsequently transported to the Royal Melbourne Hospital (**RMH**).

49. On arrival at the hospital, Mr Bashir was diagnosed as having sustained significant brain injury with subdural haemorrhage, subarachnoid haemorrhage, and right brain contusion, leading to mass effect with midline shift.[40] This required admission to the Intensive Care Unit (**ICU**) as well as neurosurgical management. Mr Bashir did not appear to have any significant injuries elsewhere on his body.

50. Part of Mr Bashir's management whilst in the ICU involved intracranial pressure monitoring (**ICP**). On day five of his admission to the ICU, Mr Bashir developed unequal pupils and a repeat CT brain scan revealed worsening of his brain injury.[41] Dr Tanya Yuen, Neurosurgeon performed a right fronto-temporal decompressive craniectomy and evacuation of haematoma.

51. On 12 June 2017, Mr Bashir suffered a cardiac arrest and was declared deceased at 10.27am.

FURTHER INVESTIGATIONS

52. The focus of my investigation then turned to the events which followed the alleged incident between Mr Bashir and Mr Ilsley on 7 June 2017. Of relevance to my investigation was Mr Bashir's admission and treatment at the RMH and the criminal investigation conducted by the Victoria Police Homicide Squad.

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[37] Statement of Jennifer Greenaway dated 19/6/17, paragraphs 14-15.
[38] Statement of Lindsay Kendrick, dated 8 June 2017, p 254
[39] Statement of Brayden Gant dated 23/6/17, paragraph 12.
[40] Statement of Dr Caroline MacCallum, Royal Melbourne Hospital, p 149.
[41] Ibid.

Mr Bashir's medical management and treatment at RMH

53. The medical e-disposition provided to the Court by the RMH stated that there was *likely migration of ICP monitor providing falsely reassuring ICP readings*.[42]

54. In order to ascertain whether this may have impacted upon the outcome for Mr Bashir, I referred this matter to the Health and Medical Investigation Team (**HMIT**) of the Coroner's Prevention Unit (**CPU**)[43] for review. In undertaking a review of Mr Bashir's matter, the HMIT considered all of the available medical evidence on the Court file.

55. The HMIT determined that the migration of an ICP monitor is a recognised problem and in Mr Bashir's case, the migration of the monitor and subsequently false readings, may have led to a delay in the recognition of Mr Bashir's deterioration and in turn, decreased, to some extent, his chances of recovery.

56. In order to further explore this issue, a statement was sought from Dr Tanya Yuen which was received by the Court on 14 November 2020.

ICP Monitor

57. In her statement to the Court, Dr Yuen noted that in intubated unconscious patients, *the ICP monitor can be dislodged despite best efforts to secure it*.[44] She further added that the *wire tip can migrate out of the brain and still be under the scalp/sitting in the burr hole largely on the surface of the brain and still give readings*.[45]

58. With respect to Mr Bashir, Dr Yuen further stated that *in hindsight, the very stable low ICP readings throughout the night of Friday 9th were due to the migration of the monitor, but were also not outside the realm of normal clinical findings*.[46]

59. Dr Yuen also referenced studies of prognostication in head injury which confirm Mr Bashir's likely grim prognosis and made the comment that earlier intervention may not have altered the ultimate outcome.[47] Dr Yuen also stated that Mr Bashir's case was reviewed in the Neurosurgery Department audit meeting, as well as the ICU Morbidity and Mortality Meeting. The case was

[42] E-Medical Deposition Form completed by Dr Haran Nathan dated 12 June 2017
[43] The Coroners Prevention Unit 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. The unit assists the coroner 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.
[44] Statement of Dr Tanya Yuen dated 14/11/20.
[45] Statement of Dr Tanya Yuen dated 14/11/20.
[46] Statement of Dr Tanya Yuen dated 14/11/20.
[47] Ibid.

also chosen by the RMH Surgical Audit Selection Committee for discussion in the Annual Neurosurgery Department Audit presentation to all surgery units.

60. Dr Yuen confirmed that corrective actions have since been implemented regarding the insertion of ICP monitors to ensure that the depth of insertion is now recorded on the operation report and clear dressings are used.

61. The HMIT noted that whilst these cannot be expected to completely mitigate the risk of ICP monitor migration, it is probably the only reasonable, practical management change available.

Epilepsy diagnosis

62. The possibility that Mr Bashir had a pre-existing seizure disorder was raised by Mr Lindsay Kendrick in his statement to police. However, Mr Bashir's medical records do not contain any report of a past history of epilepsy or seizures or medications for such a condition. In addition, Dr Yuen was unable to clarify whether Mr Bashir had a pre-existing epilepsy condition.

63. At my request, the Court wrote to Mr Bashir's family on 2 August 2022, and asked them to provide any relevant information regarding Mr Bashir's epilepsy diagnosis. In response to that request Mr Bashir's family reported that they were not aware of him having a history of epilepsy.

