



VICTORIAN INSTITUTE OF FORENSIC MEDICINE

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

**SAMANTHA ROSE
CASE NO. A00098/23**

My name is Linda Elizabeth ILES and my professional address is the Victorian Institute of Forensic Medicine, 65 Kavanagh Street, Southbank, Victoria 3006.

I am a registered medical practitioner practising as a specialist in forensic pathology.

My qualifications are Bachelor of Medicine (MB), Bachelor of Medical Science (B Med Sci) and Bachelor of Surgery (BS) with Honours, from the University of Tasmania. I am a Fellow of the Royal College of Pathologists of Australasia by examination in anatomical pathology. I hold the Diploma in Medical Jurisprudence in Pathology from the Society of Apothecaries of London (DMJ (Path)), and am a founding fellow of the Faculty of Post Mortem Imaging of the Royal College of Pathologists of Australasia.

I am employed as a Forensic Pathologist at the Victorian Institute of Forensic Medicine and am an Adjunct Associate Professor in the Department of Forensic Medicine at Monash University.

My practical experience in Forensic Pathology commenced in 2000. I commenced full time professional forensic pathology practice in Victoria in 2005. I was subsequently employed as a Consultant Forensic Pathologist in the Section of Forensic Medicine and Science at the University of Glasgow from March 2007 until January 2009 and received specialised training in Forensic Neuropathology at the University of Edinburgh. I resumed practicing forensic pathology in Victoria in July 2009.

I am head of Forensic Pathology Services at the Victorian Institute of Forensic Medicine and co-ordinate the Institute's neuropathology service.



OPINION REPORT

Case No. A00098/23
Re : ROSE deceased

I have been requested by Ms Jacqueline Krynda, senior solicitor for the Special Commission of Inquiry into LGBTIQ hate crimes, to review materials related to the death of SAMANTHA ROSE, age 41 years.

MATERIALS PROVIDED

1. P79A Report of death to the Coroner
2. Provisional and final autopsy report prepared by Dr Christopher Lawrence, inclusive of results of neuropathological examination.
3. Toxicology report of Desdemona Esmeralda Albertyn
4. Crime scene photographs
5. Autopsy photographs
6. Statement of Detective Senior Constable Paul Michael Thornton (OIC)
7. Statement of Detective Senior Constable Graem Allen Bush
8. Statement of Detective Senior Constable Tim Mealing
9. Statement of Graham John Sims
10. Statement of Senior Constable Barry Thompson
11. Statement of Senior Constable Maxwell John Sladden
12. Statement of Senior Constable John Paul Byers
13. Statement of Plain Clothes Senior Constable Andrew Bruce Pincham
14. Statement of Detective Senior Constable Christopher William Goddard
15. Statement of Constable Kerralyn Patricia Waites
16. Computer-aided sketch plan of crime scene
17. Statement of Bertha Rose (mother)
18. Statement of Max Rose (father)
19. Statement of Ian Grant Rose (brother)
20. Letter from Dr Garry Levot (NSW Agriculture) re post- mortem interval
21. Statement of Dr Alfred Steinbeck

SYNOPSIS OF MATERIALS

1. Ms Samantha Rose was found lying on her back on the floor of her [REDACTED] unit on Monday 22nd December 1997 by police on a welfare check after her relatives had not been able to contact her since Saturday December 20th 1997.
2. Ms Rose had reportedly been feeling unwell with nausea and headaches in the days prior. She reportedly attended a doctor regarding these symptoms but did not receive a specific diagnosis. There is a suggestion the symptoms were related to hormonal/oestrogen therapy.
3. Ms Rose was found lying on her back, clothed, between the kitchen and dining areas of the unit. She was located adjacent to an upturned chair.
4. Scene photographs demonstrate bloodstained fluid about the nose left side of the face right side of the nose come by the forehead and about the left side of the mouth. The back of her head is on a carpeted surface and there are no objects contacting the left or right side of her face.
5. Rounded areas of red staining are present about the front of Ms Rose's printed white T shirt.
6. Bilateral periorbital hematomas are evident (right greater than left), along with a parchmented abrasion about the right malar region extending onto the right ear lobe.
7. Areas of patchy red discoloration are noted below the lower lip and about the chin.
8. There is modelling of this skin of the forearms and exposed legs, with some possible bruising about the knuckle of the right hand, however this is difficult to discern from the video type change.
9. Disturbed objects evident within the scene photographs include a tin of plums between the deceased legs, scattered metal bracelets on the floor, eye glasses, an earring on the floor, breast prostheses on the floor, toppled over television and photographs and ironing board, and telephone receiver on the floor.

