IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2014 000273

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of Jeanette Anne Moss

Delivered On:	17 May 2022
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank
Hearing Dates:	17 May 2022
Findings of:	Judge John Cain, State Coroner
Counsel Assisting the Coroner	Ms Abigail Smith, Acting Senior Solicitor to the State Coroner

INTRODUCTION

1. Jeanette Anne Moss (**Ms Moss**) was born on 15 February 1944 and was 69 years of age at the time of her death. Ms Moss is survived by her son Derham, daughter Tara and four grandchildren.

2. Ms Moss married Harold Moss (**Mr Moss**) in 1967. Mr Moss was a restaurateur owning and managing several restaurants in South Melbourne and the CBD. He was also a shareholder in a lingerie business. After the birth of her first child, Ms Moss left the paid workforce and became the primary care giver for their children. When the children were older, Ms Moss returned to the paid workforce, working in the family business in a public relations role.

3. In early 1999, Mr Moss retired from the family business. In the period prior to his retirement, Mr Moss's business interest were experiencing some financial difficulties. Soon after retiring, Mr Moss's health deteriorated, and he was diagnosed with cancer. After a short battle with cancer, he died on 8 September 1999.

4. In 2004, Ms Moss sold the family home and moved into an apartment at 21 / 189 Beaconsfield Parade, Middle Park (**Middle Park apartment**). This property was owned by Ms Moss's sister, Dawn Ferguson who had died in 1985 and by her will, granted a life interest in the Middle Park apartment to Ms Moss.

5. Ms Moss was close to both her children and spoke to them regularly. Tara was in living in London having moved there with her partner and child in 2008. Despite the distance, Tara maintained a very close relationship with her mother, and they spoke regularly on Viber, an internet-based telecommunication service.[1] Derham, assisted his mother in managing her financial matters and would be in contact with her at least three times a week and called in to see her regularly.

6. In 2012, Ms Moss was diagnosed with pulmonary fibrosis (a lung disease)[2] and had been advised that her life expectancy was between three and five years. She took regular medication and needed oxygen to assist in the management of this condition. She was being treated at the Alfred Hospital for this condition and attended every three months for review.

7. Despite her ill-health, Ms Moss maintained an active social life enjoying the company of a wide circle of friends and acquaintances. At the time of Ms Moss' death, plans were underway to

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[1] Coronial Brief (**CB**), pg 201.
[2] Ibid.

celebrate her 70th birthday on 15 February 2014 at the Albert Park Angling Club (**Angling Club**) with her friends and family.

8. At approximately 10.23am on 15 January 2014, Ms Moss was found deceased at the Middle Park apartment by her neighbour, Ms Pauline Byrne.

THE PURPOSE OF A CORONIAL INVESTIGATION

9. Ms Moss's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as Ms Moss ordinarily resided in Victoria[3] and the death appears to have been unexpected and violent.[4]

10. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the death occurred in Victoria and a coroner suspects the death was as a result of homicide and no person or persons have been charged with an indictable offence in respect of the death.

11. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[5] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[6]

12. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[7] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[8] or to determine disciplinary matters.

13. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

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

15. 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

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3 *Coroners Act 2008* (Vic) s 4.
4 *Coroners Act 2008* (Vic) s 4(2)(a).
5 *Coroners Act 2008* (Vic) s 89(4).
6 *Coroners Act 2008* (Vic) preamble and s 67.
7 *Keown v Khan* (1999) 1 VR 69.
8 *Coroners Act 2008* (Vic) s 69 (1).
9 *Coroners Act 2008* (Vic) s 67(1)(c).

the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

16. Coroners are also empowered:

    a) to report to the Attorney-General on a death;[10]

    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;[11] 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.[12]

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

18. This finding draws on the totality of the material obtained in the coronial investigation of Ms Moss's death. That is, the court file, the Coronial Brief prepared by Detective Leading Senior Constable Kirsty Hellebrand and further material obtained by the Court.

19. In writing this finding, I do not purport to summarise all the material evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

20. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[13] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[14] 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.

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

21. On 15 January 2014, Pauline Byrne visually identified Jeanette Anne Moss, born 15 February 1944.

22. Identity is not in dispute and requires no further investigation.

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[10] *Coroners Act 2008* (Vic) s 72(1).
[11] *Coroners Act 2008* (Vic) s 67(3).
[12] *Coroners Act 2008* (Vic) s 72(2).
[13] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[14] (1938) 60 CLR 336.