64. The HMIT stated that a possible diagnosis of epilepsy was of limited relevance to Mr Bashir's medical management whilst in hospital. He did not appear to suffer any seizures in hospital and if he had, they would likely have been appropriately attributed to the head injury. He also received multiple medications in high dose that had an anticonvulsant effect. In her statement to the Court, Dr Yuen confirmed that she was not informed of any past history relating to seizures or epilepsy during Mr Bashir's time in hospital.[48]

65. The HMIT concluded that Mr Bashir was appropriately managed whilst in hospital and no preventative actions were identified.

66. Having considered the available materials, I agree with their determination.

Investigation by Victoria Police

67. Following Mr Bashir's death, Victoria Police commenced a criminal investigation into the circumstances of the alleged assault on Mr Bashir. This investigation was conducted by the Victoria Police Homicide Squad.

[48] Statement of Dr Tanya Yuen dated 14/11/20.

68. During the course of the investigation, police obtained CCTV footage from the Stay Inn Motel, the BP Service Station and other locations within the general vicinity of Sydney Road, Coburg.

69. The CCTV footage depicts the following[49]:

- Between 12.42am and 1.36am on 7 June 2017, Mr Hassoun and Mr Bashir together at the Stay Inn Motel;
- Between 1.42am and 2.10am, Ms Alimov's vehicle arriving at the BP Service Station with Mr Bashir, Mr Ali, Mr Hassoun and Mr Ilsley, as well as the interactions between the parties outside of Ms Alimov's prior to Mr Bashir and Mr Ilsley walking away; and
- Between 1.57am and 2.11am, an unidentified dark coloured Mercedes entering the BP Service Station prior to the alleged assault and subsequently Ms Alimov's vehicle driving in a northerly direction along Sydney Road.

70. Police did not locate any CCTV footage which depicted the alleged assault involving Mr Ilsley and Mr Bashir.

71. On 29 June 2017, Mr Ilsley was interviewed with respect to the alleged assault on Mr Bashir at the Melbourne North Police Station where he was arrested.

72. In his interview, he advised police that following his discussion Mr Bashir about the stolen property, Mr Bashir had moved closer to him, causing him to feel uncomfortable. He then pushed Mr Bashir in the *facial area*. He stated that Mr Bashir retaliated by pushing him in the face and came at him in an aggressive manner. Mr Ilsley alleged that Mr Bashir hit him twice, and he then threw a punch with his right hand, hitting Mr Bashir and causing him to fall backwards and hit his head on the road.[50] A reference DNA sample was also obtained from Mr Ilsley.

73. Following the provision of legal advice, Mr Ilsley partook in further interview with police and made no comment in relation to the questions that were asked. He was subsequently released by police, pending further enquiries.

74. Having reviewed the statements in the coronial brief, it is clear that there are several inconsistencies in the versions of events provided by Mr Bashir's associates. Each witnesses provides differing versions of how the group arrived at the BP Service Station, the circumstances of the incident and the event's post incident when Mr Bashir was driven to Mr Kendrick's

[49] Statement of Detective Senior Constable Maydom dated 8/1/2019.
[50] Transcript of recorded interview with Nathan Ilsley dated 29/6/17.

residence. It is also evident that some of the witnesses were drug affected on the evening of the alleged assault.[51]

75. Due to this, despite a thorough investigation, no person or persons have been charged with an indictable offence in connection with Mr Bashir's death.

76. 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 in a finding or a comment, any statement that a person is or may be guilty of an offence.

77. In making this finding, I have been careful not to compromise any potential criminal prosecution in the course of my investigation, mindful that Mr Bashir's death may be the result of homicide. I am satisfied that police have conducted a thorough and comprehensive investigation and that no further investigation by me is required.

78. I note that if new facts and 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 these findings be set aside. Any such application would be assessed on its merits at that time.

FINDINGS AND CONCLUSION

79. Having held an inquest into the death of Mr Bashir, I make the following findings, pursuant to section 67(1) of the Act:

    a) the identity of the deceased was Abdullahi Bashir, born 10 April 1990.

    b) the death occurred on 12 June 2017 at the Royal Melbourne Hospital, from 1(a) Head Injury; and

    c) Mr Bashir's death occurred in the circumstances set out above.

Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court website.

I convey my sincerest sympathy to Mr Bashir's family.

[51] Statement of Firas Ali dated 25/8/17, from paragraph 33; Statement of Julie Alimov dated 12/7/2017, from paragraph 33; Statement of Jamal Hassoun dated 1/11/17.

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

Ms Ruqiyo Mohamed, Senior Next of Kin

Detective Senior Constable Rebecca Maydom, Victoria Police

Signature:

JUDGE JOHN CAIN
STATE CORONER

Date: 18 April 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 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.