



VICTORIAN INSTITUTE OF FORENSIC MEDICINE

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

**WILLIAM ANTHONY ROONEY
CASE NO. A00022/23**

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.

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. A00022/23
Re : ROONEY deceased

I have been requested by Elizabeth Bloomfield, senior solicitor assisting the Special Commission of Inquiry into LGBTIQ Hate Crimes, to review materials relating to the death of WILLIAM ANTHONY ROONEY, date of death 20 February 1985.

MATERIALS PROVIDED

- P79A Report of death to coroner
- Form 20 medical report of Dr Vincent Versoza
- Evidence of Dr Versoza at inquest
- Coroner's report on William Rooney of Dr Ramsay
- Evidence of Dr Ramsay at inquest
- Statement of Detective Sergeant Stephen Passmore
- Statement of DSC John Tate
- Coroner's findings
- Crime scene photos
- Autopsy photos
- Photos of William Rooney in hospital

SYNOPSIS OF MATERIALS

1. On the morning of 14 February 1986, Mr Rooney was found lying between a toilet block and a concrete wall around an address at 250 Crown Street, Wollongong. Mr Rooney was noted to be "covered in blood", and a large amount of blood was in the vicinity. Ambulance officers attended. Mr Rooney was in a semi-conscious state. He was conveyed to Wollongong Hospital.
2. Mr Rooney was admitted to Intensive Care following CT imaging.
3. The non-contrast CT scan of Mr Rooney's head showed multiple skull fractures with no definite evidence of depression of fragments. Fracture lines extended through the left petrous temporal bone, the right occipital region, the left parietal region just prior to the temporal area and the right posterior parietal region. These changes were associated with extensive subarachnoid haemorrhage with

marginal midline shift to the left. A thin right parietal extra-axial collection was noted. Contusions of both frontal lobes were reported.

4. An intracranial pressure monitor was inserted, but no decompression procedure was performed. Mr Rooney was sedated and ventilated, however on the morning of 19 February, his responses decreased. A repeat CT scan was performed, showing no interval change. Mr Rooney was declared brain dead in the early afternoon of 20 February 1986.
5. At inquest, Dr Mason Ramsay, director of Intensive Care at the Illawarra Health Service, gave evidence suggesting he thought it was unlikely that Mr Rooney's skull fractures would be consistent with a 3-metre fall, however he conceded "anything is possible". He also found it difficult to reconcile the bruises on Mr Rooney's chest and the abrasion on his chin with a proposed mechanism of injury of Mr Rooney falling on his head.

Autopsy Examination

6. An autopsy on Mr Rooney's body was performed by Dr Vincent Versoza on the morning of 21 February 1986. The handwritten autopsy report documents the following:
 - a. Body of a "fairly nourished" medium built adult male, 5 feet 11 inches tall, weight not stated.
 - b. A sutured scalp excision was noted on the right frontal area in keeping with the deceased's intracranial monitor insertion.
 - c. Diffuse scalp haematoma (presumably subscalpular) "across the lower half of the occipital area extending across the back of the head".
 - d. Three linear base of skull fractures involving the posterior and middle cranial fossae are identified (side irregularly stated). One of these fractures reached the lower margin of the foramen magnum.
 - e. Brain examination describes "massive blood clot accumulation" covering the surfaces of both cerebral hemispheres and cerebellar lobes. The bleeding was described as mainly subdural in character, "coming from torn meningeal vessels".
 - f. No neck fractures or dislocation were described.
 - g. A mural thrombus was described within the heart in the region of the tricuspid valve (none noted in the pulmonary trunk).

- h. Small oval greyish green haematomas were noted on the right chest wall, about four in number, arranged in the linear manner, close to the costal arch
- i. No significant intrathoracic, intraabdominal, or pelvic organ injury was documented.
- j. An oval abrasion/contusion was seen on the medial half of the left elbow region.
- k. Contusion/abrasion about the right knee.
- l. No fracture of any long bones was noted.

Cause of death was given as:

1(a) Massive (subdural) cerebral haemorrhage and intracardiac thrombus

1(b) Torn meningeal vessels

1(c) Basal skull fractures, most probably due to a fall with back of head hitting a hard surface.

Dr Versoza's evidence at inquest

- 7. Dr Versoza stated that the greyish green haematomas on the chest wall would be "may be 3 to 5 days" of age, and therefore not the same as the age of the actual injuries that were the cause of Mr Rooney's death.
- 8. Non-depressed basal linear skull fractures of the posterior and middle cranial fossae were described in a similar fashion to as described in the autopsy report. Dr Versoza went on to describe tearing of the middle meningeal artery.
- 9. Dr Versoza went on to describe a diffuse haematoma across the occipital region of the scalp.
- 10. Dr Versoza described that on removing the brain the whole floor of the cranial cavity being covered with blood clot (this likely indicates base of skull subdural haemorrhage).
- 11. Dr Versoza identified that a fracture extending through the petrous temporal bone was responsible for bleeding from the ear.
- 12. He described an oval abrasion contusion about the left elbow and an abrasion to the right knee.

