VICTORIAN INSTITUTE OF FORENSIC MEDICINE

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

PETER SHEIL
CASE NO. A00053/23

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. A00053/23
Re : SHEIL deceased

I have been requested by Ms Caitlin Healey-Nash, senior solicitor for the Special Commission of Inquiry into LGBTIQ hate crimes, to review materials related to the death of PETER SHEIL, age 30 years.

MATERIALS PROVIDED

- P79A Report of death to the Coroner
- Toxicology Report
- Autopsy Report of Dr Colin Goldschmidt
- Death Certificate
- Statement of Peter Barry Sheil (father)
- Statement of Donald Ross
- Statement of Patricia Campbell
- Letter from Dr C Rikard-Bell
- Statement of Constable William Strange (officer in charge)
- Rick Feneley, 'Up to 80 men murdered, 30 cases unsolved', *Sydney Morning Herald* (online)
- Rick Feneley, 'He wasn't gay, but could Peter have been a gay hate victim?', *SBS* (online)

SYNOPSIS OF MATERIALS

1. Mr Peter John Shiel, age 30 years, reportedly left home at 8:30 am on Wednesday April 27 1983, to go shopping. He reportedly spoke to his mother around 7:00 PM that evening.

2. Mr Shiel had a history of schizoaffective disorder or "manic depressive illness", for which he was prescribed lithium carbonate, amitriptyline, and parenteral Modecate. He reportedly occasionally had fleeting suicidal ideation but denied any serious intent.

3. At around 10 a. on Friday 29 April 1983 a walker found the body of a male person, subsequently identified as Mr Shiel, lying on his back between some rocks about 150 metres from the Clovelly Beach car park.

4. Mr Shiel was described as wearing a blue short sleeved shirt which was open at the front, blue corduroy slacks with the fly undone, down around his hips, with the belt of his slacks also undone. He was wearing a pair of turquoise coloured underpants noted to be down below the line of his pubic hair. He was also wearing a pair of brown slip-on shoes and white socks

5. Police subsequently attended and observed Mr Shiel lying in a prone position (note differing position description from witness statement) between two large rocks. About 6 metres from his body were bloodstains on the rocks and an amount of loose change. Closer inspection revealed a trail of blood stains from this position to where Mr Shiel lay.

6. A rocky outcrop was noted approximately 20 metres above. This was described as having a very mossy surface of a highly slippery nature. Just below this area police found a magazine of a "sexual nature".

7. Police formed the opinion that Mr Shiel died after venturing onto the rock edge, losing his footing, falling to the rocks below, apparently striking his head. They concluded that he had dragged himself a distance of about 6 metres and lay in a more comfortable position between rocks. Police formed the opinion that Mr Shiel's clothing was in a state of disarray due to the fact that he had presumably been masturbating before his fall.

8. Scientific Squad Police reportedly attended the scene and photographs were taken however such photographs are no longer available.

Autopsy

9. An autopsy was performed by Dr Colin Goldschmidt at 8:00 am on May 3 1983. He described the body of a 77 kg, 171 cm tall (BMI 36.4) male without congenital anomalies.

10. <u>External injuries:</u>
    - 1.5 cm stellate laceration right occipital scalp
    - 5 cm parchment type abrasion left shoulder
    - 3 cm abrasion right shoulder
    - Numerous small abrasions over the left buttock up to 0.5 cm in maximum extent

- 1 cm hematomas over both knees
- Two 0.5 cm abrasions on the dorsal aspect of the hand above the left thumb

11. Internal injuries
    - Fracture dislocation between C1 and C2 with the head moving freely on the cervical vertebral column
    - Posterior right 9th rib fracture
    - Anterior left second rib fracture
    - Pelvic fractures (symphysis pubis and inferior right pubic ramus)
    - Bruising parietal pleura bilaterally
    - Marked lung congestion and diffuse haemorrhage
    - 4 cm haematoma posterior aspect right lobe of the liver
    - Retroperitoneal haematoma

12. Relevant negative observations
    - No skull fracture or intracranial haemorrhage
    - No comment regarding scalp bruising
    - No pleural haemorrhage
    - No comment regarding blood in large airways
    - No pericardial or cardiac injury; no great vessel injury.
    - No bladder injury

13. Mr Shiel's heart weight was recorded as 496 g. This is above upper 95% confidence intervals for a man of Mr Shiel's height and weight.

14. Mr Shiel's cause of death was given as: 1a. Multiple injuries

Toxicology

15. Toxicological analysis of blood demonstrated a blood alcohol concentration of 0.018 grams per 100 ml of blood (0.018%); radio immunoassay for morphine was negative.

    Analysis of urine was positive for cannabinoids via immunoassay technique (EMIT). No confirm entry testing undertaken.

    "Routine screening tests for poisons" was negative in liver and stomach contents.

