



VICTORIAN INSTITUTE OF FORENSIC MEDICINE

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

**CARL GREGORY STOCKTON
CASE NO. A00048/23**

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 and am an Adjunct Associate Professor in the Department of Forensic Medicine at Monash University.

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. A00048/23
Re : STOCKTON deceased

I have been requested by Ms Emily Burston, senior solicitor for the Special Commission of Inquiry into LGBTIQ hate crimes, to review materials related to the death of CARL GREGORY STOCKTON who died at Sydney Hospital on 11 November 1996.

MATERIALS PROVIDED

- Autopsy Report of Dr Christopher Lawrence
- Neuropathology Report of Dr J Raisanen
- Toxicology Report of Vincent Zurzolo
- Transcript of Coronial Inquest
- Coronial Findings
- Crime Scene and Autopsy Photographs
- Statement of OIC Detective Senior Constable Neil Andrew Walker
- Statement of Senior Constable Darren John Gregor
- Statement of Senior Constable Warren Anthony Stocks
- Statement of Plain Clothes Senior Constable Anthony Moss
- Statement of Robert William Diliberto
- Statement of Brigette Diana Paroissien
- Report of enquiries made by police at Bar Cleveland on 6-7 November 1996
- Statement of Magda Kos
- Statement of Brent Matthew Tozer
- Statement of Gavin William James
- Statement of Andrew Phillips
- Statement of Nathan Adrian Starcic
- Statement of Eric-Emmanuel Hooson
- Statement of Meffan October Kaiwai
- Statement of Alan John Clynch
- Statement of Mark Desmond Lambric
- Statement of Dr Steven Dubenec
- Statement of Dr L. H. Raj Wijetunga
- Statement of Dr Clive Woolfe 1
- Statement of Dr Astika Kappagoda
- (Statement of) A/Prof Brian David Doust
- Letter from Dr Raymond Garrick to Dr Heather McIntyre re neurological assessment of the deceased
- Medical Report of Dr Heather McIntyre (GP)
- Letter from Dr JM Matheson to Detective Senior Constable Walker
- Statement of Dr Anthony Frederick Moynham (Director, Clinical Forensic Medicine Unit)

SYNOPSIS OF MATERIALS

1. Mr Stockton had been drinking at the Bar Cleveland Hotel on the afternoon of the 5 November 1996, and left around 11.30 pm that night, apparently intoxicated.
2. In a statement given to police Brigette Paroissien indicated that she had seen Mr Stockton in her backyard at around 12:50 am on 6 November 1996. He appeared to her to be intoxicated. She spoke to him for a period of time, but he did not appear to be making sense. With the assistance of her boyfriend, they helped Mr Stockton to the alley outside. Mr Stockton did not appear to be injured. He reportedly stumbled over some bins but did not appear to be injured during this fall.
3. At around 1 am on 6 November 1996, an unidentified man helped Mr Stockton into the Bar Cleveland Hotel. The manager of the hotel observed Mr Stockton to have a black right eye, and a small cut beneath this.
4. Mr Stockton was speaking incoherently, and it was believed he was very intoxicated. Mission Beat was contacted, and welfare officers attended, taking Mr Stockton to Campbell House. He was assessed and given a bed for the night. A worker at Campbell house noted Mr Stockton had a badly bruised right eye and had swelling around his face.
5. Mr Stockton vomited several times on the morning of 6 November. He appeared disoriented and confused. He was subsequently transported to Sydney Hospital.
6. When assessed at hospital, Mr Stockton was observed to have a broken clavicle (an older injury for which Mr Stockton had been using a sling), bruising around his right eye. A CT scan of his head demonstrated a comminuted skull fracture extending from the posterior parietal region into the vertex with some displacement (no significant displacement noted by neurosurgeon Mr Matheson on review), associated with areas of intracerebral haematoma in the right temporal pole, frontal poles, both posterior parietal regions and near the vertex on the right. Mr Stockton was complaining of a headache, suffering from amnesia and disoriented to place. Mr Stockton was transferred to St Vincent's Hospital for neurosurgical management.