13. Dr Versoza indicated that it was his strong belief that the deceased came about his injuries by his head hitting a flat hard surface, and the back of the elbow also being possibly injured as part of the fall.
14. When questioned, he was of the view that given that the deceased's skull fractures were not associated with scalp lacerations (i.e. "skin... split open"), it was highly unlikely that the deceased's injuries were due to "battering of the head with hard instruments, where the wood or metal usually, may be 99% of them the skin is split open together with fracturing of the skull".
15. On questioning, Dr Versoza emphasised that the skin of the deceased's scalp, opposite the haematoma was perfectly intact with "no localisation of destruction as one might expect from a battering from a hard instrument".

Statement of DS Stephen Passmore (Scientific Investigation Section)

16. DS Passmore described the retaining wall to be 2.8 metres in height and virtually at street level to Crown Lane. The top of the retaining wall was at a similar height to the roofs of the premises facing Crown Street. The gap between the retaining wall and the roof was just over 0.5 metres. DS Passmore tested the galvanised ridge capping on the toilet block for blood and this returned a faint reaction, which he opined could have been indicative of Mr Rooney striking it as he fell. No blood was detected on the concrete block retaining wall.
17. He also identified a number of nails protruding from the front of the toilet block and found traces of blood on one of the nails, 1.35 metres from the ground. He indicated the entire area was very poorly lit.
18. DS Passmore also examined Mr Rooney's injuries in hospital and took photographs of same. He opined that Mr Rooney's injuries were not consistent with an assault victim. He noted curved marks on Mr Rooney's neck, possibly consistent with marks caused by fingernails. He noted Mr Rooney's nails were bitten down.
19. DS Passmore also examined Mr Rooney's body postmortem.

Statement of Detective Senior Constable John Tate

20. Detective Senior Constable Tate observed Mr Rooney in hospital and described his injuries. He also conducted inquiries relating to Mr Rooney's movements. He was of the opinion that Mr Rooney was under the influence of liquor and sustained his injuries as a result of falling.

Additional information

21. Information provided in the letter of instruction, but not present in the brief materials, indicate that Mr Rooney was reportedly found lying on the ground wedged between the toilet block and the wall. A large amount of blood was around Mr Rooney's face and head, and blood was coming from his mouth, nose and left ear. Mr Rooney was reportedly observed with his right leg which under the downpipe of the toilet.
22. Mr Rooney with described as wearing blue jeans and a blue coloured T shirt. His pants were partially lowered with the button and fly undone. He was unconscious and observed to be restless and disoriented.

Scene Photographs

23. A series of scene photographs of the location of the discovery of Mr Rooney's body have been provided. These are not labelled, and more than 10 photographs are provided (only 10 are described at inquest by DS Passmore), thus the orientation and relationships between these photographs is unclear to me. These black and white photographs demonstrate a carpark area bordered by a retaining wall. The car park is located adjacent to a tinned roofed structure (toilet block) bordered by a gate. There is a gap between the brick wall and the tin roof of the toilet block. Mr Rooney's body is indicated as being found on the ground between the brick wall and the wall of the toilet block. Of note, the gap between the brick wall and the tinned roof is not particularly large. Wooden beams with protruding nails form part of the wall of the toilet block. The ground appears concreted; a lump of concrete and ?Nazi paraphernalia are noted nearby.
24. Stairs are also pictured (location unclear to me) along with other parked cars along with photos of a roof line.

Autopsy photographs

(Note autopsy and clinical photographs are intermixed in the brief)

25. A series of black and white autopsy photographs demonstrate the following:
- a. Ill-defined area of presumed bruising and predominantly vertically oriented abrasion about the left antecubital fossa with possible bruising medial aspect of the left elbow.
 - b. Healing abrasion inner lower right knee.
 - c. Right frontoparietal scalp bruising associated with granular disruption of scalpular tissue (burr hole site).
 - d. Ill-defined parieto-occipital scalp bruising (note lower occipital scalp relatively spared).
 - e. Predominantly right sided frontal, parietal and occipital periosteal (skull) bruising; burr hole site right frontal bone tentatively identified.
 - f. Linear left occipitoparietal skull fracture extending into the left petrous temporal bone.
 - g. Right parietotemporal linear skull fracture bifurcating towards the squamous portion of the right petrous temporal bone.
 - h. Linear right occipital skull fracture, extending towards the foramen magnum.
 - i. Photographs of removed skull cap (differentiation between fracture lines and artefacts from sawing/removal unclear).
 - j. What appears to be a combination of subdural and subarachnoid haemorrhage about the brain.
 - k. Subarachnoid haemorrhage and likely underlying contusional injury inferior frontal and temporal lobes (contrecoup type injuries).
 - l. Subarachnoid haemorrhage and possible contusional injury, left cerebellar hemisphere (likely coup injury).
 - m. Clotted material adherent to the region of the tricuspid valve (this has appearances suggestive of post mortem blood clot and not thrombus).

