VICTORIAN INSTITUTE OF FORENSIC MEDICINE

FORENSIC MEDICAL REPORT

Report prepared by David Ranson for the NSW Special Commission of Inquiry into LGBTIQ hate crimes

Report Requested by Enzo Camporeale (letter dated 26 July 2023)
Director, Legal Solicitor assisting the Inquiry.

Date report prepared: 2 August 2023.

Preamble

I, David Ranson of 65 Kavanagh St, Southbank, 3006 hereby state that:

My Full Name is David Leo RANSON and my Professional address is The Victorian Institute of Forensic Medicine, 65 Kavanagh St, Southbank, 3006 I am a duly qualified Medical Practitioner registered in Australia. I am a Forensic Pathologist and Head of the Forensic Services Division of the Victorian Institute of Forensic Medicine.

A brief outline of my further qualifications and experience are provided in attachment 1 at the end of this report.

Acknowledgment

I, Professor David Ranson, acknowledge that I have read the Expert Witness Code of Conduct in Schedule 7 to the Uniform Civil Procedure Rules 2005 (NSW) and agree to be bound by it.

Background

At the request of Enzo Camporeale, Director, Legal Solicitor Assisting the Inquiry I prepared a medical report based, in part on matters canvased during a conference I attended by video on 11 July 2023 in relation to historical autopsy practice and procedure in New South Wales. Elizabeth Blomfield and Hermione Nicholls also attended the video conference, and I was provided with a copy of the conference notes. The conference included reference to the investigation of the death of William “Bill” Rooney who died in New South Wales in February 1986.

Details of Request

The request for an expert report contained a series of questions to be addressed as follows:

> **“Matters to be addressed in your report.**
>
> I would be grateful if you could address the following matters in your report to the extent that they are matters which fall within your expertise:
>
> 1. Your professional and academic background including when you came to Australia and why;
> 2. Your observation of forensic pathology practice and procedure in Victoria when you arrived in Australia, including but not limited to:
>   a. who undertook post-mortem examinations including what professional background, qualifications and training they were required to have;
>   b. the relationship between the person who conducted the post-mortem examination and the police officers; and
>   c. what dictated how a post-mortem examination was conducted, including what specimens and swabs were taken.
> 3. Whether, when you arrived in Australia, forensic pathology practice and procedure in the United Kingdom was similar or different to your observations of what was occurring in Victoria (i.e., your answers to question 2);
> 4. Whether, when you arrived in Australia, forensic pathology practice and procedure in NSW was similar or different to your observations of what was occurring in Victoria (i.e., your answers to question 2);
> 5. Your observation of forensic pathology practice and procedure in NSW now, including but not limited to:
>   a. who undertakes post-mortem examinations including what professional background, qualifications and training they are required to have;
>   b. the relationship between the person who conducts post-mortem examinations and the police; and
>   c. what dictates how a post-mortem examination is conducted including what specimens and swabs are taken.”

Materials

In the preparation of this report, I have had access to the following materials:

Notes of the Conference held on 11 July 2023 (prepared by Elizabeth Blomfield)
Letter from Enzo Camporeale requesting a report dated 26 July 2023

Quotes from the documentation received are set out in italics with quotation marks.

General Comments

1. I was not involved in the death investigation of William "Bill" Rooney in 1986.
2. I have not undertaken primary death investigations for coroners in New South Wales during my time undertaking Coroners Death Investigation/forensic pathology practice in Australia. However, from time to time I have undertaken second opinion work and other expert opinions in relation to New South Wales coronial and criminal death investigations.

Discussion and Opinion

I have addressed the questions set out in the letter of instructions below. The overlapping nature and potential scope of the questions have required a more narrative approach to addressing the issues and I have attempted to facilitate access to the material by inserting a few subheadings. The numbered questions set out in the letter are quoted below and formatted in italics.

1. *Your professional and academic background including when you came to Australia and why;*

I have set out a brief curriculum vitae in the appendix to this report but in summary I trained in medicine at the University of Nottingham in the UK and in in law at the University of the West of England in Bristol.

My background

My postgraduate pathology training was undertaken at the City Hospital in Nottingham and at the main hospitals in Bristol including the Bristol Royal Infirmary, Southmead Hospital, Frenchay Hospital, the Bristol Royal Hospital for Children and Bristol University Department of Pathology where I was employed as a Lecturer (Honorary Registrar/Senior Registrar in histopathology).

In addition to completing my postgraduate training (obtaining my fellowship/membership of the Royal College of Pathologists) as a histopathologist I also undertook training in forensic

pathology obtaining the Diploma in Medical Jurisprudence in Forensic pathology and undertook death investigations (autopsies) for the local coroners in the Bristol area as well as part time work as a 'Police Surgeon' (Clinical Forensic Medicine) for Avon and Sommerset Constabulary. In addition to general coronial death investigations, by the time I came to leave Bristol in early 1988 I was undertaking death investigations in criminal cases as a forensic pathologist.

I was made generally aware of the history of forensic medicine practices in Australia from a number of forensic pathologists and clinical forensic medical staff from Australia that I met at scientific/medical meetings in the UK and internationally prior to my moving to Australia. These included meeting run by the then Association of Police Surgeons and the international Academy of Forensic Sciences.

During my postgraduate pathology studies and coronial casework in the UK I had occasion to meet Professor Stephen Cordner who had been appointed to the position of Director of the new Forensic Pathology service in Melbourne in the late 1980's (then the 'Victorian Institute of Forensic Pathology' established by the Victorian 'Coroners Act (1985)) I had planned to undertake further experience and study abroad and in 1987 Professor Cordner offered me a position as a Senior Pathologist at the new Institute which I took up.