QUESTIONS AND REPONSES

1. *Following your review of your briefing material, please identify :Any additional areas of medical investigation or expert opinion you consider would assist his Honour on the issues of Mr Sheil's injuries and cause of death; and*
   If relevant, appropriate experts from whom his Honour may wish to seek further expert opinion.

The description of autopsy findings is perfunctory (see below). In the absence of any further details or photographs relevant to the scene or the autopsy examination, it is my view that there are no other avenues of medical investigation that could shed further light on Mr Shiel's cause of death, or how his death occurred.

2. *Your view as to the adequacy of the post-mortem investigations conducted with respect to Mr Sheil, including:*
   a. Your view as to the estimated time of Mr Sheil's death. Without limiting the matters which you may consider relevant to this question, please outline:
      i. Whether you agree with the estimated time of death expressed in the original autopsy report. Why/why not?
      ii. What factors relevant to Mr Sheil's death impact upon the precision with which time of death can be estimated?
   b. If the nature of Mr Sheil's injuries were such that would have enabled him to survive the initial impact and, if so, the estimated period of survivability of those injuries.

Autopsy practise has evolved significantly in the 40 or so years since Mr Shiel's death. Nevertheless, for the purposes of review I make the following comments:

- There are no documented observations of post-mortem change in the autopsy report.
- There is no documentation around the presence or absence of scalp bruising.
- There is no documentation around the presence or absence of facial injuries or the state of the orbital and oral mucosae.
- There is no documentation regarding the presence or absence of injury to the laryngeal skeleton.
- The cervical spinal cord has not been examined i.e., there is no data regarding the

presence or absence of cord transection.

- The trachea and bronchi are described as normal; this presumably means there is no haemorrhage within large airways.
- The post-mortem blood specimen has not been analysed for substances other than alcohol or morphine.
- There is no description of the presence or absence of anogential injury; there is no description of the volume of the bladder contents.
- There is no reference to the fact that Mr Shiel's heart is pathologically enlarged (if the weight recorded is correct).

The autopsy has been sufficient to determine cause of death, however is inadequate to help address the question of "how death occurred".

With specific reference to the questions outlined above regarding time of death:

The autopsy pathologist estimates that death had taken place three to four days prior to the autopsy, i.e. 3 to 4 days prior to the 3rd of May 1983. Mr Shiel's body was found on the morning of April 29 1983. There are **no** recorded post-mortem observations that give any indication as to the extent of post-mortem change, or time of death. There is no post-mortem data that allows for time of death estimation beyond when Mr Shiel was last known to be contacted on April 27, and when his body was found on the 29th of April. I believe it unlikely that the autopsy pathologist intended his estimate of time of death to be viewed with any type of precision, and this estimate should be disregarded.

Regarding Mr Shiel's injuries and their survivability, see response to question 3 below.

3. *Your view as to the medical cause of Mr Sheil's death (including, if relevant, any reasons for taking a different view to that formed by Dr Goldschmidt). Without limiting the matters which you may consider relevant to this question, please address:*

   a. *The fracture to the cervical spine between C1 and C2;*
   b. *Whether any of the lacerations, abrasions, factures, and other injuries suffered by Mr Sheil would have contributed to his cause of death; and*
   c. *Whether it is possible that Mr Sheil survived the initial fall for a period of time and was capable of moving his body to its final position?*

The autopsy report documents a C1/C2 fracture/dislocation (i.e. atlantoaxial fracture/dislocation). Whilst the autopsy report describes the head moving freely on the cervical vertebral column (this implies atlanto-occipital dislocation rather than C1/C2 atlantoaxial dislocation), it is presumed that atlantoaxial fracture/dislocation is what is being described. The specific elements of C1 and C2 that have been fractured are not described. This data would help inform mechanism of injury. For example, hyperflexion injuries consequent to a full onto the top of the head, produce a different C1 and C2 fracture pattern from burst type vertebral compression fractures that may occur due to axial loading (for example axial load transferred up through the feet pelvis and spinal column from a full with primary lower limb impact).

Furthermore, Mr Shiel's cervical spinal cord has not been examined, thus the extent of cord injury is unclear. However, based on the sublethal nature of the remainder of the autopsy findings, a significant upper cervical spinal cord injury is the only document4ed injury capable of causing death.

A fatal upper cervical spinal cord injury would render an individual incapable of moving following cord injury. However, if Mr Shiel's sustained a highly unstable upper cervical spinal fracture from a fall from a height, it is possible that voluntary movement following impact may have resulted in completed cord injury/transection. Based on the limited medical data that is available, this is the only medical explanation for movement after impact as suggested by the investigating officers. However, it should be noted that the medical information is suboptimal and likely incomplete.

Other elements of the post-mortem examination suggest death was rapid in onset following impact, as characterised by the lack of blood described within the trachea and bronchi in the setting of Mr Shiel's lungs being described as diffusely haemorrhagic (likely contused).