Hospital photographs

26. Hospital photographs dated 14/2/86 demonstrate the following:
- a. Steri-Stripped wound base of the right thumb.
 - b. Abrasion lower inner right knee.

- c. Ill defined area of possible bruising and abrasion about the outer aspect of the right eye.
- d. Area of abrasion about the right nostril.
- e. Area of abrasion or similar lateral aspect of the right chest wall.
- f. Series of bruises about the lower right chest wall below the nipple, about the costal margin.
- g. Bruising and predominantly linearly oriented abrasions on the left antecubital fossa and medial left elbow.
- h. Abrasions and/or bruising, inner aspect right upper arm.
- i. Linear abrasion right side of the neck.
- j. Possible bruising on both sides of the neck.
- k. Possible bruising left side of the chin.
- l. Superficial laceration/abrasion within the hairline, slightly to the right of the midline.
- m. Ill-defined area of abrasion at the base of the back of the neck, slightly to the right of the midline, extending on to the upper back.
- n. Photograph of possible bruising (? Right hip), site unclear.

QUESTIONS AND REPONSES

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

Autopsy practice has evolved considerably since the time of Mr Rooney's death. However, for the purposes of case review, I make the following comments:

The autopsy examination, for the purposes of helping delineate the cause and manner of Mr Rooney's death, is deficient in the following:

- a. There is incomplete documentation of Mr Rooney's cutaneous injuries.
- b. The surface of Mr Rooney's scalp has been inadequately examined (when considering the causes of blunt head trauma, hair must be removed from the scalp to assess presence/absence and the features of cutaneous injury (e.g. bruising, abrasion or laceration).
- c. The subscalpular bruising evident in the autopsy photographs does not match the description in the autopsy report.

- d. Mr Rooney's skull fractures are difficult to interpret based on the autopsy photographs; their relationship to one another is unclear. It is also unclear if some of the fracture lines are incorporated into some of the post mortem saw lines in the cranial bone. The report of Mr Rooney's CT scan in hospital possibly indicates four skull fractures (two on the left, two on the right), the autopsy report suggests three. It is possible that the additional fracture on left side forms part of the "margin" from the post mortem removal of the skull cap.
- e. There is no indication that an examination to detect the presence or absence of facial injuries, including about the oral mucosa, has been performed.
- f. There is no comment around the presence or absence of anogenital injuries. It is unclear if Dr Versoza was provided with information regarding Mr Rooney being found with his trousers partially lowered.
- g. There is no validity to the assessment of the age of bruising identified on Mr Rooney's right chest wall (i.e., there is no evidence base to enable one to conclude that the chest bruises as described by Dr Versoza are of a different age from those related to Mr Rooney's fatal head injuries).
- h. Mr Rooney's intracranial haemorrhage is erroneously attributed to torn meningeal arteries. Meningeal arterial injury typically results in extradural haemorrhage, not the subdural and subarachnoid haemorrhage further described, and as is identified in autopsy photographs.
- i. The mural thrombus described about the tricuspid valve in the autopsy report, as seen in the autopsy photographs provided, has macroscopic features that suggest post mortem blood clot (i.e. post mortem artefact) rather than thrombus. This should not be included in the cause of death.
- j. Whilst toxicological analysis of blood sampled at autopsy would not have been of assistance, an attempt to analyse blood specimens taken when Mr Rooney was first admitted to hospital (14 January 1986) would have been beneficial in helping inform the circumstances surrounding Mr Rooney's head injury.
- k. Autopsy (and clinical photographs) are black and white, which limits interpretation of images.

It is recognised that injuries that were sustained on or around 14 February would have changed considerably over the subsequent days prior to Mr Rooney being declared deceased. Significant healing of Mr Rooney's cutaneous injuries has likely to have occurred during this period, thus subtle injuries to the skin, potentially informing mechanisms around Mr Rooney's head injury, may no longer have been apparent.