2. *Your observation of forensic pathology practice and procedure in Victoria when you arrived in Australia, including but not limited to:*
   a. *who undertook post-mortem examinations including what professional background, qualifications and training they were required to have;*

The modernisation of Forensic Pathology

The 1980's were a time of reform and reorganisation of Forensic Pathology practices in many jurisdictions.

In the UK The Wasserman review and report[1] came at a time when Universities in the UK were divesting themselves of Departments of Forensic pathology which reduced the available direct employments opportunities for pathologists. As a result, the prior strong academic relationship to forensic pathology service provision was replaced by a private practitioner arrangement together with linkage to NHS pathology providers.

In Australia Sir John Norris undertook a review of the Coroners Act *Vic.* (1958) which recommended the establishment of a forensic medical institute and bemoaned the parlous state of the existing State services. This review led to the Coroners Act (1985) including the establishment of the Victorian Institute of Forensic Pathology (VIFP) now the Victorian Institute of Forensic Medicine (VIFM) as an independent statutory authority. The Institute

[1] Wasserman, G. J. (1989). Report of the Working Party on Forensic Pathology. United Kingdom: H.M. Stationery Office. (While some of the structure this review put into place is still present in other respects the modern movement towards more stringent long-term training and experience was not well anticipated in the report and indeed the current structure in the UK while reigning in potential costs has been identified as having quality and capacity issues.)

commenced its preliminary administrative and embryonic operational activities in the late 1980s and gradually became operationally self-sufficient with the completion of the building of the new premises (which included the Coroners' Court) in Kavanagh Street and the Institute moved into the new building during the middle of 1988. The Institute rapidly grew with the employment of a new generation of full-time forensic pathologists with postgraduate training and specialist qualifications in Pathology and/or forensic pathology.

I arrived at the Institute in February 1988 and worked initially in the old city mortuary before helping to set up and establish the new operating forensic pathology system in Victoria in the then VIFP's new premises. This time involved a transition away from the old model of a single state forensic pathologist with hospital pathologists and private clinical pathologist providing the coroners medical death investigations that were for the most part limited to the performance of full autopsies.

Prior to the establishment of the institute (VIFP/VIFM) and the employment by the Institute of a Director and pathologists who had received specialist postgraduate training in forensic pathology, many of the pathologists engaged by the State to carry out autopsy examinations for the coroner and police were not formally trained in forensic pathology. Indeed, it is my belief that the sole State employed forensic pathologist in Victoria, prior to the Institute managing these services, had not received any long term formal accredited postgraduate training in pathology or forensic pathology at all. The other sessional or fee-for-service pathologists from the hospital and laboratory pathology services in Victoria who undertook forensic and coronial pathology work for the Coroner and police were trained and experienced pathologists with a variable range of experience in criminal type forensic death investigations.

Training

It is noteworthy, in relation to this current inquiry, that in the years just before the establishment of the Institute in Melbourne general practitioners and other non-pathology medical specialists in Victoria were NOT engaged to carry out coronial autopsies much less those death investigations that were considered to be 'suspicious deaths' that might have occurred in criminally related circumstances. From what I was told by my interstate colleagues at meetings of the Royal College of Pathologists of Australasia this was not the situation in some other Australian States where Government Medical Officers often undertook such death investigations for the Coroner as well as a range of other State required clinical medical tasks. It was apparent to me from these conversations that some of these practitioners were from general clinical disciplines and had not undertaken/completed full postgraduate accredited training programs in pathology or undertaken further sub-specialist postgraduate training in forensic pathology.[2]

The 1985 Coroners Act in Victoria expressly required that autopsies be undertaken by "pathologists" or doctors working under the supervision of pathologists. (This referred to the situation where trainee pathologists undertaking postgraduate specialist training to become

[2] https://www.health.nsw.gov.au/about/history/Publications/history-medical-admin.pdf Appendix 7, pg. 170 and 171)

pathologists could perform autopsies under direct supervision of the Institute's pathology specialists.)

As to what the definition of a pathologist was, the legislation defined a pathologist for the purpose of the Act as being a doctor who had obtained the Fellowship of the Royal College of Pathologists of Australasia or an equivalent postgraduate qualification. All of the new pathology specialists employed by the institute from late 1987 had such qualifications. Indeed, the inclusion of a representative of the Royal College of Pathologists of Australasia in the governance arrangements of the Institute was set out in the enabling legislation with the requirement that one of the persons appointed to the Institutes governing council needed to be a Fellow of the College.

In common with the Royal College of Pathologists of the UK, the postgraduate training curricula and requirements of the Royal College of Pathologists of Australasia did not originally include forensic pathology as an independent pathology discipline.[3] However, it was possible to request examination/assessment in Anatomical Pathology with a slant towards forensic pathology practice and this combined examination system continued for several years. With the establishment of the Institute Professor Cordner (it's Director) petitioned the College to establish a Diploma of Forensic pathology to permit Anatomical pathologists to gain a further add-on qualification in this field. Around the same time the College developed Forensic Pathology as an independent pathology discipline on the same level of academic and experience as any of the existing clinical pathology disciplines.

Scope and standards of practice

In my experience of reviewing many Autopsy (Post-Mortem) reports from the 1970's and early 1980's it became clear to me that the scope and extent of the documented autopsy examination processes were far less than I would consider appropriate when I commenced forensic pathology practice in 1988 in Victoria. It is of course possible that the limited scope of these earlier autopsy reports reflected limitations in documentation rather than limitations in the examinations, but this is hard to verify except in the case of a few pathologists who, while producing limited reports also kept extensive personal notes and diagrams that were often of more use in coming to an understanding of their observations than the final reports they issued.

