



VICTORIAN INSTITUTE OF FORENSIC MEDICINE

**THIS DOCUMENT DETAILS THE NATURE AND RESULTS OF
THE MEDICAL INVESTIGATION INTO THE DEATH OF**

**ANDREW CURRIE
CASE NO. A00006/23**

**THIS IS AN AMENDED REPORT AS AT 24/01/2023
AND SUPERSEDES ANY PREVIOUS REPORTS**

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.

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OPINION REPORT

Case No. A00006/23
Re : CURRIE deceased

I have been requested by Ms Caitlin Healey-Nash, senior solicitor assisting the Special Commission of Inquiry into LGBTIQ Hate Crimes, to review materials relating to the death of Mr ANDREW CURRIE (date of birth 05 August 1959), on or around 13 December 1988.

MATERIALS PROVIDED

- P79A Report of death to coroner
- Toxicology report
- Autopsy report (author Dr William Brighton)
- Death certificate
- 7 scene photographs
- File concerning Mr Andrew Currie
- Statement of Constable Phillip Dean Greenhalgh (officer in charge)
- Crime information intelligence system – Person of interest report for Andrew Ronald Currie
- Fact sheets goods in custody and other offences – Andrew Ronald Currie
- Statement: GB
- Second statement of GB
- Toxicology report of Prof Alison Jones

SYNOPSIS OF MATERIALS

1. Mr Andrew Ronald Currie, aged 29 years, was found dead on 13 December 1988 on the floor of a toilet block in Nolans Reserve in North Manly. He was located lying face down in a very shallow puddle of water. He was found by a friend (Mr GB) after GB and Mr Currie's mother went looking for him after he did not return home the previous night.
2. Mr Currie had a history of drug use for many years and on 12 December 1988, he reportedly told Mr Blyton that he had used Nembudeine tablets. Mr Currie was known to police regarding his previous drug use.

3. When he was found, Mr Currie was wearing a brown V neck jumper, a yellow t-shirt, a pair of blue jeans, a pair of blue underpants and a pair of thongs. On his person was a concession card, three keys on a keyring, a cigarette lighter, two blue handkerchiefs and a pouch of tobacco.

Autopsy Examination

4. Autopsy conducted by Dr William Brighton on 17 December 1988 demonstrated the following:
 - a. Mr Currie's body was described as being 163 cm in height and 65 kg in weight (body mass index of 24.5). He was described as being of average physique and normal nutritional status.
 - b. Post mortem lividity was noted over his back and his face was noted to be suffused.
 - c. No significant injuries were described, however on the right temple and forehead, two areas of abrasion were noted, and it was opined these were consistent with pressure in the perimortem period.
 - d. Some slight reddening of the skin over the central forehead between the eyebrows and over the front of the nose was noted, but "no frank bruising involved".
 - e. No needle puncture marks were identified.
 - f. No internal injuries or congenital deformities were noted.
 - g. Dark brown/dark green material was noted in the nostril region, oropharynx and stomach.
 - h. Heart weight was recorded as 400 g. Patchy atheroma was noted in the proximal anterior descending coronary artery. No myocardial changes were identified.
 - i. No pleural effusions were noted. Both lungs reportedly showed acute oedema and marked passive congestion (left lung 750 g, right lung 890 g). No airways obstruction was identified.
 - j. Laryngeal skeleton was intact.
 - k. Stomach contained a quantity of dark brown to dark green material, mostly vegetable material and fluid.
 - l. Histological examination of organs was unremarkable save the presence of slightly bridging fibrosis and mild lymphocytosis in the liver.
 - m. Mr Currie's cause of death was given as poisoning by a combination of pentobarbitone, codeine, methadone and morphine.

Toxicology

5. Liver, gastric contents, blood, urine and bile along with blood from the left and right sides of the heart were submitted for toxicological analysis. The following substances were present in blood:
 - a. Pentobarbitone (12 mg/L).
 - b. Codeine (3.4 mg/L).
 - c. Methadone (0.12 mg/L).
 - d. Morphine (0.07 mg/kg).No alcohol was present in blood.
6. Pentobarbitone, codeine and methadone were detected in gastric contents. Morphine was detected in urine. Chloride analysis was performed on blood sampled from both left and right side of the heart.
7. HIV and hepatitis B testing was negative.
8. Prof Alison Jones, clinical toxicologist has given an opinion that Mr Currie most likely died as a consequence of codeine and pentobarbitone overdose on a background of methadone use.

Scene Photographs

9. Scene photographs depict the following:
 - a. an adult male (presumably rolled) in a supine position, lying adjacent to an area of damp concrete.
 - b. The neck seam of his T-shirt is torn.
 - c. Brown coloured material present about the nose and right side of the face.
 - d. Areas of red discolouration present about the eyebrows.
 - e. Apparently yellowing teeth in the exposed maxillary alveolar ridge. A number of teeth appear to be absent.

Statements

9. In a statement provided by Constable Phillip Greenhalgh, Mr Currie was described as having his face covered in what appeared to be bile or body fluids, having a few grazes to his face and his teeth appearing to be dislodged.

10. In a statement provided by GB he described Mr Currie as being “under the influence of a drug, being very slow and slurred speech” at around 8:30 pm on 12 December 1988.