Q2. *The nature of Mr Rooney's injuries; without limiting the matters which you may consider relevant to this question, please outline your views regarding: (a) Whether Mr Rooney's injuries are consistent with an accidental fall from 3 metres; (b) Whether Mr Rooney's injuries are consistent with having been pushed off a 3-metre platform (i.e. was there a degree of force involved in a fall); (c) Whether Mr Rooney's injuries are consistent with having been hit by an object; (d) Whether you agree with the opinion of Dr Versoza that "battering of the head with hard instruments, whether wood or metal" usually splits open the skin with the fracturing of the skull.*

Due to inadequate documentation of injuries in the autopsy report, and the lack of a comprehensive forensic medical examination after Mr Rooney was admitted to hospital, addressing the mechanism by which Mr Rooney's sustained his injuries is difficult. However, it should be noted that:

- a. Skull fractures, in particular base of skull fractures, are well recognised to occur in the setting of low (<3 metres) fall¹. These types of fractures can occur in a setting of a fall from this height where an individual lands in an inverted or semi-inverted position.
- b. *If Mr Rooney's injuries were sustained in a 3-metre fall with a primary impact to his head, there is no material available to me to determine the fall was accidental or whether Mr Rooney was pushed. Data indicates that the type of fractures sustained by Mr Rooney could be sustained from a 3-metre fall; additional force from a push is not necessarily required to produce these head injuries.*
- c. I am unable to definitively exclude that Mr Rooney's injuries could not have been inflicted by an object. A 2015 review of discriminating factors in fatal blunt head trauma from low level falls and homicide demonstrated that whilst lacerations were more common in homicidal head trauma with skull fracture, they were still absent in 23% of cases².
- d. Whilst I agree with Dr Versoza blunt force trauma to the head applied with an implement resulting in skull fracture is more commonly associated with skin lacerations, that is not necessary the case, as Le Fevre's review indicates².

Q3. *To the extent that there are inconsistencies in the conclusions drawn by Dr Versoza and Dr Ramsey, whose conclusion should be preferred and why?*

My interpretation of the evidence given by Dr Versoza is that he considers injuries sustained in a fall to be the most likely the mechanism of injury, whereas Dr Ramsay appears to suggest that it is highly unlikely that such head injuries could be sustained in a fall as described. It is my view that doctors Versoza and Ramsey both express a level of certainty about the mechanism of Mr Rooney's injuries beyond that which supported by the contemporary evidence base.

Based on the limited evidence available for review, I favour Dr Versoza's interpretation because:

- a. The type of base of skull fractures observed and described are well recognised to occur from an inverted fall of less than 3 metres with primary impact around the top of the head.
- b. Mr Rooney does not demonstrate extensive cutaneous injuries to either the front or back of his body that may be seen as a result of an assault where multiple impacts are sustained.
- c. The linear abrasions in front of the left elbow (antecubital fossa) demonstrates directionality; it is possible that they may have occurred via contact with a protruding roof structure or wall nails in the scenario described.

However, I am not convinced that the post mortem examination conducted has been sufficient to exclude multiple scalp impacts, or subtle cutaneous or bony injuries, to allow any type of accurate event reconstruction. If Mr Rooney's injuries had been sustained in a fall, I cannot say how that fall may have come about (i.e., an accidental fall, or whether Mr Rooney was pushed between the retaining wall and toilet block roof). It is also noted that Mr Rooney has a relatively paucity of documented post cranial injuries given the relatively small space for him to fall into (gap approximately 50 cm) given his height (5 foot 11 inches/180 cm) in a headfirst fashion. The small abrasion on his neck is non-specific, but this could represent a fingernail abrasion. There is no indication as to when this may have been sustained.

On the evidence available, I am unable to exclude either mechanism. Examination of the literature demonstrates that Mr Rooney's injuries, as much as they have been documented, could have been sustained as a result of a fall from around 3 metres in height, with primary impact to the head, or could have be sustained via homicidal

means (i.e. blunt trauma to the head by an implement). I agree with the original coroner's determination that the mechanism of Mr Rooney's injuries is undetermined.

For the purposes of the commentary above, it is assumed that there are alternative access points to the site where Mr Rooney was located (for example, through an unlocked gate, or via the toilet block).

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

Review of Mr Rooney's medical imaging from his admission to Wollongong Hospital may provide additional medical data, however it is unlikely that this still exists. Careful analysis of the pattern of Mr Rooney's injuries might have been possible if documentation of his injuries was more thorough, however in the absence of a more accurate data set, further investigations are unlikely to be conclusive.

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

Based on the materials available for review, I am unable to determine the manner of Mr Rooney's death, i.e. I cannot discriminate between blunt trauma applied to the back of the head by an implement, a fall from a height with impact to the top of the head, or a push resulting in a fall from a height of around 3 metres with impact to the top of the head. Mr Rooney's cause of death is reasonably described as:

1(a) Blunt head injuries.

I am unable to determine the cause of the blunt head injuries with any degree of certainty.

References

1. Rowbotham S., Blau S. Skeletal fractures resulting from fatal falls: A review of the literature. *For Sci Int* 2016, 266: 582.e1-582.e15.
2. Le Fevre T., Alvarez J-C., de la Grandmaison GL. Discriminating factors in fatal blunt trauma from low level falls and homicide. *For Sci Med Pathol* 2015, 11:152-161.

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 within a thin black rectangular border.

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