IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 0980

FINDING INTO DEATH WITH INQUEST

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

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**ROBERT RICHARD HOFF**
Delivered on:	29 June 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	29 June 2017
Counsel assisting the Coroner:	Leading Senior Constable, Kelly Ramsey, Police Coronial Support Unit
Representation:	Nil
Catchwords:	Homicide, no person charged with indictable offence in respect of a reportable death, mandatory inquest

TABLE OF CONTENTS

HER HONOUR:

BACKGROUND

1. Robert Richard Hoff (**Mr Hoff**) was a 50-year-old man who resided at Carrum Downs at the time of his death.

2. Mr Hoff was a boarder with an elderly couple, Peter and Teao McMahon, for approximately ten years. He was an introverted man who had never been in a relationship and was gentle and sensitive.

3. He was employed as a process worker at Chef's Pantry in Boundary Road, Braeside. He travelled to and from work by bus and train. When travelling to and from work, Mr Hoff carried a small sports bag, containing his lunch.

4. Mr Hoff was not known to have any friends and his only visitor was a cousin, Andrew Hoff, who visited him every couple of months.

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Mr Hoff's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was violent, unexpected and not from natural causes.[1]

6. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] 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.

7. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] 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 expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

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[1] Section 4 *Coroners Act 2008*
[2] Section 89(4) *Coroners Act 2008*
[3] *Keown v Khan* (1999) 1 VR 69

9. For coronial purposes, the phrase "*circumstances in which death occurred,*" 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.

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 Court's "*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*.[4] 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.

VICTORIA POLICE HOMICIDE INVESTIGATION

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

14. Mr Hoff's death was investigated by the Homicide Squad. Despite this investigation, no person or persons have been charged with an indictable offence in connection with Mr Hoff's death.

[4] (1938) 60 CLR 336

15. I note the observations of the Victorian Court of Appeal in *Priest v West*,[5] 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."*

16. 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.[6]

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

18. In this case, I acknowledge that the Victoria Police Homicide Squad has conducted an extremely thorough investigation in this matter.

19. In making this Finding, I have been careful not to compromise any potential criminal prosecution in the course of my investigation, mindful that Mr Hoff's death is an unsolved and open homicide case.

20. The Coroner's Investigator, Detective Leading Senior Constable Victor Anastasiadis, has provided a statement to the Court in relation to this matter.

21. The confidential nature of the Victoria Police's ongoing investigation prevents me from reciting each and every matter which has been established by the Homicide Squad. However, Detective Leading Senior Constable Victor Anastasiadis' statement indicates that the following important matters have been established and are able to be disclosed:

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[5] (2012) VSCA 327
[6] *Perre v Chivell* (2000) 77 SASR 282

(a) the assault on Mr Hoff appeared to be a random attack by an unknown person or persons;

(b) despite the extensive investigation conducted by the Homicide Squad, no person or persons of interest have been formally identified or located in relation to Mr Hoff's death; and

(c) no person has been charged with an indictable offence in relation to Mr Hoff's death; and

(d) the homicide investigation into Mr Hoff's death is ongoing and the file remains open.

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

22. On 17 March 2011, Teao McMahon identified the body of Mr Hoff, to be that of her boarder, Robert Richard Hoff, born 19 June 1960.

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

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

24. On 16 March 2011, Dr Malcolm Dodd, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr Hoff's body. Dr Dodd provided a written report, dated 14 June 2011, which concluded that Mr Hoff died from blunt force trauma to the head and aspiration of gastric content.

25. Dr Dodd commented that:

(a) Mr Hoff had multiple areas of blunt force trauma to the head, face and neck regions, as well as fractures to his right hand;

(b) aspiration of gastric content (culminating in asphyxia) is a common consequence of blunt force trauma to the head, particularly of this magnitude.

26. Toxicological analysis of post mortem specimens taken from Mr Hoff were negative for common drugs and alcohol.

27. I accept the cause of death proposed by Dr Dodd.

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

28. At approximately 5.04am, on Wednesday, 16 March 2011, Mr Hoff left home to catch a bus to work. Mr Hoff was captured on CCTV, walking along Orsett Court, carrying a sports bag and turning left onto a path between Orsett and Hendon Courts (**the path**).

29. Shortly thereafter, Mr Hoff was assaulted while walking along the path.

30. At 7.15am, a local resident saw Mr Hoff lying prone on the path with blood pooled around his head. The resident telephoned emergency services, requesting an ambulance. Police were also notified and attended the scene.

31. Mr Hoff was found to be deceased and to have suffered multiple blunt force trauma injuries to the head and neck area. Mr Hoff's sports bag was missing and has not been located.

FINDINGS AND CONCLUSION

32. Having investigated the death of Mr Hoff and having held an Inquest in relation to his death on 29 June 2017, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Robert Richard Hoff, born 19 June 1960;

    (b) Mr Hoff died on 16 March 2011, at Orsett Court, Carrum Downs, Victoria, from blunt force trauma to the head and aspiration of gastric content; and

    (c) the death occurred in the circumstances set out above.

33. Despite an extensive criminal investigation conducted by Victoria Police, no person or persons have been identified, to date, as being responsible for causing Mr Hoff'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 Hoff's death.

34. I convey my sincerest sympathy to Mr Hoff's family and friends.

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

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

    (a) Andrew Hoff, senior next of kin;

(b) Detective Leading Senior Constable Victor Anastasiadis, Coroner's Investigator, Victoria Police;

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

Signature:

JUDGE SARA HINCHEY
STATE CORONER
Date: 29 June 2017