Autopsy report

10. Dr Christopher Lawrence attended the scene at [REDACTED] Addison St Kensington at 1300 hours on 22/12/1997. Early decompositional changes were noted including fly larvae about the face and eggs in the nose and mouth. He noted brown fluid on the deceased's face.
11. An autopsy was performed on 22 December 1997 at 1400 hours. Pertinent findings as described in the report are as follows:
 - Well-developed male weighing 58.5 kg and measuring 155 centimetres in height (body mass index 24.4)
 - No conjunctival petechial haemorrhages present; nose showing "some injury"; teeth in fair repair.
 - No evidence of neck injury.
 - Ill-defined 40 x 15 mm red bruise on the left cheek; deep to this extensive bruising over the left zygoma and left temple region.
 - Left periorbital hematoma and fracture of the left orbital plate.
 - Linear fracture in the left temporal region running through the petrous temporal bone associated with 5 ml extradural hematoma. Fracture extending into the left middle cranial fossa. Fracture extends posteriorly running across the occiput to the right temple region.
 - Running continuously from the region of the left ear to the right ear is a confluent red bruise.
 - On the skin of the left occipital region is an area of petechial haemorrhages immediately behind the ear.
 - On the right occipital region is a compression mark in two small lacerations.
 - On the right cheek is a 30 x 15 mm brown abrasion associated with bruising of the right cheek, a right periorbital hematoma and fracture of the right orbital plate.
 - 20 x 5 mm rectangular abrasion on the lateral right cheek and a slight abrasion over the (sic) left ear
 - 30 ml subdual hematoma over the left frontal and basal region.
 - Contusions of the inferior right frontal lobe, right inferior and lateral temporal lobes and lateral left temporal lobe
 - Slight bruising in an aspect of the upper lip; multiple areas of abrasion on the upper and lower lips with a confluence area of abrasion 3 x 10 mm immediately below the lower lip. No associated significant bruising.

- Large amount of blood in the nasopharynx with nasal bones intact to palpation.
- Haemorrhagic abrasion left nostril
- 100 mm diameter blue bruise lateral right shoulder.
- 10 mm bruise medial aspect right upper arm
- Posterior aspect right forearm haemorrhagic superficial abrasion
- Left forearm brown non-haemorrhagic abrasion
- 40 mm diameter blue bruise on the sacrum to the right of the midline associated with a haemorrhagic superficial abrasion
- Haemorrhagic abrasion to the dorsum of the right foot.
- Strap muscles of the neck uninjured; laryngeal skeleton intact.
- No tongue bruising.
- Upper airways containing blood. Pleural surfaces of both lungs mottled consistent with haemo-aspiration. Cut surface of the lungs reveals congestion, consistent with haemo-aspiration.

Histology

Histological examination of tissues from the heart kidney liver and spleen were unremarkable save the presence of early autolysis. Microscopic examination of lung tissue demonstrated intra-alveolar and intrabronchial haemorrhage. No acute inflammation in the form of acute bronchopneumonia or acute bronchitis is described.

Neuropathology

The brain was examined after a period of fixation but your pathologist Dr Michael Rodriguez. His findings were as follows:

1. Traumatic subarachnoid haemorrhage
2. Multiple cerebral contusions right inferior frontal, lateral temporal, bilateral
3. Diffuse cerebral oedema
4. Primary traumatic brainstem haemorrhage, rostral tegmental and dorsal basis pontis
5. Early decompositional change

(Note: additional extradural and subdural haemorrhage at primary autopsy)

Cause of death given as:

1a. Head injury.

Dr Lawrence was of the opinion that the pattern of injuries was strongly suggestive of an assault.

Toxicology

12. Screening tests performed on urine and liver tissue was negative for cannabinoids, amphetamines, barbiturates, heavy metals, common drugs, opiates benzodiazepines, cocaine, CNS drugs ,volatile poisons. No alcohol was detected in blood.

Autopsy photographs

13. Autopsy photographs demonstrate the following:
- Area of erythema, possible bruising, above the left iliac crest
 - Rectangular shaped parchmented abrasion below a right periorbital hematoma; posterior to this injury is an area of parchmented abrasion on the right side of the face; scattered areas of abrasion are present about the right earlobe. No photographic scale is included.
 - Extensive area of erythematous ?abraded injury/excoriation about the upper lip, below the lower lip and chin.
 - Small area of bruising medial aspect left upper eyelid.
 - Patterned injury left side of the face, comprising intradermal bruising with alternating approximately horizontally oriented linear components extending to involve the left earlobe. No photographic scale is included.
 - Ill-defined areas of erythema about the forehead.
 - The hair has been shaved from the scalp. Areas of irregularity and noted about the scalp along with areas of epidermal disruption. It is not possible to determine whether these represent injuries or artefact.
 - Area of bruising above and to the right of the natal cleft.
 - Extensive subscapular bruising about the left temporal, right temporal, left parietal and right parietal scalp. No obvious occipital scalp bruising.
 - No clear views of the subscapular tissue about the frontal scalp and forehead.
 - Small amount of extradural haemorrhage associated with a linear fracture of the left temporal bone into the middle cranial fossa.

