IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000551

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Bariyow Mohamed Hussein
Date of birth:	7 May 1973
Date of death:	29 January 2024
Cause of death:	1a: Unascertained
Place of death:	131 Cranwell Street Braybrook Victoria 3019
Keywords:	Homelessness, unascertained

INTRODUCTION

1. On 29 January 2024, Bariyow Mohamed Hussein was 50 years old when he was found deceased in the room where he had been staying. At the time of his death, Bariyow was homeless, but had been allowed to sleep in a disused office space at a car wrecker's workshop at 131 Cranwell Street, Braybrook, Victoria.

2. Bariyow was born and raised in South Sudan, where his father still lives. He had referred to having an uncle[1] who lived in the Braybrook area, but otherwise did not have any known local relatives. He was unemployed and kept to himself. The sympathetic owner of the car wreckers, Mr Haji Rajabi, allowed him to sleep on site without paying rent until he could find himself a job and another place to live. The workers at the car wrecking business were the only people with whom he had regular contact.[2]

3. Bariyow was medically obese and was observed to live an unhealthy lifestyle featuring alcohol consumption, poor diet, poor sleep, lack of exercise and limited engagement with medical care.[3] Mr Rajabi observed him to be looking particularly unwell in early January 2024, and Bariyow reported having a headache and that sometimes his heart went too fast or felt like it was stopping.[4]

4. Bariyow had two previous presentations to the Emergency Department at Footscray Hospital in 2022 for chest pains and upper respiratory tract infection,[5] and two presentations to a local general practitioner clinic in 2022, also for chest pains and respiratory symptoms.[6]

THE CORONIAL INVESTIGATION

5. Bariyow'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.

6. 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

[1] It is not known whether this uncle was a familial relative or used the title 'uncle' informally.
[2] Statement of Haji Rajabi, Coronial Brief.
[3] Ibid.
[4] Ibid.
[5] Appendix 4 – Email from Western Health regard Footscray Hospital records dated 12 March 2024, Coronial Brief.
[6] Statement of Dr Thant Syn; Maidstone Family Clinic patient health summary, Coronial Brief. I note Dr Syn, the clinic medical records and Western Health records use the surname 'Ahmet'.

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.

7. 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.

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

9. This finding draws on the totality of the coronial investigation into the death of Bariyow Mohamed Hussein 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.[7]

10. In considering the issues associated with this finding, I have been mindful of Bariyow's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

11. On the morning of Monday 29 January 2024, Bariyow was located unresponsive on his bed by two employees when they returned to the workshop after the weekend.[8]

12. They immediately called emergency services and moved Bariyow to the floor on instruction from the triple zero call-taker. They observed Bariyow to be deceased.

[7] 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.

[8] Statements of Mohammadreza Ramezani and Mohammad Jamili, Coronial Brief.

13. At 11:04 am, witness Jeremy Truong was notified of a nearby incident via the Good SAM phone application. This application alerts nearby registered users that a person requires first aid.[9] Mr Truong attended at 11:06 am and quickly ascertained that Bariyow was deceased, as he was cold to the touch and without a pulse.[10]

14. Ambulance and police members subsequently attended and confirmed his passing.[11]

Identity of the deceased

15. On 29 January 2024, Bariyow Mohamed Hussein, born 7 May 1973, was visually identified by an employee at the car wreckers who had known him for 8 months, Mr Mohammad Jamili. Identity is not in dispute and requires no further investigation.

Medical cause of death

16. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine conducted an external examination on 31 January 2024 and provided a written report of her findings that same day.

17. The examination of a postmortem CT scan showed loss of grey/white differentiation in the brain, a little pseudo-subarachnoid haemorrhage, no skull or cervical spine fracture, no coronary artery calcification, a full stomach and small kidneys.

18. The external physical examination revealed no other insights or cause of death, but as the senior next of kin had objected to the autopsy, I directed that no further investigations be undertaken.

19. Toxicological analysis of post-mortem blood samples did not identify the presence of alcohol or any other common drugs or poisons.

20. Dr Baber provided an opinion that the medical cause of death remained 1(a) unascertained, and in these circumstances, I accept her opinion.

FINDINGS AND CONCLUSION

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

[9] The application has been rolled out across Victoria to support the work of Ambulance Victoria and allows emergency responders who hold first aid qualifications to assist to provide early CPR.
[10] Statement of Jeremy Truong, Coronial Brief.
[11] Statement of Adrien Chanard, and Appendix 2 'Verification of Death' form by Ambulance Victoria, Coronial Brief.

a) the identity of the deceased was Bariyow Mohamed Hussein, born 7 May 1973;

b) the death occurred on 29 January 2024 at 131 Cranwell Street, Braybrook, Victoria 3019, from 1(a) unascertained; and

c) the death occurred in the circumstances described above.

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

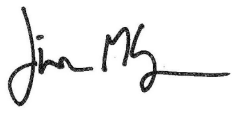
Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Adan Bariyow, Senior Next of Kin

First Constable Adrien Chanard, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 23 January 2025

NOTE: Under section 83 of the *Coroners Act 2008* (**the Act**), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.