IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2003 1166

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Deceased:	**NIKOLAI MEDAV RADEV**
Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Hearing date:	8 December 2016
Delivered on:	8 December 2016
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Counsel assisting the Coroner:	Ms Jodie Burns, Senior Legal Counsel
Representation:	Nil
Catchwords:	Homicide, no person charged with indictable offence in respect of a reportable death, mandatory inquest

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HER HONOUR:

BACKGROUND

1. Nikolai Madev Radev (**Mr Radev**) was born on 29 January 1959 in Bulgaria. He migrated to Australia in June 1980.

2. At the time of his death, Mr Radev was 44 years old. He lived at 11 Gould Street, Brighton, Victoria.

3. Mr Radev had two daughters and was in a relationship with [redacted] at the time of his death.

4. Mr Radev had a substantial criminal history which included armed robbery, drug trafficking and possession, burglary and theft. While he did not have an identifiable occupation or employment, Victoria Police intelligence records indicate that he was a 'Stand-over man' and that he supplied chemicals for amphetamine production with high profile 'gangland' criminals.

THE PURPOSE OF A CORONIAL INVESTIGATION

5. At the time of Mr Radev's death, the *Coroners Act 1985* (Vic) applied. From 1 November 2009, the *Coroners Act 2008* (**the Act**) has applied to the finalisation of investigations into deaths that occurred prior to the commencement of the Act.[1] Mr Radev's death constituted a '*reportable death*' under the *Coroners Act 1985* (Vic), as his death occurred in Victoria and was both unnatural and violent.[2]

6. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[3] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

[1] Coroners Act 2008, section 119 and Schedule 1. All references which follow are to the provisions of this Act, unless otherwise stipulated.
[2] Section 3, definition of 'Reportable death', *Coroners Act 1985.*
[3] Section 89(4) *Coroners Act 2008.*

7. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[4] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

8. The term '*cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

9. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all of the 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.

10. 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 'prevention' role.

11. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (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; 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. These powers are the vehicles by which the prevention role may be advanced.

12. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[5] 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.

13. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was

[4] *Keown v Khan* (1999) 1 VR 69.
[5] (1938) 60 CLR 336.

as a result of homicide (and no person or persons have been charged with an indictable offence in respect of the death), or the deceased was immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

14. While Mr Radev's identity was not in dispute and he was not a person placed in "*custody or care*" as defined by section 3 of the Act, his death is considered to be a homicide. Therefore, it is mandatory to conduct an inquest into the circumstances of his death because no person or persons have been charged with an indictable offence in respect of the death.

VICTORIA POLICE HOMICIDE INVESTIGATION

15. Immediately after Mr Radev's death, Victoria Police commenced a criminal investigation because the death was considered to be a homicide.

16. Mr Radev's death was initially investigated by the Homicide Squad and then transferred to the Purana Task Force. Despite this investigation, no person or persons have been charged with indictable offences in connection with Mr Radev's death.

17. I note the observations of the Victorian Court of Appeal in *Priest v West*, [6] 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.*"

18. 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.[7]

19. Section 7 of the Act specifically states that a coroner should avoid unnecessary duplication of inquiries and investigations, by liaising with other investigative authorities, official bodies or statutory officers. The rationale behind this provision is to allow for consideration of public interest principles that weigh against the potential benefits of any further investigation, such as further cost to the community. It also acknowledges that although a number of authorities

[6] (2012) VSCA 327.
[7] *Perre v Chivell* (2000) 77 SASR 282.

or organisations may have the mandate to investigate, some are more appropriately placed than others to do so in any given circumstance.

20. In this case, I acknowledge that the Victoria Police, through the Purana Task Force, has conducted an extremely thorough investigation in this matter.

21. In making this Finding, I have been careful not to compromise any potential criminal prosecution in the course of my investigation, mindful that Mr Radev's death is an unsolved homicide case which Victoria Police continues to investigate.

22. The Coroner's Investigator, Detective Senior Constable Michael Gilbert, has provided to the Court a statement in relation to this matter.

