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**SPECIAL COMMISSION OF INQUIRY INTO LGBTIQ  
HATE CRIMES: EXPERT REPORT IN RELATION TO  
THE DEATH OF RICHARD SLATER FROM  
PROFESSOR MICHAEL BESSER AM**

REFERENCE: Emily Burston

Senior Solicitor Assisting the Inquiry NSW Government  
Department of Premier and Cabinet

PROFESSOR MICHAEL BESSER AM

16<sup>th</sup> March 2023

I am responding to the letter of 7<sup>th</sup> March 2023 from Emily Burston, Senior Solicitor assisting the Special Commission of Inquiry into LGBTIQ hate crimes, requesting an expert report in relation to the death of Richard Slater who died aged 69 on 22<sup>nd</sup> December 1980 at the Royal Newcastle Hospital.

I have received a letter of instruction with a brief of evidence including autopsy reports, witness statements, police material and specialist medical officer reports together with hospital attendance statements as well as the report of a death to the Coroner.

I have reviewed this material in detail and will refer to it in the body of my report. Attached to this report is my Curriculum Vitae (short version).

I, Professor Michael Besser AM, Consultant Neurosurgeon, 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.

My report will consist of the following:

1. Summary of the clinical case
2. Review of the autopsy
3. Discussion with Literature review
4. Address to the question posed
5. Concluding remarks
6. References

## **THE CLINICAL CASE**

Richard Slater was a 69 year old pensioner who had a long established history of atherosclerotic heart disease. His first myocardial infarction was 12 years previously on a background of hypertension of over 10 years duration. He suffered a cardiac arrest and a further myocardial infarction five years prior during hernia repair surgery. He also apparently had an enlarged prostate causing urinary frequency.

Mr Slater had stable angina over many years but was active and self sufficient despite his advanced coronary disease. He was able to drive and walk whilst carrying out his daily activities. Police statements indicate that his family background

included a daughter and grandson. There was no known associated criminal activity and he lived with his family in Newcastle.

According to Mr Slater's grandson it was his weekly custom to buy lottery tickets after walking across Birdwood Park in the Newcastle CBD. On 19<sup>th</sup> December 1980, after parking his car and purchasing the lottery tickets around midday or shortly thereafter, Mr Slater entered the public toilet block in Birdwood Park. He was found at approximately 1 pm lying half prone on the blood stained toilet floor in a semi-conscious state.

According to witness, police and ambulance statements he had congealed blood covering the left side of his face where there was a significant left ear laceration. Mr Slater had his belt and fly undone with his genitalia exposed and his pants halfway down his buttocks. At least one leg was initially found to be in the urinal trough and he was making moaning sounds but initially not responding to voice. Police and ambulance were called and responded promptly.

When ambulance officers arrived they found Mr Slater as described but now trying to pull his trousers up and responding to vocal commands. He was able to give his name and denied being assaulted. However he was confused and disorientated.

Ambulance and police officers noted blood splattered on the toilet walls as well as the toilet floor. Apart from the ear laceration there were obvious eye, face and chest contusions and abrasions. It was clear he had been punched and probably kicked in an obvious assault. Police concluded that he had been struck, initially at least, whilst upright.

Mr Slater was admitted to the Royal Newcastle Hospital at 1.32pm that day under the care of neurosurgeon Dr Anthony Bookallil. Initial examination showed that he was conscious and cooperative but disorientated and confused with a speech disturbance. There was no other focal neurological deficit.

Multiple abrasions and bruising to face and chest with bilateral parietal scalp haematoma were noted. Also there was a large right sided parieto-temporal scalp haematoma. There were bilateral periorbital haematoma with subconjunctival haemorrhage, worse on the left side where there was a clinically obvious left cheek fracture.

A brain CT scan showed haemorrhagic contusion of the left temporal lobe and a small left parietal intracerebral haematoma with surrounding contusion and cerebral oedema already causing some mass effect on surrounding brain structures.

Skull and facial x-rays showed a frontal skull fracture and confirmed a left maxillary fracture together with disruption of the floor of the left orbit.

Mr Slater's neurological status remained stable but 24hrs after admission he suddenly developed acute pulmonary oedema and was transferred to the coronary care unit under the care of a cardiologist. From the cardiac view point he seemed to initially improve over the next 24 hours.

On the 21<sup>st</sup> December 1980 Mr Slater became drowsier and was commenced on steroids to obviate likely increasing cerebral oedema and rising intracranial pressure. The next day, December 22<sup>nd</sup> at 5pm, he had a sudden cardiac arrest and died. Subsequent post mortem showed a very large myocardial infarction.

## **THE AUTOPSY**

The post-mortem showed extensive fractures of the skull base involving the roof of both orbits and the cribriform plate as well as the floor of the left orbit and maxillary antrum.