7. The statement of Dr Astika Kappagoda also indicates that Mr Stockton also had multiple facial bone fractures demonstrated on facial x-ray.
8. Mr Stockton underwent a right frontotemporal craniectomy, right frontal and temporal partial lobectomy and insertion of an intracranial pressure monitor on 7 November 1996. Despite treatment Mr Stockton further deteriorated and died 11 November 1996.
9. Neurosurgeon Mr J M Matheson was of the opinion that Mr Stockton's head injuries could only have occurred from multiple repeated blows and was inconsistent with impaction from a motor vehicle accident.
10. Forensic physician Dr Anthony Moynham was of the opinion that Mr Stockton received some trauma to his right side as the injuries were "to the right side of his head and to the right clavicle" and he opined that they may have occurred from a fall or from a large object such as a motor vehicle.

Autopsy

11. An autopsy was performed by Dr Christopher Lawrence on 12 November 1996. He observed the body of a well developed, adult male weighing 67 kg and measuring 181 cm in height. Status post right temporoparietal craniectomy. He noted the following injuries:
 - Two healing contusions on the right temporal scalp, 3 cm and 7 cm in dimension respectively.
 - Continuous/bruising from the right temple to the left temple and from the frontal bone posteriorly to the occiput.
 - Right periorbital haematoma
 - 2.5 cm bruise with central healing abrasion lateral aspect left eyebrow
 - Bruising behind the left ear
 - Bruising over the left mandible and upper neck
 - Yellow bruising over the right clavicle and shoulder
 - Unhealed fracture right clavicle with callus
 - 7 cm area yellow bruising right axilla
 - Small yellow bruises chest wall
 - Healing fractures right first and third ribs

- 3 cm abrasion posterior right back
 - Right buttock and flank small bruises and healing abrasion
 - 10 x 5 cm brown bruise left buttock
 - 2 cm brown bruise posterior left elbow
 - 6 cm brown bruise with 1.5 cm healing abrasion inferolateral right knee
 - 6 x 3 cm area punctate purple bruising left anterior thigh
 - 2.5 cm orange bruise anterior left knee
 - 6 x 3.5 cm bruise with central healing abrasions anterior left tibia
 - Subcutaneous bruise over the right mandible
 - 3 cm contusion on the posterior parietal scalp near the midline
 - Comminuted skull fractures with a depressed fracture of the post area parietal bone and superior occipital bone, extending through the sagittal suture, fractures of the right and left parietal bone, extending to the left side of the frontal bone.
 - Extradural and subdural haemorrhage (status post craniectomy)
 - Inferior frontal and temporal brain contusions.
12. In summary, Dr Lawrence noted severe head injuries as above, and characterised the injuries to the right clavicle and right ribs as older injuries.
13. Dr Lawrence identified three apparent areas of head impact - the right temporal region, the posterior parietal region and the left temporal. He opined that the pattern of injuries could represent an assault. He suggested that whilst alternatively the severity of injuries could be caused by being struck by a motor vehicle, the pattern of the other injuries is not typical of a pedestrian collision, however the head injuries could be produced if the decedent was lying on the road when struck.
14. Dr Lawrence indicated the antemortem blood sample demonstrated a blood alcohol concentration of 0.014%, and diazepam.

Toxicology

15. The results of analysis of post-mortem samples non-contributory given the time elapsed between injury and death.

Autopsy photographs

16. The provided autopsy photographs demonstrate the following:
- Stigmata of recent medical intervention including recent right sided craniectomy
 - Right periorbital bruising; likely healing superficial laceration outer canthus
 - Healing abrasion and bruising right knee
 - Abrasion/superficial laceration left shin
 - Petechial bruising left inguinal region
 - Two areas of abrasion right frontotemporal scalp, adjacent to craniectomy scar, in an area of variably shaved scalp skin, associated with underlying bruising
 - Yellow coloured bruising around ?right buttock
 - Brown bruising +/- abrasion left adjacent to natal cleft
 - Area of brush abrasion, ?site
 - Bruising region left parietal scalp
 - Small abrasion outer canthus left eye with surrounding bruising
 - Scalp bruising occipital region
 - Left retroauricular bruising
 - Ill-defined scalp bruising adjacent to vertex
 - Extensive subscalpular bruising about right craniectomy site, left frontal scalp, left temporal scalp, left parietal scalp
 - Comminuted bilateral skull fractures involving the sagittal suture (see attached diagramme Appendix A)
 - Right frontal temporal craniectomy bone deficient, drain in situ
 - Bilateral inferior frontal and temporal contusions
 - Subcutaneous bruising angle of left mandible (jaw)
 - Subcutaneous bruising along right mandible
 - Subcutaneous deception of face with soft tissue injury and/or fractures difficult to define