In addition to these pathology practice issues on my arrival in Australia I observed that there were differences in aspects of police investigative practices into some deaths particularly those which might involve criminal activity or responsibility. The increasing focus on forensic science technology, evidence/intelligence based investigative processes and evidence management systems that had started to be a feature of UK death investigations in the 1980's did not seem to be in place to the same degree in Australia, including Victoria where I was working. In part, this was typified by an attitude that all

[3] The major disciplines of pathology that the Royal colleges had curricula for and set examinations in were: Histopathology (Anatomical Pathology), Microbiology, Haematology and Chemical Pathology. Today this has become expanded and now includes Forensic Pathology, Immunopathology and Genetic Pathology with other subdisciplines and linked faculties being created to address the more sophisticate training needs of the medical workforce.

persons taking part in such death investigations were working for the police and their work scope and standards were at the direction of police. This was a 'state of affairs' that would not be tolerated today but is perhaps understandable given that in many Australian jurisdictions the resources needed for modern forensic pathology practices were not in place and indeed in some jurisdictions the doctors undertaking this work were not accredited pathologists. A corollary of this however, was that there was an investigatory power imbalance between police investigators and the non-police based technical forensic medical service providers.

Coroners

A similar situation existed with respect to Coroners and in many ways, it was the introduction of the State Coroner role in Victoria which created the opportunity for change. By the late 1980's the vast majority of Coroners in Victoria were magistrates and while regional magistrates could act as Coroners, for the most part, suspicious deaths were actively investigated by the full time specialist Coroners at the permanent Coroners' Court in Melbourne.[4] As a result Coroners took a far more active part in the death investigation process[5] and this provided the forensic pathology service with a greater freedom of practice in particular one that was less influenced by police perspectives.

b. the relationship between the person who conducted the post-mortem examination and the police officers; and

Police

The relationship between police and pathologists undertaking autopsies for the coroner and the criminal justice system has long been a complex one with different jurisdictions resolving the operational issues in different ways. In some jurisdictions police would directly engage the doctor whom they wish to undertake this work, with the coroner making the necessary legal orders but playing little part in the choice of doctor/pathologist.

In other jurisdictions of which Victoria is an example, police play little part in the organisation of the forensic pathology service and have no control as to the choice or qualifications of the pathologist undertaking the medical legal death investigation. Instead, the VIFM, as a government Statutory Authority within the Justice (rather than the health) portfolio, was treated more like a court from a government administrative perspective than a medical or forensic science service organisation. While police are represented on the

[4] Note that today the Coroners Act 2008 (Vic) established the Coroners Court as an independent Court in its own right with no administrative or jurisdictional link with the Magistrates' Court. Even before this legislation the coronial management of death investigations had been centralised to Melbourne and managed by full time Coroners. In addition, non-metropolitan magistrates no longer had any involvement in Coronial work and the full time coroners and judicial investigators played an active part in investigations instructing police as to the avenues of enquiry they wished to have followed.

[5] Coroners are 'on-call' and routinely attend problematic death scenes. They expect to be briefed in real time by police investigators as to the progress and scope of investigations and can and do direct police in regard to certain aspects of an investigation that they believe are pertinent to their judicial investigation and inquest process.

council of the Institute, they are but 1 of approximately 15 Council members and the State Coroner (now a County Court Judge) rather than police has the greatest engagement with the Institute's executive management in agreeing exactly how the forensic pathology service operates.

While these formal governance arrangements are critical in underpinning the day-to-day operations of a forensic medical service, they are also important in setting the culture as to the relationship that develops between the medical professionals, the police/key emergency services and related justice agencies and the courts. It is clear to me that the increased professionalisation of Forensic Pathology created by the establishment of a state-wide independent Statutory Authority within the Ministry of Justice allowed forensic pathologists to be increasingly independent of police with regards to the way in which they undertook their professional forensic medical work.

In jurisdictions without this independence of approach and/or an employment structure that was fee-for-service based, allowed closer working relationships and fiscal links to develop over the years between police administrative and operational command within police operational regions with their local regional medical practitioner that undertook all the autopsy work in coronial or criminal matters. At a local level this would include the development of personal professional relationships between police investigators and local government medical officers or forensic pathologists.

In addition, the generally unpopular nature of forensic medical work made recruitment of sufficient general medical practitioners (let alone pathology specialists) problematic, and this resulted in relatively small numbers of doctors working in professional forensic medical isolation in some regions often for very many years.

The absence of peer review, quality assurance standards and systematic case quality review is often a feature of solo forensic medical work performed in settings of professional and geographical isolation and has the potential to lead to idiosyncratic practice, cultural acceptance of lesser standards, reduced scope of examination and medical opinions at odds with changes in the evidence/knowledge base for expert opinions including those brought about by emerging new knowledge.

c. what dictated how a post-mortem examination was conducted, including what specimens and swabs were taken.

Autopsies

It is difficult to give any precision in attempting to address this question of past practice since the answer is likely to be based on the particular training and/or experience of both the medical practitioners and police officers engaged in the investigation.

Given that in the 1970's and much of the 1980's there was little acceptance by the Royal College of Pathologists of Australasia and other royal colleges of the independent discipline of forensic medicine/pathology, the production of consensus standards of forensic practice and practice guidelines centred on a scientifically rigorous evidence base

that is so common today, was limited or non-existent. The main information available to doctors who engaged in forensic pathology practice would have come from the major 'classic' forensic medical textbooks as well as articles in the relatively few forensic medical journals at that time.