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

23. Dr Sarah Parsons a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, performed an autopsy on Jeanette Anne Moss on 15 January 2014 and provided a written reported dated 21 May 2014.

24. The post-mortem examination revealed injuries to the neck consistent with having been inflicted by a sheet which was surrounding the neck.[15] The autopsy also showed evidence of blunt force trauma to the face, chest (with a fractured rib) upper limbs and back. In addition, the report states that there was facial and conjunctival petechial, facial congestion, multiple bruises on the face and neck muscles along with fractures through the larynx and hyoid bones. In these circumstance, Dr Parsons opined '*that a degree of manual strangulation cannot be entirely excluded.*'[16]

25. Dr Sarah Parsons concluded that a reasonable cause of death was:

1(a) Neck compression

26. I accept the opinion of Dr Parsons as to the cause of death.

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

27. On 12 January 2014, at approximately 12.30pm, Mr Dieter Baisch (a long-time friend) arrived at Ms Moss's apartment to attend lunch at the Angling Club. They travelled there together in Ms Moss's car, arriving at approximately 12.45 pm.[17] Mr Baisch and Ms Moss left the Angling Club at approximately 5.15pm and arrived at Ms Moss' apartment at 5.30pm. Mr Baisch drove himself home and over the next two days he made a number of calls to Ms Moss but did not speak to her. He did not see Ms Moss again.

28. At 8.49pm on 12 January 2014, Ms Moss made a phone call to a friend, Ms Elsie Johnston. The call was not answered but later returned at 9.08pm and they talked about plans to attend the Genesis Fitness Centre the following morning. Both were members and regular attendees.

29. On 13 January 2014, Ms Moss and Ms Johnston attended the Genesis Fitness Centre and left the premises at around 10.30am after their gym session. They subsequently stopped at the Coles Supermarket on Bay Street in Port Melbourne where they both picked up shopping before

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[15] CB, pg 102.
[16] Ibid.
[17] CB, pg 248.

attending the Melbourne Bakehouse for coffee. At approximately 11.15am, they left the coffee shop and Ms Moss drove Ms Johnston to her home.[18]

30. Around the middle of the day on 14 January 2014, Ms Moss had a short phone conversation with a friend Ms Eileen Lillie. Ms Moss told Ms Lillie that she had a medical appointment the following morning (15 January 2014) and that the very hot weather was adversely affecting her, and she felt unwell.[19]

31. At or around 12.30pm, Ms Moss spoke to Ms Pauline Byrne (**Ms Byrne**) to make arrangements for Ms Byrne to take Ms Moss to a medical appointment at the Alfred Hospital on 15 January 2014. Ms Byrne arranged to meet Ms Moss downstairs at the front of the building at 10.10am the following morning.

32. According to Ms Moss' telephone records, the last call that she made was to the Melbourne Racing Club at 12.45pm on 14 January 2014. At 2.52pm, a call was made to Ms Moss's mobile number. This call was unanswered.[20] There were two further calls made to Ms Moss landline phone number after that time, one at 6.37pm the other at 7.03pm which were not answered.

33. At approximately 10.10am, on the morning of 15 January 2014, Ms Byrne moved her car to the front of the apartment building and waited for Ms Moss to arrive to go to her medical appointment. Ms Moss was usually a very punctual person so when she had not arrived downstairs as planned at 10.10 am, Ms Byrne called to see where she was. Ms Byrne made calls at approximately 10.15am to both Ms Moss' landline and mobile phone with no answer. After a short time, Ms Byrne decided that she should see if anything was wrong and went up to the apartment gaining access to the apartment by using a spare key that was secreted near the door to the apartment in a fire hydrant cupboard.[21]

34. Upon entering the apartment, Ms Byrne found Ms Moss on the floor in the spare bedroom. Ms Byrne located Ms Moss' phone on the kitchen bench called Derham immediately and advised that she had found Ms Moss on the floor in the spare room, and she thought that she had died.[22] Derham called an ambulance immediately.[23] Ambulance Victoria arrived at the scene and examined Ms Moss, declaring her deceased at 10.41am on 15 January 2014.

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[18] CB, pgs 106 – 107.
[19] CB, pg 115.
[20] CB, pg 960.
[21] CB, pg 126.
[22] CB, pg 127.
[23] CB, pg 156.

35. When Ms Moss was found in the apartment, she was wearing the same clothing, (leggings and a black shirt) that she had worn to Genesis on 14 January 2014. This was confirmed from CCTV footage obtained from Genesis, Dickson Pharmacy and Coles Supermarket.

36. Police attended the apartment to commence their investigation and observed that there was a white cloth around Ms Moss's neck which appeared to have been torn or cut from the bottom of sheet on the bed adjacent to her head. Police also observed scuff marks on the wall near Ms Moss' feet.[24] A crime scene was established as Police considered the death suspicious.[25]

37. At the scene police observed that there was a bottle of wine open on the kitchen bench, which was half full and two wine glasses in the dishwasher. Two empty beer stubbies were also observed to be on the bench above the dishwasher, near the kitchen sink.[26]

38. Attending police also noticed that there was an open drawer in the loungeroom and another in the main bedroom. There was also a single drawer that contained jewellery and watches on the deceased bed in the main bedroom. It was unclear whether any jewellery was missing from the apartment, particularly as a drawer containing jewellery was on the bed. There were no signs of forced entry, and it did not appear to be any sign of a disturbance that would indicate unwanted entry to the apartment.[27]

39. Derham contacted Tara regarding Ms Moss' death, and she subsequently arranged a flight to Melbourne arriving on 18 January 2014. On 19 January 2014, Tara attended the Middle Park apartment to speak to police and determine whether anything had been stolen, including Ms Moss' jewellery. Tara did not believe that anything was missing from the apartment.[28]

40. On 23 January 2014, Tara again attended the Middle Park apartment and advised police that some items of jewellery including a gold and diamond bar necklace, along with a signet ring that Ms Moss wore on her little finger and engagement ring with a yellow central diamond and smaller diamonds had not been located.

41. CCTV footage obtained by investigating police from Gensis Fitness Centre, Dickson Pharamcy and Coles Supermarket in Port Melbourne, showed Ms Moss wearing the signet ring and a bracelet on 14 January 2014. These items have not been found since. It is possible that these

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[24] CB, pgs 370 - 371.
[25] CB, pg 372.
[26] CB, pg 371.
[27] CB, pgs 371 - 372
[28] CB, pg 203.

items were stolen from her apartment, but further investigations have not revealed any additional information that assists in determining what happened to these items of jewellery.[29]

HOMICIDE INVESTIGATION BY VICTORIAN POLICE

42. Immediately after Ms Moss's death, the Victoria Police Homicide Squad commenced a criminal investigation. The investigating police interviewed approximately thirty-one persons of interest conducted a door knock of the adjoining apartments reviewed CCTV footage as part of their investigation.

43. It is the opinion of the investigating police that whoever attended Ms Moss' apartment on 14 January 2014, and was subsequently involved in her death, was unexpected or a person or persons that Ms Moss knew well and trusted.[30]

44. Despite this thorough and extensive investigation police have been unable to establish how Ms Moss's injuries occurred and the surrounding circumstances. To date, no person or persons have been charged with indictable offences in connection with Ms Moss's death. In light of this extensive investigation, 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 Ms Moss's death.

45. It is important to note that it is not the purpose of a coronial investigation to investigate possible criminal conduct to compile a brief of evidence in preparation for a future criminal trial. Section 69 of the Act expressly prohibits a coroner from including in a finding or a comment, any statement that a person is or may be guilty of an offence.

46. In making this finding, I have been careful not to compromise any potential criminal prosecution in the course of my investigation, mindful that Ms Moss's death may be the result of a homicide.

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

FINDINGS AND CONCLUSION

48. Having investigated the death of Jeanette Anne Moss and having held an inquest in relation to her death on 17 May 2022 at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

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[29] CB, pg 15.
[30] CB, pg 26.

a) that the identity of the deceased was Jeanette Anne Moss;

b) that Jeanette Anne Moss died sometime between 12.47pm and 2.52pm on Tuesday 14 January 2014 at Apartment 21 of 189 Beaconsfield Parade Middle Park, from Neck Compression; and

c) that Jeanette Anne Moss death was violent, and from injuries sustained as a result of the actions of person or persons unknown. The precise circumstances in which these events took place are also unknown.

49. I convey my sincerest sympathy to Ms Moss's family and friends.

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

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

Ms Moss's family

Detective Leading Senior Constable Kirsty Hellebrand

Signature:

JUDGE JOHN CAIN
STATE CORONER

Date: 17 May 2022

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 inquest. 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.