QUESTIONS AND REPONSES

Q1. *Following your review of your briefing material, please identify:*

- a. *Any additional areas of medical investigation or expert opinion you consider would assist his Honour on the issues of Mr Stockton's injuries and cause of death; and*
- b. *If relevant, appropriate experts from whom his Honour may wish to seek further expert opinion.*

The craniectomy bone specimen is missing in the autopsy photographs, and the interpretation of scalp bruising is limited by secondary bruising from neurosurgical intervention, and limited photographs of the reflected scalp at autopsy. Review of Mr Stockton's original CT scan of his head prior to surgery on admission to Sydney Hospital may assist with demonstrating the complete pattern of skull fracturing, and may also demonstrate discrete scalp haematomas, helping delineate separate sites of impact. However it is quite possible that this scan is no longer available for review. Similarly, the statement of Dr Astika Kappagoda indicates that Mr Stockton also had multiple facial bone fractures demonstrated on facial x-ray. This does not appear in any of the other medical evidence. If this Xray (or report of such Xray) still exists, it would be helpful to review to either exclude or include facial fractures in the consideration of injury mechanism.

Input from a forensic anthropologist regarding the observed pattern of skull fractures can be of assistance. Thus, I have requested VIFM forensic anthropologist Dr Samantha Rowbotham, to review the autopsy photographs and produce a schematic of the skull fractures observed. This schematic is attached (appendix A).

I note that there is no material in the brief regarding any description in Mr Stockton's medical record of any injuries observed on admission to either Sydney Hospital or St Vincent's Hospital. If these were documented and available, this might assist in interpreting injury patterns.

Q2. Your view as to the adequacy of the post-mortem investigations conducted with respect to Mr Stockton.

Autopsy practice has evolved since the time of Mr Stockton's death. Nevertheless, the post-mortem investigations with respect to Mr Stockton appear reasonably comprehensive, particularly for the time when the autopsy was undertaken. Minor criticisms include the "cleanliness" of the photographs, particularly the of head, with residual blood staining making interpretation of injuries difficult, and the lack of a scale in photographs demonstrating injuries.

A subcutaneous dissection of the limbs and back does not appear to have been undertaken. The presence (or absence) of occult bruising can help inform injury patterns and possible mechanisms of injury. Whilst the teeth are described as being in fair repair, and the nose as showing no abnormality, there is no description of the

presence or absence of oral mucosal injury, and there is no indication as to the presence or absence of subcutaneous facial bruising, or fractures, to help resolve the issue around the presence or absence of facial fractures.

The craniectomy specimen (i.e., the excised bone from the right side of the skull) does not appear to have been received with Mr Stockton's body, and there is no documentation around this being separately examined. Thus, the involvement of excised frontotemporal cranial bones in the pattern of skull fracturing cannot be interpreted.

The most helpful investigation in this instance would have been a forensic medical examination proximate to the time that Mr Stockton was admitted to hospital with his injuries. Unfortunately, this is infrequently done. This is a problem that persists today.

Q3. *Your opinion as to the manner and cause of Mr Stockton's death and the reasons for that opinion.*

Without limiting the matters which you may consider relevant to this question, please outline your views regarding:

- c. How Mr Stockton may have suffered his head injuries;*
- d. The likely sequence of the injuries suffered by Mr Stockton;*
- e. The likelihood that Mr Stockton's death was caused, or contributed to, by a fall;*
- f. The likelihood that Mr Stockton was struck by a motor vehicle; and*
- g. The likelihood of Mr Stockton being the victim of an assault.*

Sequence of injuries

Based on the witness statements it appears that Mr Stockton most likely sustained his injuries after leaving the Bar Cleveland Hotel around 11.30 November 5 1996. Brigitte Paroissien did not describe Mr Stockton as having facial injuries when in her back yard. If she is a reliable witness, then it appears that Mr Stockton sustained his injuries between 12.50 am and 1 am on November 6, as indicated by the bar manager who observed both a bruise and a small cut about Mr Stockton's right eye. There is no further description of facial injuries from any of the witnesses, aside from a worker at Campbell House who noted Mr Stockton had a badly bruised right and had swelling around his face. Given that the hair on the right side of Mr Stockton's scalp was shaved in preparation for craniotomy, it may be that the two abrasions to the right side of his

head may have been obscured by his hair and not reported by witnesses. There is no report of Mr Stockton sustaining injuries whilst in Campbell House.