The more limited the forensic medical and legal knowledge base and/or experience of the pathologist undertaking a forensic autopsy the greater the risk that they are influenced by the opinion and expectations of the investigating police when it comes to the scope and depth of the examination of the body of a deceased. An experienced and speciality forensic pathologist is more circumspect in the way they evaluate the information police provide them and while they do not ignore the information they are provided with, they do not necessarily automatically accord it a high level of accuracy or reliability. This is not to say that Police deliberately mislead pathologists, rather it is an acknowledgment that any investigation involves an emerging/developing and growing iterative knowledge base that changes with time. The tasks undertaken by the medical pathology team occur largely at one relatively short block of time during the overall death investigation and often at a time when the understanding of the circumstance may be uncertain and indeed dynamically changing.

Today *'contextual bias'* is recognised as a major risk to investigations in forensic medicine and science as well as policing. The steps that could be taken to mitigate its influence in forensic pathology investigations are demanding and require a team approach to facilitate processes such as 'sequential unmasking' of circumstantial information, rigid application of common examination standards and operator blinding to other test results. These approaches are almost impossible to apply to services provided by doctors working in isolation as sole practitioners.

Forensic Science

The role of the forensic science laboratories is also important. Forensic Science services are sometimes based within the Police organisations and or other government scientific or health agencies. Their organisational and/or professional linkage to regional forensic doctors undertaking occasional autopsies for coroners and the police outside of their busy routine clinical medical work are likely to have been variable at best and probably limited. In major centres the scope for regular engagement between the specialist forensic medical practitioners and the forensic scientific staff would have been far easier to establish however, in remote areas without local forensic scientific staff this opportunity for cross fertilisation of forensic knowledge and practice improvements would have been far more difficult to achieve. In addition, operational communication between regional forensic medical staff and central state forensic scientific staff may have relied on the local police channels. (e.g. to inform the medical practitioners about changing State laboratory policies or requirements for test samples in particular case/investigation types.)

The centralisation of both forensic pathology and forensic science laboratory services in Victoria has meant that the two services, although under different governance arrangements, have been able to develop the necessary professional discipline collaborations and mutual operational arrangement to ensure effective linked up services

without the need for investigative police divisions acting as a go between which has the risk that it might modulate the information flow.

The scientific evidence base underpinning forensic practice, sampling procedures, testing and analytical procedures and the eventual expert opinions is always changing and needs to be continually challenged by the practitioners themselves as well as tested by the processes involved in adversarial trial. Professionally isolated (including solo) practice, provides limited scope for peer to peer learning or continuing professional development and limited regional casework numbers affects the scope and currency of practice of the medical practitioners concerned. Such factors represent serious impediments to the ongoing support of safe and up to date evidenced based forensic pathology/medical practice. Improved video conferencing and communication modalities can assist with some of these factors today but the establishment of a fully connected, peer reviewed, quality assured forensic medical service team remains one of the major safeguards to idiosyncratic, out-of-date practices and erroneous expert opinions.

3. *Whether, when you arrived in Australia, forensic pathology practice and procedure in the United Kingdom was similar or different to your observations of what was occurring in Victoria (i.e., your answers to question 2);*

Procedures and Standards

The appointment of Professor Cordner, as the first Director of the Institute and myself (later the Head of Forensic Pathology and Deputy Director) both of whom had trained extensively in the UK represented a significant new direction to forensic pathology practice in Victoria in the 1990's and later across other Australian jurisdictions. During the 1980's in the UK the policing approach to major crimes had become increasingly sophisticated and regulated with a far more rigorous approach to forensic scientific and administrative procedures for the management of investigations and collection of forensic evidence. These developments were less evident when I first started in forensic pathology in Victoria in 1988 but there was an active appetite for change among many agencies lead in part by the new State Coroner Hal Hallenstein who almost routinely attended suspicious death scenes and supported clear protocols for greater reliance on both the scientific and legal investigation processes.[6] With this support the Institute (VIFM) was able to actively develop a more rigorous and standardised approach to autopsies and forensic sampling in conjunction with the forensic scientists at the Victoria Police laboratory and within a few years these processes had radically changed the approach to autopsies across Victoria including more extensive photographic documentation of medical findings and forensic sampling during post-mortem investigations.

[6] https://www.gettyimages.com.au/detail/video/state-coroner-hal-hallenstein-walks-around-at-queen-news-footage/700578868

This increase in forensic standards was strongly developed by the Institute. For example, while in the past there might have been 10 to 20 or so photographs of a forensic autopsy and its findings with the image views determined by what the police photographer believed the court would be prepared to admit as an exhibit, the Institute's new pathologists would insist on perhaps 100 or more images based on recording all of the external and internal findings regardless as to whether a court might find them prejudicial rather than probative. The aim of this approach was to attempt to record as much imaged based material as possible (regardless of its likely admissibility) to allow those reviewing a case to have access to a level information as close as possible to that of the original examining pathologist.

Another example can be seen in the way the Institute's pathologists reviewed the forensic medical literature and created sets of minimum standards for a range of autopsy types. These standards were then integrated into the quality review process so that autopsy reports were reviewed against the agreed standards and any identified deficit communicated to and actively discussed by the forensic pathology team as a peer based learning exercise.

4. *Whether, when you arrived in Australia, forensic pathology practice and procedure in NSW was similar or different to your observations of what was occurring in Victoria (i.e., your answers to question 2);*

Perhaps the main difference in NSW (particularly its regional services) from Victoria was a combination of the effects of both geography and personnel, two linked factors that both influenced the degree of expertise and facilities available to be brought to bear on the forensic medical investigation of deaths.

