IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 003841

FINDING INTO DEATH WITH INQUEST

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

Inquest into the death of: DUNCAN ROSS

Delivered on:	13 May 2015
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing dates:	7 May 2015
Findings of:	JUDGE IAN L GRAY, STATE CORONER
Police Coronial Support Unit:	Leading Senior Constable K Taylor, assisting the Coroner.

I, JUDGE IAN L GRAY, State Coroner, having investigated the death of DUNCAN ROSS

AND having held an inquest in relation to this death on 7 May 2015

at Melbourne

find that the identity of the deceased was DUNCAN ROSS

born on 24 November 1970

and the death occurred 10 October 2011

at the Alfred Hospital, 55 Commercial Road, Melbourne Victoria 3004

from:

I (a) COMPLICATIONS OF HEAD INJURY

in the following circumstances:

Background

1. Mr Ross was a 40-year-old man who lived in a nine-room residential boarding house at 8 Ashleigh Avenue, Frankston.

2. On Friday 30 September 2011, Mr Ross had been drinking with fellow residents Mr Andrew Giovanof and Mr Anthony Fowler from around midday.

3. In the early evening, they visited Mr Ross' girlfriend at her home in Werribee. Mr Ross had been staying there from Monday 26 to Thursday 29 September due to apparent tensions between him and another resident, Mr Raymond Heeps.

4. On Friday 30 September, Mr Ross, Mr Giovanof and Mr Fowler had been attempting to find alternative accommodation without success. They therefore asked Mr Ross' girlfriend if they could stay at her home. She agreed initially; but then became scared of Mr Giovanof and Mr Fowler due to their behaviour. She told Mr Ross that he could stay, but that the others were to leave. All three men left and returned to the boarding house.

5. According to Mr Giovanof, the three men then began planning to rob and assault Mr Heeps when they returned to the boarding house. They returned home, continued drinking in Mr Giovanof's room and continued their discussion.

6. The three men armed themselves with an orange metal bar and pieces of timber, went out to the corridor and began smashing the walls and balustrades. At one point, Mr Fowler went outside and Mr Ross and Mr Giovanof went to Mr Heeps' room.

Circumstances of death

7. Mr Ross and Mr Giovanof demanded that Mr Heeps let them into his room. Mr Heeps attempted to reason with the men, stating that they could talk in the morning. He telephoned 000 and requested police attendance, stating that he feared for his life. He then opened the door to his room to attempt to speak to Mr Giovanof to persuade him to stop. When Mr Heeps opened the door, his pet dog escaped from the room.

8. Mr Heeps stated that he heard his dog let out a cry in pain, and so he opened the door again. He stated that Mr Ross began to swing a wooden implement at him, so he took it from Mr Ross and struck him with it, before returning to his room. He telephoned 000 again and told the operator that he had struck Mr Ross in self-defence.

9. Mr Ross sustained a head injury, which was bleeding. He returned to his room downstairs and was found by Mr Fowler and Mr Giovanof lying on his bed, unconscious.

10. Paramedics attended the boarding house and Mr Ross was transported to the Alfred Hospital where he underwent evacuation of an area of haematoma. He suffered complications following the procedure and his injuries were not survivable. Mr Ross died in hospital on 10 October 2011.

Police investigation

11. Mr Fowler and Mr Giovanof left the address to avoid police, initially climbing over the back fence into the backyard of the premises next door, and hiding behind a shed. On 17 November 2011, during a search of the area, police found an orange metal pole and a piece of wooden balustrade in this area, consistent with weapons thought to have been used by Mr Giovanof and Mr Fowler.

12. Police attended the boarding house and investigated the incident. They interviewed Mr Heeps on the morning of 1 October 2011, who admitted to striking Mr Ross to the head with a piece of timber that Mr Ross had been wielding. Mr Heeps stated to police that he did so in self-defence, as he feared the three men due to their threats and actions.

13. Police interviewed Mr Fowler on 9 November 2011. He made no admission that he was a party to any of the actions, and his recollection was affected by his consumption of alcohol.