Given Mr Stockton's intracranial injuries comprise predominantly contusions, which often become more extensive in the hours following injury, a delayed presentation is not precluded by the injuries observed.

Cause of Mr Stockton's head injuries

Mr Stockton's cause of death can reasonably be ascribed as **blunt head injuries**, which is approximately equivalent to the cause of death given by Dr Lawrence (**craniocerebral injuries**).

Based on my interpretation of the autopsy photographs and the autopsy report, there have been a minimum of **five** blunt impacts to the head and face as follows:

1. Right eye (whilst periorbital bruising can have a number of sources, an abrasion/superficial laceration in this area indicates a direct impact)
2. Right temporal scalp (areas of abrasion)
3. Back of the head (substantial impact)
4. Left temporoparietal scalp (bruising seen on scalp skin)
5. Left frontal scalp (discrete bruising on reflected scalp in autopsy photographs)/left periorbital region (abrasion noted).

The bruising observed to the left and right jawlines may represent discrete impacts, or may represent extension of contiguous scalp bruising.

This minimum number of impacts to the head and face involves discrete impacts in at least 4 planes of the face and head (i.e. front of the face, left side of the head, back of the head, right side of the head).

The pattern of skull fractures observed is due to very significant blunt force impact to the back of Mr Stockton's head. Fractures of this extent are not observed from blunt impacts result from a simple fall from an individual's own height (verbal communication, Dr Rowbotham, with reference to survey of skull fractures seen at VIFM). The energy required to produce this extent of comminuted fracture, if due to a fall, requires additional force (i.e., a significantly accelerated fall).

Given the number of impact points as outlined above, and the extent of skull fracturing, Mr Stockton's head injuries clearly cannot be accounted for by a simple fall. A fall from a significant height with impact to the back of the head may be able to produce this pattern of skull fractures but does not appear plausible in the circumstances as described.

Mr Stockton's pattern of injuries could be accounted for by an assault with multiple forceful impacts to the head. An accelerated fall onto the back the head could be accommodated in this scenario.

Whilst an impact from a motor vehicle would impart the energy requisite in Mr Stockton's pattern of skull fractures, his lack of post-cranial injuries makes this scenario unlikely. The right rib and clavicular fractures that Dr Anthony Moynham relied upon to inform his opinion that the deceased's injuries were caused by a motor vehicle collision are older injuries and are unhelpful in this regard. It is difficult to envisage a scenario where Mr Stockton could receive such severe craniocerebral trauma without substantive injury anywhere else on his body.

Whilst it cannot be excluded that Mr Stockton's skull fractures have not been sustained by his head being run over, there are no cutaneous injuries to indicate that this has taken place. I find it difficult to accommodate the number of planes of injury into this scenario, unless some of these injuries were sustained in a separate incident. This scenario is significantly less likely, in my view, than an either an accelerated impact with the ground, or a substantive broad-based blow to the back of the head, it cannot be completely excluded.

Q4. *Any recommendations for further investigation with respect to determining the manner and cause of Mr Stockton's death.*

Review of medical records describing cutaneous injuries on admission to hospital, along with review of admission head CT scan (films or report) and facial bone Xray (films or report) may provide further information. It is unlikely however that this information will be allow for clear delineation between possible mechanisms of injury in this case.

Q5. *Any other comment, within your expertise, which you consider to be relevant to the manner and cause of Mr Stockton's death.*

In the interests of disclosure, I am well acquainted with Dr Lawrence (original autopsy pathologist) and have received teaching from him early in my career. I do not believe this has influenced the views that I have expressed above.

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.

A handwritten signature in cursive script, appearing to read 'Linda', enclosed in a thin black rectangular border.

Assoc. Prof. Linda E. Iles
B Med Sci, MB BS (Hons), FRCPA, DMJ (Path), FFPMI (RCPA)
Forensic Pathologist
Head of Forensic Pathology
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Appendix A – Schematic of skull fractures (produced by forensic anthropologist Dr Samantha Rowbotham)