Nothing is made in the autopsy report of Mr Shiel's enlarged heart. Whilst his heart weight is increased beyond normal limits, his heart is described as normal. It may be that the heart was not weighed properly at autopsy (hearts weighed without complete evacuation of blood clot can exaggerate their weight); it may be that Mr Shiel coincidentally died with an enlarged heart. Or it may be the case that Mr Shiel's pathologically enlarged heart contributed to his cause of death in the setting of significant trauma. However, this is highly speculative in the setting of potentially unreliable autopsy information.

Concerns regarding the thoroughness of the autopsy examination notwithstanding, based on what is documented, a reasonable cause of death would be:

1a. Cervical spine injuries sustained in a fall.

4. Your view as to any conclusions that can be drawn from the toxicological analysis.

A small amount of alcohol was detected in blood sampled after death (approximately 0.02%). This may be due to ingestion of alcohol prior to death; however this is a small amount and would not render Mr Sheil intoxicated. Alternatively, this small percentage of alcohol may be the result of post-mortem alcohol production. Regardless, given the low concentration, it is unlikely to be contributory.

Cannabinoids were detected in post-mortem urine via immunoassay. This is a screening test, and due to potential cross reactivity, a positive result requires confirmation via other means. This does not appear to have been undertaken. If this is a true result, it indicates the consumption of cannabis sometime prior to death. It cannot however be implied that Mr Shiel was necessarily affected by cannabis at the time of his death.

5. *Your view as to whether Mr Sheil's injuries were consistent with misadventure, suicide, or foul play. Without limiting the matters which you may consider relevant to this question, please address:*

   a. *The position that Mr Sheil was found in, including his prone position, blood staining and coins located about six metres from Mr Sheil's body;*
   b. *The evidence as to the estimated time of Mr Sheil's fall, including the time of sunset and Mr Sheil's 9:00pm curfew;*
   c. *The position of Mr Sheil's trousers and shirt when his body was found;*
   d. *The evidence of investigating police that a pornographic magazine was found "nearby" to Mr Sheil's body;*
   e. *The evidence that Mr Sheil's route home passed a number of known gay beats; and*
   f. *Mr Sheil's mental health at the time of his death, taking into consideration the medication regime he was prescribed.*

Regarding the position in which Mr Shiel was found, there is an inconsistency between what was described by witness Mr Donald ROSS ("lying on his back"; i.e. a supine position) and a prone position as described by police. Given that Mr Ross was able to describe the position and state of Mr Shiel's trousers, underpants and belt, his account in more persuasive. Regardless, in the absence of scene photographs I am unable to say whether this is due to the direct position in which Mr Shiel landed, or whether he rolled or tumbled into this position following initial impact. The presence of described blood staining and loose coins 6 metres from the location in which Mr Shiel's body was found, suggest that he either tumbled into this final position, or was capable of moving to his final position. Given his fatal cervical spinal injury, notwithstanding the caveat described above, the latter appears less likely. Based on the autopsy report, the only injury described capable of leaving blood stains is the laceration to his scalp.

In regard to the state of Mr Shiel's clothing when he was found (shirt open at the front, slacks with fly and belt undone), whilst this could partially be explained by his urinating prior to a fall, it would seem unnecessary to open one's shirt to do so. I have no specialist knowledge that can cast further light on why Mr Shiel was found in this state of partial undress. However, this observation should inform a more thorough post-mortem examination and trace evidence sampling. This does not appear to be included in the Report of Death to Coroner, i.e., does not appear to have been made available to the autopsy pathologist.

Non-pathology related evidence appears to suggest suicide is unlikely to be the manner for Mr Shiel's death (no reported change in mood around the time of his death; body found in a location with a shorter fall than in immediate surrounding areas). There is no information in the autopsy material as described to indicate whether Mr Shiel's death was the result of misadventure, accident, or foul play.

6. *In your opinion, what information is missing in the documentation available to the Inquiry, or the quality or adequacy of the information that has been provided to you, that would be useful for you in order to provide your opinion on the manner and/or cause of Mr Sheil's death?*

There is significant lack of detail regarding the scene of Mr Shiel's death, including the pattern of blood staining where his body was found. There is a significant lack of detail with regards to both positive and negative autopsy findings to inform questions around how Mr Shiel's death occurred. However, autopsy findings that can help delineate

whether a fall from a height is the consequence of foul play, misadventure, suicide or accident are uncommon. This does not mean they should not be sought. Most often, police investigative findings including circumstantial information, witness observations and scene reconstruction are the most important elements in determining manner of death.

7. *Please provide any other comment, within your expertise, which you consider to be relevant to the manner and cause of Mr Sheil.*

I have no further comment.

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.

Assoc. Prof. Linda E. Iles
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