14. Police interviewed Mr Giovanof on 14 November 2011. He made admissions to discussing the robbing of Mr Heeps with Mr Ross and Mr Fowler, and provided an account of his own movements and those of Mr Ross and Mr Fowler on 30 September 2011.

15. On 8 October 2012, police sought an opinion from the Office of Public Prosecutions (OPP) as to whether there was sufficient evidence to charge Mr Heeps with the offences of murder or manslaughter, relating to Mr Ross' death. Further opinion was sought on whether Mr Giovanof and Mr Fowler should be charged with the offences of affray, attempted aggravated burglary and criminal damage.

16. The OPP informed police that the Director of Public Prosecutions, Crown Prosecutor and other OPP staff had reviewed the brief of evidence, and advised that there was sufficient evidence to establish an offence of murder or manslaughter in respect of Mr Heeps' actions, but that the prosecution would be unable in all the circumstances to properly negate the defence of self-defence that would likely be raised by Mr Heeps. Police therefore determined that Mr Heeps should not be charged with any offence.

17. The OPP advised that there was sufficient evidence to charge Mr Fowler and Mr Giovanof with affray, attempted aggravated burglary and criminal damage. The men were charged with these offences and I am informed that the matters are to be heard at a committal mention at the Magistrates' Court in the coming months.

Coronial investigation and inquest

18. Apart from a jurisdictional nexus with the State of Victoria, reportable deaths are, generally, deaths that appeared to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury.

19. As well as Mr Ross' death being reportable, an inquest into his death was mandated as I suspect that his death was the result of homicide,[1] and no person was charged with an indictable offence in respect of the death.[2]

20. This finding draws on the totality of the material the product of the coronial investigation of Mr Ross' death. That is, the brief of evidence compiled by the Coroner's Investigator Detective Leading Senior Constable (DLSC) Peter Towner, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them. All this material will remain on the coronial file. In writing this finding, I do not purport to summarise all evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

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[1] Section 52(2)(a) *Coroners Act 2008 (Vic)*.

[2] Section 52(3)(b) Coroners Act 2008.

Findings as to uncontentious matters

21. In relation to Mr Ross' death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. His identity and the date and place of death were not at issue. I find, as a matter of formality, that Duncan Ross, born on 24 November 1970, aged 40, died at the Alfred Hospital, 55 Commercial Road, Melbourne Victoria 3004, on 10 October 2011.

22. Nor was the medical cause of death contentious. On 13 October 2011, an autopsy of Mr Ross' body and post mortem CT scanning (PMCT) were performed by Pathologist Dr Paul Bedford at the Victorian Institute of Forensic Medicine, who formed the opinion that the cause of his death was *complications of head injury.*[3] Dr Bedford stated that '*no specific injury relating to a strike to the head has been identified, noting that bruising to he head has occurred as a result of neurosurgical intervention thus hindering interpretation*'.[4]

23. Neuropathology examination of the brain by Forensic Pathologist Dr Linda Iles revealed a history of craniectomy and evacuation of acute right subdural haematoma, secondary mass effect and organising residual acute subdural haematoma.[5]

Conclusion

24. I am satisfied, based on the evidence before me, that Mr Ross' death was the result of homicide, and that Mr Heeps caused his death by striking him with a wooden implement, thereby causing his head injuries.

25. However, I do not make a determination that an indictable offence may have been committed in connection with the death, as I am satisfied that Mr Heeps' actions were in self-defence.

I convey my sincere condolences to Mr Ross' family and friends for his death in 2011.

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[3] Report of Dr Paul Bedford dated 13 December 2011.

[4] Ibid page 9.

[5] Report of Dr Linda Iles dated 28 December 2011.

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

Ms Patricia Ross, Senior Next of Kin

Ms Jacqui Brown, Alfred Health Clinical Governance Unit

DLSC Peter Towner, Victoria Police, Coroner's Investigator

LSC King Taylor, Police Coronial Support Unit.

Signature:

JUDGE IAN L GRAY
STATE CORONER
Date: 13/5/2015