While Victoria, before its reforms, had still relied predominantly on trained pathologists for coronial and forensic autopsy services throughout the State, NSW, outside the larger centres, relied on Government Medicals Officers (GMOs) many of whom were not trained pathologists.

Prior to arriving in Australia (1988) I had had the opportunity to discuss the death investigation (autopsy) role of some GMOs in NSW with a few of the practitioners involved and I also spoke with clinical forensic medical staff in Victoria who were employed by Victoria Police and who did not undertake any such autopsy work. I continued to discuss these service issues with these practitioners following my arrival in Australia as we had the opportunity to meet at the various forensic science and medical meetings that occurred each year.

Then and today, it is my view that small regional mortuaries, even when based in hospitals are unable to offer the same level of facilities that the larger and better resourced centralised modern specialist forensic medical centres are able provide. Maintaining many mortuaries over a large geographical area, particularly in the larger States and Territories, is expensive and administratively onerous if the service is required to ensure that health and safety and forensic contamination concerns are met as well as be able to provide the

emerging new formal investigative/legal/forensic requirements essential to support the criminal justice process.

In my view the trained forensic pathologists in Sydney and some of their forensically experience clinical pathology colleagues in major regional hospitals would have been better placed to undertake the more complex potentially criminal related death investigations than the less pathology experienced GMOs. Those GMOs who did undertake such autopsy work would have varied as to their level of expertise and training and this would have been relevant to the exercise of their judgement and the opinion of the police with whom they usually worked as to whether the case before them in their region would be better managed if transferred away to the more comprehensively equipped central forensic facilities staffed by appropriately trained specialist forensic pathologists.

It is a feature of forensic medical death investigation that predicting the level of complexity and skill that a case requires, in advance, is often problematic and the choices or decisions regarding this can become self-fulfilling. While telephone calls could have been made to provide support and guidance by experienced pathologists to their less experienced GMO colleagues, I am not sure how often this took place or to what degree the formal quality processes of case review and audit with educative feed back to the medical practitioners involved were undertaken.[7]

In part these factors are common to all forensic medical services and specialist police investigations both with regard to the personnel chosen to deal with different case types and the resources and facilities that can be brought to bear on the investigation. Predicting investigative needs in advance can be straightforward under the principle that “common situations occur most commonly”! However, as an investigation proceeds, identification of emerging critical and problematic issues becomes a matter that needs an agile and flexible operational service to be able to change track and vary the scope of the investigation. This requires adequate service resourcing and capability as well as considerable capacity for case review/audit and the related education/training needs that this identifies.

The linking of forensic medical services in NSW to health care services also changes its relationship to police investigation services and the needs of the courts and broader justice systems. It has the potential to disconnect justice policy from forensic medical service provision and the placing of forensic medical services within justice was one of the key benefits of the Victorian system that developed during the 1990’s. Moving all coronial autopsies out of hospital and health services and into a dedicated Justice agency in Victoria over the last 30 years has allowed forensic medical agencies to focus on delivering the policy and operational requirements of the justice system and government Attorneys General rather than having to submit to the operational and financial health policy requirements needed to deliver health services to the community.

At an operational level close working relationships between police and forensic medical investigators are inevitable during casework. However, a degree of professional

[7] Of course, today modern video communication has transformed the opportunity to engage in video consultation in both legal (advice and hearings), policing and medical service settings.

independence is essential (indeed forensic medical teams often find themselves helping coroners investigate police) and this needs to be reinforced by independent governance and organisational arrangements.

5. *Your observation of forensic pathology practice and procedure in NSW now, including but not limited to:*

    a. *who undertakes post-mortem examinations including what professional background, qualifications and training they are required to have;*

The forensic pathology system in NSW has been transformed with vast improvements in the last decade or so. While this has been of considerable community and government service benefit it has taken a surprising amount of time to come to fruition.

In the 1990's and early 2000's the VIFM received/hosted several visiting planning teams from NSW who were looking at the Victorian approach. Unfortunately, these did not result in any real substantial changes in the structure, plant and facilities of the service in the short term and would take another decade or so for sufficient investment in the medical death investigation system available to Coroners in NSW to permit the required level of change that had been long sought by their forensic practitioners and their clients. From my experience this legacy of inaction resulted in a self-fulfilling difficulty in achieving change particularly in recruiting Doctors with the necessary postgraduate training and experience to deliver the new services that were needed.

Today NSW full time forensic pathologists have the appropriate specialist postgraduate qualifications and experience (and technical resources) to undertake sophisticated forensic medical death investigations. In order to bring forensic pathology staffing levels up to acceptable numbers the NSW service has needed to invest in recruiting some staff from overseas. This has been a requirement of many forensic pathology services in Australia and New Zealand and has been necessary since there remains a worldwide shortage of forensic pathologists and many forensic pathology services have had great difficulty in sourcing locally trained candidates. In this environment achieving satisfactory recruitment of appropriately trained personnel has not just been an issue of fiscal remuneration and employment contract benefits but has also been related to the deferred benefits of a heathy organisational culture and high professional standing of the employing organisation as well as opportunities for research for some individuals and other professional benefits including laboratory resources that might encourage appropriately trained individuals to actively seek employment with the organisation. In addition, there is an operational need for forensic pathology service organisations to contribute to the postgraduate training of these specialists in order to ensure long term continuity of their service. This is not just a parochial or local based activity, supporting international training of forensic pathologists has both indirect and direct benefits in improving the overall availability of such specialists and can greatly assist with local service staffing in the long term. In my opinion investment in postgraduate training of forensic pathologists is an essential aspect of the operation of

forensic pathology services, albeit one that may take over 10 years for the real benefits to the service to be realised.

The several major centres in NSW now deliver very high quality forensic pathology services. They are well equipped and have operational systems that actively support quality assurance, audit and the sort of commitment to professional development that the Royal College of Pathologists of Australasia and the NSW criminal justice system requires. I am not familiar with the details of the current forensic autopsy service across NSW but as a NATA assessor I have had occasion to visit a regional NSW health care facility that did undertake some of the more 'routine' (non-criminal) coroner's autopsies that are ordered. The general (non-forensic) pathologists undertaking this work in addition to their health care work for patients were certainly committed to performing this type of medicolegal forensic work to the very best of their ability. However, their capacity to do is often limited by their professional and geographical isolation from the State's full time forensic pathologists and the competing needs of their clinical medical pathology work for their hospital.

This model where non-forensic pathologists undertaking a large proportion of the non-forensic coronial autopsies and specialist forensic pathologists undertake potential criminal related death investigation is in some ways similar to that found in New Zealand and the UK where hospital non forensic clinical pathologists undertake a significant proportion of the non-suspicious, non-criminal medical death investigation work for the coroner. In both these overseas jurisdictions concerns have been raised about service quality although often for different reasons based on their organisational arrangements.

The situation in Victoria is administratively easier with only forensic pathologists carrying out all the types of medicolegal death investigation work for the coroner resulting in a more uniform approach to the depth and scope of examination. This situation is supported by the fact that all Victorian Coroners undertake their work in the same building/facility (65 Kavanagh Street, Southbank) as all the State's forensic pathologists.

There is another factor to consider in relation to forensic pathology service delivery and the operations of the coroners jurisdiction in which they work and that relates to the wider purpose of a medico-legal death investigation. In the Victorian Coroners Act (2008) the preamble and purposes make it clear that there is a strong public health and safety requirement for the death investigation service.[8] In addition, S8 addresses some of the factors that any 'person' exercising a function under the act is to have regard to. Cultural

[8] **Preamble**

The coronial system of Victoria plays an important role in Victorian society. That role involves the independent investigation of deaths and fires for the purpose of finding the causes of those deaths and fires and to contribute to the reduction of the number of preventable deaths and fires and the promotion of public health and safety and the administration of justice.

This role will be enhanced by creating a Coroners Court and setting out the role of the Coroners Court and the coronial system and the procedures for coronial investigations.

and family factors have a large part to play in this section[9] and it would seem that these factors apply to coroners, forensic pathologists and police alike.

b. the relationship between the person who conducts post-mortem examinations and the police; and

As mentioned above the situation in NSW now is very different from the position several decades ago. The recent greater employment of experienced and trained forensic pathologists in NSW has resulted in a highly skilled and more independent service able to establish clear forensic medical protocols and quality systems to support a modern forensic pathology service.

Forensic pathologists in Australia are not directly employed by police agencies and today have a far greater operational linkage with coroners than with police on a day-to-day basis.

It is certainly the case that in some Australian jurisdictions as well as New Zealand and the UK, the police have a more integrated role in the administration of the coroner's death investigation process particularly with respect to ordinary coroners' cases and of course play a very significant operational role in the investigation of deaths involving criminal conduct. In contrast in Victoria police involvement in routine coroners' cases in Victoria has continued to decrease with today police having a far more limited role in the initial administrative aspects of the coroners' medico-legal death investigation.

Importantly the linkage between forensic pathologists and police today is far more of a mutual team-based approach to investigation than having all aspects of the operation being necessarily police led. This scenario of an evenly balanced multidisciplinary approach to death investigations would not have been nearly as strong a feature of investigations several decades ago particularly in regions where the doctor undertaking the autopsy was not a trained forensic specialist and may have relied on police investigators to lead on the scope and extent of many of the forensic medical aspects of the autopsy.

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[9] **8 Factors to consider for the purposes of this Act**
When exercising a function under this Act, a person should have regard, as far as possible in the circumstances, to the following—
(a) that the death of a family member, friend or community member is distressing and distressed persons may require referral for professional support or other support;
(b) that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death;
(c) that different cultures have different beliefs and practices surrounding death that should, where appropriate, be respected;
(d) that family members affected by a death being investigated should, where appropriate, be kept informed of the particulars and progress of the investigation;
(e) that there is a need to balance the public interest in protecting a living or deceased person's personal or health information with the public interest in the legitimate use of that information;
(f) the desirability of promoting public health and safety and the administration of justice.

c. *what dictates how a post-mortem examination is conducted including what specimens and swabs are taken.*

Today the training resources and professional documentation available to forensic pathologists that address the acceptable standards for autopsy practice are well developed and widely available. Some are found in the guidelines produced by the various professional organisations of forensic pathologists including the professional training and accreditation type organisations such as the medical Royal Colleges. Regardless of the quality of such documentation it can only set general guidelines for routine case work as well as some of the more commonly seen special investigation types such as drownings, fire deaths, firearm related deaths etc.

It will always be the situation that individual cases will sometimes involve scenarios for which no clear guidelines have yet been produced. Here it is the experience and training of the practitioner that permits them to apply the principles illustrated in standard guidelines with a risk management approach that enables them to best tailor them for the particular case scenario they face. In many ways this risk analysis approach is exactly what is expected of a medical consultant specialist (and indeed is similar to the analytical processes and risk management choices expected of a senior lawyer or police investigators).