QUESTIONS AND REPONSES

- Q1. *Adequacy of the post mortem investigations conducted with respect to Mr Currie. Without limiting the matters which you may consider relevant to this question, please outline (a) Your opinion, if you are able to give one, as to whether Mr Currie’s teeth were “dislodged”, as noted by the officer in charge? and (b) What, if any, significance you consider there may be to any disparity between the observation of the officer in charge and the post mortem report regarding the state of Mr Currie’s teeth?*

Based on the materials provided to me, very little can be said with regards to the state of Mr Currie’s teeth. In contemporary autopsy practice, it is standard to comment on the state of a decedent’s dentition and the presence or absence of oral mucosal injuries. This may not have been a common practice in 1988. I am unable to determine based on the autopsy report how carefully oral cavity and perioral region was examined.

In the limited series of scene photographs provided, Mr Currie’s teeth appear to be yellowed and numerous absent from the alveolar ridge. Whether his teeth were recently dislodged or historically absent cannot be determined. Whilst significant force is required to dislodge teeth in the absence of underlying dental and periodontal disease, it is noted that those with a history of illicit drug use have a high incidence of dental caries and periodontal disease (Yazdanian et al. 2020). In particular those with a history of chronic methadone use have an increase incidence of dental decay and enamel erosion. In the event of underlying dental and periodontal disease, dislodging of teeth either in the post mortem period or consequent to a low energy impact from an agonal fall or collapse may be observed. There is no autopsy documentation of other facial trauma.

- Q2. *View as to the medical cause of Mr Currie’s death (including any reasons for taking a different view to that formed by Dr Brighton and/or Prof Jones). Without limiting the matters which you may consider relevant to this question please*

outline (a) Whether you consider that the water on the floor is likely to have played any role in the mechanism of death?

It is my view that Mr Currie's cause of death can reasonably ascribed as:

I(a) Mixed drug toxicity (pentobarbitone, codeine, methadone).

This is not significantly different from the opinions of Dr Brighton and Prof. Jones. I agree with Prof. Jones that the morphine detected in Mr Currie's blood is most likely present due to the metabolism of codeine.

In the post mortem setting, in the majority of cases, the presence of a "toxic" level of a CNS depressing drugs cannot be determined in isolation. In order to determine the most likely cause of death of an individual whose blood contains central nervous system depressants, exclusion of other potential causes of death, usually via autopsy examination is required. This is particularly the case in the setting of a known history of chronic use of central nervous system depressants (licit or illicit). In this instance, whilst Dr Brighton's autopsy report is brief, it appears to reasonably exclude other causes of death.

It should be noted that some asphyxial causes of death (such as suffocation) may leave no physical findings at autopsy, or may only have subtle, non-specific findings evident on very close examination. In a similar vein, there are no diagnostic autopsy findings that can definitively identify drowning as a cause of death (i.e., it is often also a diagnosis of exclusion). In the setting of death due to CNS mediated depression of cardiorespiratory function, in some cases an element of relative asphyxia related to prone positioning *may* contribute to death. In this instance, it is not possible to know how deep the film of water surrounding Mr Currie's body was at the time of his collapse, and whether this would have covered his mouth and/or nose. However, unless the floor of the toilet block was particularly uneven, this is unlikely to have contributed particularly more significantly to Mr Currie's death than a potential element of prone (face down) positioning (partial covering of the mouth and nose in prone positioning in obtunded individual).

I note in the toxicology report, assays for specific gravity and chloride in blood taken from left and right heart blood specimens has been reported. At the time that this autopsy was conducted, it appears likely there was a vogue for assessing relative chloride concentrations in left and right heart blood samples when considering deaths

potentially related to drowning (for example, report into the death of Mr Cyril Olsen – Case A00206/22). That does not mean that drowning was necessarily considered a cause of death for this case; this could be a control sample. Regardless, any diagnostic utility of this test has long been refuted.

Q3. View as to whether Mr Currie's injuries and bodily condition were consistent with misadventure, suicide, or foul play.

The superficial injuries/minor abrasions to Mr Currie's face, and the dislodgement of his teeth as described by the police officer, can *potentially* be ascribed to perimortem phenomenon rather than significant injury causing death. Significant blunt force trauma to the face prior to death can be excluded if a thorough examination of the mouth, associated oral mucosa, nose and facial soft tissues has been performed. It is not possible to say whether this has been undertaken based on the autopsy report.

Based on the information presented to me, Mr Currie's death is most likely consistent with misadventure. However, it should be noted that it is possible for another individual to contribute to death via an asphyxial mechanism (e.g., smothering) when the individual is already in a state of significant central nervous system depression. This can rarely be excluded, particularly on autopsy examination alone.

Q4. Any recommendations for further investigations with respect to determining the manner and cause of Mr Currie's death.

I do not believe, based on the historical material that is available, that further investigation could be of any utility.

Q5. Please provide any other comment, within your area of expertise, regarding the likely cause of Mr Currie's death.

Nembudeine was an Australian preparation from Abbott Pharmaceuticals (Martindale: The Complete Drug Reference, 129th Edition, 1989). I believe it is no longer available. Nembudeine's active ingredients included paracetamol (acetaminophen), codeine phosphate and pentobarbital sodium. The codeine, pentobarbitone, and morphine (as a metabolite of codeine) identified in Mr Currie's blood can be ascribed to ingestion of Nembudeine tablets. Of note, this preparation also contained paracetamol. Paracetamol quantification however requires an acid screen, which may not have been undertaken at the time of Mr Currie's toxicological analysis.

Reference

Yazdanian M, Armoon B, Noroozi A et al. Dental caries and periodontal disease among people who use drugs: a systemic review and meta-analysis. *BMC Oral Health* (2020) 20:44

<https://bmcoralhealth.biomedcentral.com/articles/10.1186/s12903-020-1010-3>

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.



Date Signed: 24 January 2023

Dr Linda E. Iles
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