23. The confidential nature of the Victoria Police's ongoing investigation prevents me from reciting each and every matter which has been established by the Purana Task Force. However, Detective Senior Constable Gilbert's statement indicates that the following important matters have been established and are able to be disclosed:

    (a) Victoria Police identified a number of persons that could provide assistance with the criminal investigation, including two protected witnesses[8] and the person who is alleged to have shot Mr Radev (**the alleged shooter**);

    (b) in the months prior to his death, Mr Radev reportedly expressed a need to meet with his amphetamine manufacturer, stating "product quality" concerns. Persons in the amphetamine production syndicate, including Protected Witnesses A and B, reportedly believed Mr Radev to have ulterior motives for his request to meet the amphetamine manufacturer;

    (c) increasing tensions between those involved in the amphetamine production syndicate reportedly led a number of them to decide that Mr Radev should be killed;

    (d) Mr Radev was lured to Queen Street, Coburg, under the guise of meeting with the amphetamine manufacturer;

    (e) Protected Witness A drove the alleged shooter to and from Queen Street, Coburg, and saw that person shoot Mr Radev;

[8] Two of those persons are protected witnesses and cannot be named. Therefore, they will be referred to as Protected Witness A and Protected Witness B herein.

(f) the alleged shooter died in 2004; and

(g) the firearms used to shoot Mr Radev have not been located.

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

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

24. On 17 April 2003, the Deceased was visually identified by [redacted] to be Nikolai Medav Radev, born 29 January 1959. Mr Radev's identity was also confirmed by fingerprint matching.

25. Identity is not in dispute in this matter and therefore requires no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

26. On 16 April 2003, Dr Shelley Robertson, a Forensic Pathologist who was then practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr Radev's body. Dr Robertson provided a written report, which concluded that a reasonable cause of death was '*multiple gunshot injuries*'. Dr Robertson commented that:

(a) Mr Radev had no significant natural disease;

(b) a total of ten separate entry and exit injuries were described, some of which were produced by projectiles exiting other parts of the body;

(c) six of the gunshot injuries involved the head and trunk, of which two (one involving the head and one involving the chest) produced rapidly fatal injuries; and

(d) toxicological analysis of post mortem samples taken from Mr Radev showed the presence of tetrahydrocannabinol and a small amount of alcohol.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

27. At about 1.00pm on Tuesday, 15 April 2003, Mr Radev was seen at the Brighton Baths Café with four associates from the amphetamine production syndicate (**the associates**), including Protected Witness B.

28. Following discussions regarding Mr Radev's concerns about the quality of the amphetamine that he was receiving, the associates agreed to go to Coburg with Mr Radev to meet with the

amphetamine manufacturer. Mr Radev drove himself and a passenger in his own car to Queen Street at Coburg. Protected Witness B drove by himself in a separate vehicle to Coburg. The remaining associates present at the Brighton Baths Café travelled separately to Coburg.

29. On arriving at Queen Street, Coburg, shortly prior to 4.30pm, Mr Radev and his passenger got out of the vehicle and commenced to walk toward Reynard Street, Coburg. Mr Radev then returned to retrieve a cigar from his car.

30. Protected Witness A, who had driven the alleged shooter to Queen Street, Coburg, stopped their vehicle next to Mr Radev. The alleged shooter reportedly got out of a vehicle and began firing shots at Mr Radev with two handguns.

31. Mr Radev fell to the ground and the alleged shooter was observed to continue to fire shots into him as he lay on the ground.

32. The alleged shooter then got back into the car and Protected Witness A drove away, turning left into Reynard Street and later onto Melville Road.

33. At approximately 4.30pm, Mr Radev's body was discovered on the roadway in Queen Street, Coburg. Victoria Police and emergency services were notified and a registered nurse attempted to administer first aid until the ambulance arrived and confirmed that Mr Radev was dead.

34. Victoria Police police officers, including Homicide Squad police officers, attended the scene.

FINDINGS AND CONCLUSION

35. Having investigated the death of Nikolai Medav Radev and having held an Inquest in relation to his death on 8 December 2016, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) that the identity of the deceased was Nikolai Madev Radev, born 29 January 1959; and

    (b) that Mr Radev died on 15 April 2003, at Queen Street, Coburg, Victoria, from multiple gunshot injuries; and

    (c) that the death occurred in the circumstances set out above;

    (d) that despite an extensive criminal investigation conducted by Victoria Police, no person or persons have been identified, to date, as being responsible for causing Mr Radev's

death. On that basis, I am satisfied that no investigation which I am empowered to undertake, would be likely to result in the identification of the person or persons who caused Mr Radev's death.

36. I note that in the future, if new facts and circumstances become available, 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.

37. I convey my sincerest sympathy to Mr Radev's family and friends.

38. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

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

    (a) Mr Radev's family.

    (b) Detective Senior Constable Michael Gilbert, Coroner's Investigator.

    (c) Inspector Michael Hughes, Homicide Squad, Victoria Police.

    (d) Detective Senior Sergeant Michael J Dwyer, Officer in Charge of the Purana Task Force, Victoria Police.

Signature:

JUDGE SARA HINCHEY
STATE CORONER
Date: 8 December 2016