Where formal guidelines have gaps it is team-based consultation with colleagues and co-investigators that provides important safeguards for an investigation. At the VIFM the body of any deceased person subject to a medico-legal death investigation is not released back to the family until the case has been presented to, and discussed with, other forensic pathologists (initial peer review) and this process includes a specific consideration by the team as to the need for any additional examination/testing or specimen sampling. Where the death involves criminal conduct considerations this consultation can include Police and other forensic scientific specialists.

The autopsy report prepared in relation to Mr Rooney's death

In relation to compiling this report I was subsequently asked to consider and express a view as to the adequacy of the post-mortem undertaken in relation to Mr. Rooney''s death and the report produced by Dr Vincent Verzosa the Government Medical Officer who performed the post mortem examination of Mr Rooney. I was asked to consider 3 other questions[10] the first two of these I have endeavoured to include in the above material and the following relates to the 3rd additional question.[11]

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[10] The two additional questions dealt with above were:

1. provide further background to explain how you became aware of NSW autopsy practices (for example, attending seminars);
2. provide information regarding your understanding of NSW autopsy practices (in relation to both post-mortem examinations and reports) in 1986, including:
    a. any information regarding the role of autopsy examination (noting that the circumstances of death are a critical feature of any finding as to manner and cause of death); and
    b. your understanding of clinical consultation as at 1986.

"3. ......the adequacy of the post-mortem undertaken and the report itself."

It is my understanding that a detailed pathological analysis/review of Dr Verzosa's findings as to fact and the opinion he provided with regard to the accuracy of his findings and the appropriateness of his deductions has already been undertaken and presented to the inquiry. Given this I shall focus my review on matters relating to the adequacy of the examination itself and the adequacy of the report produced given the circumstances and the context in which the death occurred. These two perspectives are not mutually exclusive and there will perforce be areas of overlap. In addition, it needs to be remembered that this autopsy was undertaken after William Rooney had been in hospital from the 14th to the 20th of February 1986 and it is my opinion that the injuries he originally received would have been modified/changed as a result of the body's normal healing processes by the time he died and the autopsy findings described in the report need to be read with this in mind.

The purpose of a forensic autopsy as part of a medicolegal death investigation is often considered to be limited to a determination of 'Cause of Death'. In my view this is incorrect. There are many potential purposes to an autopsy but in regards to this matter, one critical purpose is to record the findings as to fact in such detail and in such manner that another pathologist reviewing the material would be able to be put in a position as close as possible to the original examiner and in any event the reviewer would be able to properly understand the evidence base used by the original examiner to arrive at their conclusions. In other words, the report ought to be technically, medically and scientifically *'reviewable'*.

The following points are a list of some of my opinions regarding features of the report that may be useful to consider.

- The limited nature of the report includes it being approximately only some 300-400 words which is, in my opinion, inadequate considering the circumstances involved in this death, as reported to me. The limited nature also includes the scope and depth of the report and the range of information found in its contents.
- The above limitation cannot necessarily be used to indicate/conclude that the extent of the autopsy was limited to just those areas commented on in the text since other areas of the body may have been examined but the findings not referenced in the report, and this could include potential negative findings.
- The report lacks any significant analysis of the factual findings with respect to forensic injury interpretation or incident reconstruction apart from a rider to part 1(c) of the cause of death statement. The evidential reasoning that leads to this conclusion is not clearly set out even though it may well be correct. While a Forensic Pathologist may be expected to draw inferences from a number of these recorded observations/findings it is unlikely that a non-medical person would

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[11] The third question addressed bellow was:
3. review the autopsy report prepared in relation to Mr Rooney's death and express a view as to the adequacy of the post-mortem undertaken and the report itself.

necessarily be able to draw forensically significant conclusions from the report in this format. It is of course possible that such opinions (e.g. as to causation) might be sought subsequently from the report's author (in a supplementary report or in oral testimony) or another medical practitioner such as a forensic pathologist.

- The autopsy template (form) used is generally of an antiquated style, with several features that are problematic, including, for example, the section regarding the opinion on time of death. Prescribing the format for such reports in this manner, while of assistance where the persons completing them needs guidance, are problematic when used by trained persons since it can act to limit their information provision rather than enhance it. This is not to devalue case type guidelines and standards documents which are of considerable assistance in ensuring the quality of autopsy examination and reporting.
- Handwritten reports are often difficult to evaluate (intelligibility, limited narrative detail etc.), and yet these were quite common around this time. Handwritten reports may be a function of a requirement to provide an 'immediate' report and this is in itself problematic since if this was the purpose then the opportunity for the medical examiner to consider the nature of any expert opinions or conclusions they might consider necessary to communicate would be seriously time limited. Of course it is certainly possible that a medical examiner might limit their report to a didactic statement focusing on objective facts particularly it they believed that the report might be considered by another who would be providing an expert opinion as to the observed facts recorded.
- The nature of the underlining of words in the report is interesting and appears to be a form of summary of key findings or points of significance, embedded within the body of the report.
- While external injuries are described, only a few appear to have any measurement associated with it, and this makes interpretation of the report in regard to the circumstances in which the injuries occurred particularly difficult. The use of imperial measurement rather than metric is also antiquated even for this time.
- Textual descriptions of skull, fractures are particularly problematic when it comes to understanding the extent of injuries. Diagrams and photographs are essential adjuncts to textual description of such injury types and if present should be referenced in reports.
- While there are a few observations of significant specific negatives other areas of the body are referenced only in general or are not specifically commented on.
- Identification of observations that may relate to Mr. Rooney's period of treatment in hospital are limited to the neurosurgery related procedure of pressure monitoring and little comment is made regarding other medical management features or on the effect of healing on injury appearances.