- Bilateral orbital plate fractures associated with herniation of right orbital contents into the cranial cavity.
- No further views of calvarial fractures available.
- Area of soft tissue bruising about the region of the left masseter muscle in the vicinity of the left external auditory meatus.
- Smaller area of soft tissue bruising adjacent to the right external auditory meatus.
- Subcutaneous bruising about the right deltoid region.
- Blue bruise inner aspect right upper arm.

QUESTIONS AND REPOSES

1. *The adequacy of the post-mortem investigations conducted with respect to Ms Rose.*

Autopsy examination has been reasonably comprehensive and is sufficient to determine cause of death. However, some descriptive details are lacking, and the extent of photography limits capacity for thorough review. In particular, no scales of measurement have been used in post-mortem photography. This is particularly pertinent to the injury to the left side of Ms Rose's face. There is a clear patterned injury (intra-dermal bruise; photographs 209 and 230) involving her left cheek and earlobe that has distinct rectangular linear components, and some possible circular areas towards the nose. This is not described as a patterned injury in the autopsy report. Without a scale applied, it is difficult to compare this injury to potential objects that may have caused it.

No photographs of the oral mucosa available for review. The presence or absence of significant injury in this area is important in assessing the nature and severity of the injury to the perioral region.

No specific photographs of the deceased's hands are available. There is no comment or description in the report regarding the deceased's hands and the presence or absence of offensive or defensive injuries, which in my view would be important observations in this case. Some of the scene and autopsy photos raise the possibility of bruising to the hands and forearms, however without dedicated photographic views, bruising these regions cannot be confirmed nor excluded.

There is what appears to be red bruising the region of the left iliac crest in photograph 206, however I cannot be definitive based on a single photograph.

The extent of skull fracturing is not evident in the autopsy photographs. For the purposes of review, the description in the autopsy report is the only source of information.

A subcutaneous dissection of all limbs or the back of the decedent is not described. This procedure is important in excluding occult bruising, which may be informative in determining the mechanism of injury.

I note that clothing, scalp hair, pubic hair, fingernails were taken for evidence. It is not clear whether this material was analysed. Although there is no autopsy evidence of anogenital injury, analysis of anogenital swabs would have been prudent.

2. The manner and cause of Ms Rose's injuries;

Ms Rose's cause of death is best described as: **1a. Blunt head injuries.**

Characterising the extent of Ms Rose's injuries based on autopsy photographs is limited by their number and quality. Based on the autopsy report, it appears that there have been blunt impacts to at least two planes of the face and head, i.e., left side of the head and face, right side of the head and face. On first principles, sustaining injuries to multiple different planes of the head, is not indicative of a simple fall. There is limited potential for a complex fall inside Ms Rose's home. For example, there are no stairs *inside* her home. It is noted that her home was located on the third story of her building, however given the nature of her head injuries, these in my view preclude a complex fall related to stairs *outside* of her home (see below).

There is no post-mortem evidence that Ms Rose was intoxicated at the time of her death, nor is there evidence of any underlying medical condition that may have precipitated multiple falls in the setting of delirium or confusion.

Dr Lawrence has suggested that there are "probably at least two impact sites on the back of the head". These are not clear to me in the photographs. Photographs of the reflected scalp show extensive temporal and parietal bruising, but not occipital bruising. The description of occipital injury in the report is not particularly convincing.

The cause for the area of excoriation or possible abrasion around the chin, perioral region and nose is unclear. Whilst photographs are not available, Dr Lawrence's report particularly describes a relative lack of mucosal bruising in this area, with teeth and facial bone intact. This makes a direct blow to the front of the face less likely to be the cause of this appearance. Possibilities include excoriation from gastric contents post-mortem, abrasion from a soft but irregular surface (e.g. carpet), antemortem dermatitic condition exacerbated by post mortem congestions, or a combination of these things. I cannot take this any further based on the material available.

Dr Lawrence concluded that the pattern of injuries is strongly suggestive of an assault. I cannot exclude that Ms Rose's head injuries are not due to blows to the left and right side of her head. However, it is possible that this spectrum of injuries may represent a significant crush injury (see below).

