



MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Ronald Charles Ross

Find, pursuant to Section 28(1) of the Coroners Act 1995, that:

- a) The identity of the deceased is Ronald Charles Ross;
- b) The circumstances of death cannot be determined;
- c) The cause of Mr Ross' death cannot be determined; and
- d) Mr Ross died between about 16 April and 16 May 2016 at his home in Glebe, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into the death of Ronald Charles Ross. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; relevant police and witness affidavits; medical records and reports; and forensic evidence.

Ronald Charles Ross was born in Kenya on 21 October 1949 and was aged 66 years.

Mr Ross enlisted with the Royal Australian Air Force in 1968 as a safety equipment worker and was discharged in 1974. After leaving the Air Force Mr Ross worked as a dive instructor in New South Wales and Queensland. He worked for a period of more than 25 years until 2010. He was a highly skilled and proficient diver. Mr Ross married and divorced twice. He had no children.

Mr Ross had suffered with vascular disease and, in about 2010, he was diagnosed with a calcified artery occlusion of the left lower leg. This required surgery to bypass the femoral artery. Mr Ross was advised by doctors to immediately stop smoking to avoid amputation of part of the leg. He had been a smoker since a young age. He did then cease smoking.

Mr Ross moved to Tasmania in about 2014. The evidence indicates that by that time his health had deteriorated significantly and he was drinking alcohol to excess. Family members who lived in Tasmania became extremely concerned about his health. They tried to assist him but to no avail.

Mr Ross had a somewhat reclusive lifestyle. It appears that he did not look after his health and did not regularly visit his general practitioner. On the known evidence, his last doctor's

visit was on 17 July 2014, almost two years before his death. This was a standard examination to obtain a certificate for Centrelink purposes. His general practitioner listed his current conditions as hyperlipidaemia (high cholesterol), hypertension and hearing loss.

In April 2016 the brother of Mr Ross, Anthony Ross ("Anthony"), tried to contact him on the phone. He tried for around two weeks, however, the phone always rang out as Mr Ross did not have his phone connected to a message bank. It was at this stage that Anthony became concerned and went to Mr Ross' house at 27 Shoobridge Street, Glebe, to check upon him.

Anthony noticed that both cars belonging to Mr Ross were at his home address and appeared to have not been used for some time. When he knocked at the door he noticed a collection of mail at the door, which he considered unusual.

At approximately 12.55pm on Monday 16 May 2016 Anthony telephoned police as he was concerned for his brother's welfare. Police officers attended the address at approximately 1.35pm on the same day. They found the residence locked and secured. Police spoke with Mr Colin Humphrey, who was Mr Ross' landlord and who lived in the upper part of the same premises. He rented the lower portion of the premises to Mr Ross through Edwards Windsor Real Estate. In his affidavit for the investigation, Mr Humphrey said that he last saw Mr Ross about a month previously. However, he had heard Mr Ross' radio or television operating occasionally over this period and noticed that the blinds were continuously closed. He had not seen anyone coming or going from the property. It is apparent that Mr Humphrey also lived a somewhat reclusive lifestyle and did not associate with Mr Ross to any significant degree.

Police contacted Edwards Windsor and two property managers arrived to open the unit. When Police officers entered the residence they observed a male obviously deceased slumped across the middle of the bed. His body was decomposed.

Forensics and CIB officers attended the residence. Due to the decomposed state of Mr Ross, identification was not possible. DNA analysis using samples taken from personal items at the home and a steering wheel swab from his car were used to positively confirm his identity.

There is no evidence in the investigation that would suggest the involvement of any other person in the death of Mr Ross and no evidence that gives rise to any suspicion surrounding his death.

An autopsy was carried out on the body of Mr Ross by forensic pathologist, Dr Donald Ritchey. Due to the advanced state of decomposition Dr Ritchey was unable to identify a cause of death. Blood samples could not be obtained for testing.

Although I cannot determine the cause of Mr Ross' death or circumstances leading to death, it would seem more likely that he died as a result of a medical event or alcohol related issue. It is less likely, from his position in the house when found, that he suffered a fatal accident or injury. I am satisfied that his death was not the result of foul play.

Comments and Recommendations:

I extend my appreciation to investigating officer Constable Michael Tew for his investigation and report.

The circumstances of Ronald Charles Ross' death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the Coroners Act 1995.

I convey my sincere condolences to the family and loved ones of Mr Ross.

Dated: 13 December 2017 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner