VICTORIAN INSTITUTE OF FORENSIC MEDICINE

OPINION REPORT

RUSSELL PHILIP PAYNE
CASE NO. A00197/22

My name is Linda Elizabeth ILES and my professional address is the Victorian Institute of Forensic Medicine, 65 Kavanagh Street, Southbank, Victoria 3006.

I am a registered medical practitioner practising as a specialist in forensic pathology.

My qualifications are Bachelor of Medicine (MB), Bachelor of Medical Science (B Med Sci) and Bachelor of Surgery (BS) with Honours, from the University of Tasmania. I am a Fellow of the Royal College of Pathologists of Australasia by examination in anatomical pathology. I hold the Diploma in Medical Jurisprudence in Pathology from the Society of Apothecaries of London (DMJ (Path)), and am a founding fellow of the Faculty of Post Mortem Imaging of the Royal College of Pathologists of Australasia.

I am employed as a Forensic Pathologist at the Victorian Institute of Forensic Medicine.

My practical experience in Forensic Pathology commenced in 2000. I commenced full time professional forensic pathology practice in Victoria in 2005. I was subsequently employed as a Consultant Forensic Pathologist in the Section of Forensic Medicine and Science at the University of Glasgow from March 2007 until January 2009 and received specialised training in Forensic Neuropathology at the University of Edinburgh. I resumed practicing forensic pathology in Victoria in July 2009.

I am head of Forensic Pathology Services at the Victorian Institute of Forensic Medicine and co-ordinate the Institute's neuropathology service.

OPINION REPORT

Case No. A00197/22
Re : PAYNE deceased

I have been requested by Ms Francisca Lilly, solicitor for Crown Solicitor NSW to provide opinion regarding the death of Mr Russell Philip PAYNE (date of death 2 February 1989)

Materials considered in compiling opinion report

- P79A report of death to the coroner
- Statement of Detective Sergeant P. Moss
- Statement of John Malcolm Willis
- Medical report upon examination of the dead body of Russell Philip Payne
- Statement of Dr A. Davison, Pathologist
- Toxicology report
- Cause of death certificate
- Death certificate
- Series of 41 black and white photocopied scene and post mortem photographs

SYNOPSIS OF MATERIALS

1. On the evening of 2 February 1989, police attended Mr Payne's address in relation to a report of a deceased person being present. Police observed Mr Payne lying supine on the kitchen floor. He appeared to have deep bruising and abrasion to his testicles and penis. There appeared to be blood on his penis which was swollen. There was a large bruise on his right hip with a green tinge. There were reportedly no signs of forced entry. There were no signs of violence in the flat. In the bedroom there were containers that appeared to contain vomit. There was also vomit on the bedroom floor. There were items of clothing found in the laundry which appeared to have blood on them. The bed cover appeared to have dried blood on it. Mr Payne, who was 33 years old, was last seen alive at 2:30 pm on 30 January 1989.

2. Police reported what appeared to be smeared blood around the deceased's upper thighs and legs. Small drops of what appeared to be blood were on the floor of the kitchen.

3. Beside the deceased's bed were several containers containing prescription medications for various medical conditions.

4. On the floor of the bathroom, several handkerchiefs and underpants were located, apparently stained with blood. A stained sponge was also present in the bathroom sink and the underside of the toilet was stained.

5. In the bedroom was a sawn piece of timber (thought to be a broom handle), the rounded end of which was stained with dark material. A large number of erotic photographs were located in the deceased's bedroom.

Autopsy

6. An autopsy was performed at 3:30 pm on Friday, 3 February 1989 by Dr Alan Davison. Summary of his pertinent findings as follows:
   a. The body was that of a well-nourished male of slight athletic build measuring 5 feet 6 inches in height, clothed with a dark blue singlet. Rigor mortis was absent and early decomposition was present (described features suggest early marbling).
   b. Bruising described about the right anterior iliac crest 5.0 cm x 4.0 cm with superficial blister formation and yellow discolouration.
   c. Bruising of the right scrotum and under surface of the penis.
   d. Maggot infestation about the pubis and right eye.
   e. Small area of bruising to the right occipitotemporal scalp associated with a hairline fracture in the midline extending into the right posterior cranial fossa.
   f. No associated intracranial haemorrhage or brain injury.
   g. Strap muscles of the neck free from bruising and the laryngeal skeleton intact.
   h. Blood tinged fluid within the pleural cavities and pericardial sac.
   i. Soft spleen.
   j. Bruising of the soft tissues on both sides of the penis with bruising extending to involve the spermatic cord on the right.
   k. A metal object with a spike at its base present in the penile urethra 1-2 cm from its distal end. The urethra was discoloured and there was inflammation with purulent exudate.
   l. No features to suggest obstructive uropathy (i.e. nothing to indicate that the urethral foreign body resulted in total obstruction of urine flow).
   m. Bruise of the muscle of the abdomen near the anterior iliac crest and bruising of the muscle around the right shoulder.

n. Death opined to have occurred some three days previously.

7. Histological sections were taken along with a swab from the penile urethra and anus.

8. The metal object located in Mr Payne's urethra was thought to be part of a television antenna.

9. Dr Davison opined the death was caused by septicaemia as a result of an acute urethritis, most probably caused by insertion of a foreign body into the penile urethra.

10. Injuries to the pelvic and groin regions opined to be caused by a fall some 24-36 hours prior to death, whilst the fracture of the skull was consistent with a fall occurring immediately prior to death.

11. No evidence of asthma in the sections of lung. Epilepsy was by exclusion, not a factor in this man's death.

12. Small abscesses and micro-abscesses noted in the lung associated with extensive bacterial colonisation of many organs and spleen.

Toxicology

13. Doxepin was detected in liver, stomach contents and blood.

QUESTIONS AND REPONSES

Q1. The adequacy of the post mortem investigations conducted with respect to Mr Payne.

Autopsy practice has changed significantly since 1989. Regardless, the autopsy and associated investigations appears reasonably comprehensive. Although the photographs supplied are difficult to interpret in their current state, it is evident that they have been taken to photo document both salient positive and relevant negative findings

at autopsy. Whilst review of the histological sections is pending, the current material is adequate for me to express a view on cause of death.

Whilst the quality of photographs available for review is poor, the autopsy photographs in particular, appear to be taken to demonstrate areas of injury, bruising and swelling as documented in the autopsy report. They also (attempt) to document the skull fracture, and lack of associated intracerebral injury. The autopsy report and photo documentation suggest to me that the autopsy has been performed in a thoughtful way, with a view to excluding major trauma contributing to or directly causing death.

Whilst the autopsy report documents a swab taken from the penile urethra, it is not clear whether this underwent microbiological testing, or if it was sent for analysis for semen (or something else). No results are recorded. Appropriate toxicological studies have been performed.

Q2. *The nature of Mr Payne's injuries (a) The likely sequence of Mr Payne's injuries (including but not limited to the injuries to the genitals, the bruising to this hip and pelvic region, and the fracture of his skull); (b) Whether Mr Payne's injuries to his genitals appear to be self inflicted; and (c) Whether Mr Payne's injuries (excluding the injuries to his genitals) are consistent with a fall in his home, or are more likely to be caused by other means, for example misadventure, fall, suicide or foul play.*

The swelling and bruising to Mr Payne's genital region as described, and as suggested by the (now) poor quality photographs, need not be a manifestation of direct genital trauma. In my view, it is highly likely that these changes are a manifestation of Fournier's gangrene complicating urethral foreign body.

The bruising described to Mr Payne's hip and pelvic region cannot be accurately dated based on the autopsy report or the photographs. The bruising in the right inguinal region has an odd shape in the photographs, more suggestive of either bruising that has tracked from another location, of soft tissue haemorrhage related to infection. In the setting of sepsis, Mr Payne is likely to have bruised easily. In the setting of necrotising infection in the genital region, this may represent soft tissue infection and necrosis as opposed to direct trauma. Appearances could also represent a combination of these elements. I am unable to differentiate based on the materials available.

Findings at the scene (for example, vomit in containers in the bedroom) suggest that Mr Payne had been unwell for a period of time preceding his death, in keeping with systemic sepsis, as diagnosed by Dr Davison. Blood spots located around the house and on clothing *may* have come from his infected penile urethra (this does not exclude another source, however none other is identified at autopsy).

I note that Mr Payne was found on his back. Whilst there is evidence of blunt trauma to the back of Mr Payne's head, this is not associated with intracranial injury and it is not unreasonable to conclude that this injury may have been sustained during an agonal event (i.e. a fall backwards) given the absence of any recorded associated intracranial injury. This may also account for the bruising identified in the muscle of the right shoulder.

It appears that Mr Payne's genital pathology is a consequence of infection related to urethral foreign body. There is nothing precluding Mr Payne inserting foreign body into his urethra himself. Whilst insertion of foreign bodies into the urethra is uncommon, it is well described in the setting of autoeroticism and masturbatory behaviour, as well as in psychiatric conditions[1,2]. There are no findings in the material that I have available to review that necessitates the involvement of another person in Mr Payne's death.

The findings described around Mr Payne's skull fracture are in keeping with a fall with occipital headstrike. The absence of associated intracranial pathology is also in keeping with this being an agonal event and not the primary cause for Mr Payne's death.

Q3. View as to the medical cause of Mr Payne's death (including any reason) to take a different view to that performed by the forensic pathologist who conducted the autopsy.

My view as to Mr Payne's cause of death is not significantly different to that of Dr Davison. Findings are consistent with death as a consequence of septicaemia secondary to Fournier's gangrene, precipitated by a urethral foreign body. I have yet to examine the histological sections taken at autopsy. Fournier's gangrene is a necrotising soft tissue infection of the perineum and surrounding tissues and can be seen in the setting of urethral trauma. Fournier's gangrene is a life-threatening condition associated with high morbidity and mortality. There are case reports in the literature of Fournier's gangrene precipitated by self-inserted urethral foreign bodies[3,4].

Q4. View as to any conclusions that can be drawn from the toxicological analysis.

Toxicological studies demonstrate the presence of the antidepressant drug doxepin within stomach contents, liver and blood. Of note, doxepin is subject to post mortem redistribution. It is not present in excessive concentrations in the matrices examined. Toxicological studies indicate the use of doxepin prior to death; I do not believe it has contributed to Mr Payne's death.

Q5. Any recommendations for further investigations with respect to determining the manner and cause of Mr Payne's death.

It is my view, based on the materials that I am able to review, that Mr Payne's death can be completely explained as a consequence of a natural disease process secondary to misadventure (i.e., a foreign body in the urethra). Mr Payne's autopsy appears to have been comprehensive and there are no features in the materials available to me to suggest either suicide or foul play. If the histological slides become available, I will review and issue another report if that review substantially changes my opinions expressed above.

Q5. Please provide any other comment within your expertise which you consider to be relevant to the manner and cause of Mr Payne's death.

Fournier's gangrene has been reported previously in the setting of a self-inserted urethral foreign body[3,4]. Based on the material that I have available to review, it appears to me that Mr Payne's genital injuries have occurred in a similar manner. There are no findings in the material that I have available to review that necessitates the involvement of another person in Mr Payne's death.

References

1. Mahadevappa N, Kochhar G, Vilvapathy KS, Dharwadkar S, Kumar S. Self-inflicted foreign bodies in lower genitourinary tract in males: Our experience and review of literature. *Urol Ann* 2016;8:338-42.

2. Bedi N, El-Husseiny T, Buchholz N, Masood J. "Putting lead in your pencil": self-insertion of an unusual urethral foreign body for sexual gratification. *J R Soc Med Sh Rep* 2010;1:18. DOI 10.1258/shorts.2010.010014

3. Jiwrajka M, Pratap K, Yaxley W, Dunglison N. Result of health illiteracy and cultural stigma: Fournier's gangrene, a urological emergency. *BMJ Case Rep* 2017. doi:10.1136/bcr-2017-220836.

4. Elawdy MM, El-Halwagy S, Mousa EE, Maliakal J. Self-insertion of an odd urethral foreign body that led to Fournier's gangrene. *Urol Ann* 2019;11:320-3.

I, Dr Linda Iles, acknowledge for the purpose of Rule 31.23 of the Uniform Civil Procedure Rules 2005 that I have read the Expert Witness Code of Conduct in Schedule 7 to the said rules and agree to be bound by it.

I hereby acknowledge that this statement is true and correct and I make it in the belief that a person making a false statement in the circumstances is liable to penalties of perjury.

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