3. Without limiting the matters which you may consider relevant to question 2, please outline your views regarding:

- a. Whether it is possible that Ms Rose remained conscious and/or able to move for a period of time after she sustained her injuries and if so, for how long;
- b. Whether Ms Rose's head injuries could have been sustained by a fall and/or contact with an object. If you consider the head injuries could have been sustained by an object, please state or describe the object.

a. Ms Rose is described as having extensive intracranial injuries including extradural haemorrhage, subdural haemorrhage, subarachnoid haemorrhage, multiple cerebral contusions, diffuse brain swelling, and of particular importance, what is described as traumatic brainstem haemorrhage. If the pontine haemorrhages described by Dr Rodriguez are indeed traumatic haemorrhages, and not the result of brain swelling and raised intracranial pressure, this signifies significant primary traumatic brain injury, and is highly suggestive of rapid unconsciousness following injury. I note that there is no description of acute bronchitis or bronchopneumonia on post-mortem lung histology that might suggest a period of prolonged unconsciousness prior to death. Given these findings, I do not believe a complicated fall outside of Ms Rose's home, for example on the steps outside, could account for her injuries.

b. There is a distinct patterned injury (intra-dermal bruise) involving the left side of Ms Rose's face including her left earlobe. This is associated with underlying soft tissue

haemorrhage. Scene photographs clearly demonstrate that this is not an artefact of post-mortem positioning. Unfortunately, this photograph has been taken without scale, therefore comparison comparing the dimensions of this injury to possible objects, particularly those in Ms Rose's residence, is not possible. For example, the vents of the upturned television have a linearity similar, to an extent, to the linear patterning of intradermal bruising to the left side of her face. However, I cannot determine from the photographs the profile of this part of the television, nor can I accurately compare this to the injury on the left side of her face. Linear intradermal bruises such as this can in some instances be caused by stomping on the face (with a shod foot). In this instance however the injury extends to involve the earlobe and is particularly wide. Given the limited information I have available, this is less likely to be caused by a single stomping injury, however I am reluctant to exclude this given the poor documentation of this injury.

The presence of impact/contact injuries on both sides of the face and the head, in combination with the location of skull fractures, including orbital roof fractures with intracranial herniation of orbital contents, and the extent of intracerebral injury, including primary traumatic brainstem haemorrhages, raises the possibility of a crush type injury from a heavy object. And whilst I cannot exclude direct blows to the face with an object/weapon as being the cause of Ms Rose's injuries, I regard the former mechanism of injury as being more likely.

4. Any recommendations for further medical investigations or expert opinion you consider would assist His Honour with respect to determining the manner and cause of Ms Rose's death.

The patterned injury to the left side of Ms Rose's face raises the possibility of a crush injury. The only object I can see in the scene photographs that may cause such an injury is the toppled over television. If there is any information available regarding the make and model of the television, it may be useful to review images of all surfaces of the television to compare with the injuries to Ms Rose's face. This may be helpful even though there are no photographs of these injuries with scale. Given the passage of time, it is recognised that this information may no longer be available.

5. Please provide any other comment, within your expertise, which you consider to be relevant to the manner and cause of Ms Rose's death.

Dr Rodriguez' neuropathologic examination identified primary traumatic brainstem haemorrhages – this is a very significant traumatic brain injury, and is important in considering the cause for Ms Rose's injury for two reasons:

Firstly, this finding implies rapid incapacitation following injury. There is nothing in the immediate vicinity of Ms Rose's body to account for this patterned injury, which may suggest that her body has been moved.

Secondly, primary traumatic brainstem haemorrhages are unusual in traumatic brain injury sustained in a physical assault without the use of a discrete weapon/ heavy object. Such an injury could occur via crush injury to head from a heavy object.

Fatal crushing head injuries from falling televisions are well recognised in children, with older style cathode ray tube televisions (such as that depicted in scene photos) being significantly heavier than contemporary flat screen TVs. However, this mechanism of injury is much less common in adults, for obvious reasons (i.e., the victim's head has to be between the level of the television and the floor at the time the TV topples).

The scattered objects (bracelets, eyeglasses, breast prostheses, earring) and disturbed furniture (ironing board, television) raise the possibility of an altercation/disturbance in Ms Rose's home. Such an altercation may account for Ms Rose's head injuries i.e., the television falling on her head during an altercation/scuffle. Whilst this is only a speculative mechanism of injury, it can account for the spectrum of pathological findings in this case.

Based on the information I have available to review, I cannot readily construct a scenario that does not involve another individual in Ms Rose's death in some capacity.

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.

Assoc. Prof. Linda E. Iles
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