- It is probable that there are some inaccuracies (for instance inconsistencies with the CT scan regarding type of intracerebral haemorrhage (Subarachnoid vs subdural) and cardiac thrombus) However, while limited in the descriptions and in the declared scope, the key findings of importance have been noted and considered and in my view the report is, while certainly not ideal, representative of some autopsy reports prepared by non-pathologists of the time. Indeed the report is of the type and content that coroners and police from those regions might consider 'normal' and not worthy of being questioned or expanded on for investigative purposes.
- There may be many reasons for the lack of any clear description or evidence of examination of genital or anal regions in the report or for the lack of reference to forensic samples (swabs etc.) from the body. Since the report does not disclose the nature or existence of the prior medical/social/circumstantial information available to Dr Verzosa we are not aware of what he knew or did not know by reference to his report alone. In addition, the prior substantial period of hospitalisation may have been taken into consideration as to the value (or lack of) of the collection of certain forensic swabs at the autopsy of Mr. Rooney. That said, if in doubt it is always important in any forensic examination to speculatively collect potentially forensically significant samples even if the information yield is likely to be low or non-existent and this is even more relevant when the case may involve an unknown alleged perpetrator.
- In relation to the above, any discussion between police investigators and Dr Verzosa as to the investigation type and scope required at autopsy may well have been influential in the subsequent selection of examination procedures and specimen collection to be performed. Doctors rarely work in an information vacuum and medical history/background is an essential part of the planning of the medical examination to be undertaken. However, where circumstances are uncertain or in doubt a prudent forensic pathologist will 'over-collect' material that might potentially be forensic value.

It does not seem to me that the Autopsy report of Dr Verzosa as part of the investigation of Mr. Rooney's death is particularly unusual for the time. However, when viewed in retrospect it is deficient and unhelpful in a number of areas and these defects themselves interfere with the ability to adequately review the medical and sociolegal aspects of the death investigation.

The reliance of the State of New South Wales on the work of doctors who were not accredited pathologists among their Government Medical Officers to undertake pathology work (autopsies) has a strong historical basis as seen in the document "A History of Medical Administration in NSW 1788-1973" referenced above. I believe that at the time this autopsy was undertaken the risks and dangers of this approach had already been recognised and was being addressed in other jurisdictions.

Attachment 1

Professional details

1. **My full name is; DAVID LEO RANSON.**
2. **I am a legally qualified Medical Practitioner and specialist in forensic medicine.**
3. **My professional address is; 65 Kavanagh St Southbank, Victoria.**
4. **My currently held professional positions are; (N.B. I am now transitioning to retirement with a consequent alteration in my roles and responsibilities.)**
   a. Deputy Director of the Victorian Institute of Forensic Medicine (VIFM)
   b. Head of the Forensic Services Division of the Victorian Institute of Forensic Medicine.
   c. National Forensic Pathology Advisor to New Zealand
   d. Adjunct Clinical Professor in the Department of Forensic Medicine, Monash University
   e. Adjunct Professor in the Law School of La Trobe University
5. **My Professional Qualifications (by examination) are;**
   a. Bachelor of Medical Science (1st Class Honours – Pathology)
   b. Bachelor of Medicine and Bachelor of Surgery
   c. Bachelor of Laws
   d. Fellow of the Royal College of Pathologists (UK – Histopathology)
   e. Fellow of the Royal College of Pathologists of Australasia
      i. (Anatomical/Forensic Pathology)
   f. Diploma of Medical Jurisprudence
      i. (Forensic Pathology)
6. **My Professional Fellowships and Memberships include;**
   a. Foundation Fellow of the Australian College of Legal Medicine
   b. Foundation Fellow of the Faculty of Clinical Forensic Medicine of the Royal College of Pathologists of Australasia (RCPA)
   c. Foundation Fellow of the Faculty of Post-mortem Imaging of the Royal College of Pathologists of Australasia (RCPA)

d. Foundation Fellow of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London (RCP London)

7. Prior Experience

a. My specialist pathology training commenced in 1981 and I have been engaged in independent professional practice in Forensic Medicine and Pathology since 1987.

b. From 1981-1988 I was a Lecturer in the Pathology Department of Bristol University in the United Kingdom.

c. From 1986-1988 I was a part time forensic physician (Police Surgeon) with Avon and Somerset Constabulary.

d. From 1988-1991 I was a part time forensic physician (Police Surgeon) with Victoria Police.

e. In 1988 I was appointed a senior pathologist at the Victorian Institute of Forensic Pathology.

f. From 1992 to 2001 I was the Assistant Director in charge of the forensic pathology division of the Victorian Institute of Forensic Medicine.

g. In 2001 I was appointed the Deputy Director of the Victorian Institute of Forensic Medicine.

h. In the last 35 years at the Victorian Institute of Forensic Medicine I have carried out thousands of medico-legal death investigations largely in Australia but also including overseas jurisdictions. These have included investigations into both injuries and deaths of both adults and children. Many of these death investigations have involved undertaking autopsies at the request of jurisdiction's Coroners.

i. I have also undertaken death and related forensic investigations, including case reviews, for the legal representative of both the Crown and individuals charged with criminal offences.

j. I have given ordinary and expert testimony in relation to death and injury investigations, I have provided evidence to a wide variety of Courts Tribunals and Formal Enquiries/Hearings including proceedings in; Magistrate's courts, Coroner's Courts, District Courts, County Courts and Supreme Courts both in Australian jurisdictions and overseas.

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 the penalty of perjury.

David Leo RANSON
B.Med.Sci. B.M. B.S. LLB. FRCPath. FRCPA. FACLM. FFFLM. (RCP.) FFCFM. (RCPA.) FFPMI. (RCPA) DMJ. (Path.)

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