Examination of the brain showed a small left subdural haematoma. There was an extensive subarachnoid haemorrhage over the posterior half of the brain. The posterior half of the left temporal lobe showed extensive traumatic haemorrhagic contusion as did the anterior half of the left occipital lobe. There was considerable cerebral oedema present and cerebellar coning was noted. The latter may have represented an agonal event.

Severe atherosclerotic disease was present with a large myocardial infarction involving almost the whole of the left ventricle. This was not survivable. Evidence of old previous myocardial infarction was also demonstrated.

Frank blood was present in the abdominal cavity secondary to spleen lacerations together with some retroperitoneal haemorrhage from left renal trauma.

Extensive soft tissue trauma to both periorbital regions with subconjunctival involvement together with facial bruising and lacerations was seen. This was mainly left sided but also present on the right. There was a sutured 3 cm laceration at the back of the left ear lobe. The upper anterior chest showed scattered bruising with considerable haemorrhagic involvement of the muscular tissue.

Mr Slater's shirt and trousers showed evidence of human semen.

## **DISCUSSION WITH LITERATURE REVIEW**

Mr Slater was assaulted with considerable force as demonstrated by the extensive skull base and facial fractures as well as the numerous soft tissue injuries to head and body. The extent of his injuries indicates that several blunt force blows were used.

Mr Slater's traumatic brain injury was very significant with extensive haemorrhagic contusion in both temporal and parietal lobes of the left cerebral hemisphere. The left temporal lobe is dominant in speech function in 90% of the population and would account for his speech disturbance and confusion.

Haemorrhagic contusion brain injuries are known to progress and enlarge particularly in patients with hypertensive vascular disease. Inevitably this results in increasing cerebral oedema and raised intracranial pressure. This would account for Mr Slater's increasing drowsiness prior to his terminal myocardial infarction and was confirmed on the post-mortem study.

In my experience older patients over 65 years of age have a significant mortality with a traumatic brain injury of this extent. This is supported by the extensive local and international literature. The prognosis for a full recovery would be very poor and I disagree with Dr Bookallil's comments in this regard.

Dacey and colleagues described the considerable neurosurgical complications that can occur after apparently minor head injuries and the classic paper by Rockswold and others showed the significant incidence of closed head injured patients who "talked and deteriorated". Many of these died, particularly in the older age group. Fabbri documented increasing age as an early predictor of an unfavourable outcome

in what initially appeared to be a moderate head injury as assessed in the emergency department.

## **MATTER TO BE ADDRESSED**

- 1. Your view as to the extent that Mr Slater's head injuries would have affected his comprehension and the coherency of his answers to attending ambulance and police officers.*

Mr Slater suffered a severe traumatic brain Injury with significant haemorrhagic contusions to his dominant left cerebral hemisphere. In particular the left temporal lobe was involved which controls both expressive and receptive speech.

The contusion injury in his posterior temporal region merged with the haemorrhagic contusion in the anterior parietal lobe causing additional confusion and disorientation in his mental state.

I have no doubt that his comprehension was compromised and the coherency of his answers to the first attendees, including ambulance, police and emergency department personnel, would have been significantly affected.

## **CONCLUDING REMARKS**

The death of Mr Slater was most likely due to a forceful, multiple assault causing haemorrhagic contusions to his dominant hemisphere together with subarachnoid haemorrhage and a small subdural haematoma. At the age of 69 years this combination of pathologies carries a high mortality rate with a very poor outlook for functional recovery.

Mr Slater had the additional co-morbidity of severe atherosclerotic cardiovascular disease on a background of long standing hypertension. He had a number of myocardial infarctions in the past and had stable angina.

The agonal event causing the immediate death of Mr Slater was heart failure due to a massive myocardial infarct. However I agree with the expert report of Professor Adams that the assault and subsequent severe traumatic brain injury precipitated his cardiac events. The evidence for this opinion has been well set out in the literature review by Dr Adams in his comprehensive report.

## REFERENCES

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Kok RK et al (1997) Acute traumatic subdural haematoma: outcome and outcome prediction. *Neurosurg Rev*; 20: 239-244

Kurland D, Hong C, Aarabi B et al (2012) Haemorrhagic progression of contusion after traumatic brain injury. *J Neurotrauma*; 29 (1): 19-31

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Rockswold GL, Leonard PR and Nagib MG (1987) Analysis of management in 33 closed head injury patients who "talked and deteriorated". *Neurosurgery*; 21 (1): 51-55

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A handwritten signature in black ink, appearing to read 'Michael Besser', written in a cursive style.

**PROFESSOR MICHAEL BESSER AM**

16th March 2023