



VICTORIAN INSTITUTE OF FORENSIC MEDICINE

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

SCOTT MILLER CASE NO. A00216/22

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

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

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

I am employed as a Forensic Pathologist at the Victorian Institute of Forensic Medicine.

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

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

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OPINION REPORT

Case No. A00216/22

Re : MILLER deceased

I have been requested by Ms Kate Lockery, principal solicitor for the Special Commission of Inquiry into LGBTIQ Hate Crimes, to review materials pertaining to the death of Mr SCOTT MILLER (date of birth 27 July 1975).

MATERIALS PROVIDED

- Interim post mortem report
- Provisional autopsy report (Dr Duflou)
- Final autopsy report (Dr Duflou)
- Toxicology report
- Neuropathological report
- DAL certificate
- Additional DAL certificate
- Transcript of coronial inquest
- Coronial findings
- Crime scene photographs
- Autopsy photographs
- Police running sheet
- Statement of plain clothes Senior Constable Michael Lane
- Statement of Detective Senior Constable Lyle William Van Leeuwen
- Statement of Detective Senior Sergeant Carlton Graeme Cameron
- Report of detective sergeant Desmond “New information on Darling Harbour death”
- Statement of Sean Kelly
- Statement of Jane Carter

SYNOPSIS OF MATERIALS

1. Mr Scott Miller was drinking with friends on the evening and night of Saturday, March 1, 1997. He and friends had watched the Mardi Gras parade. He was last seen by a friend at the Orient Hotel in the early hours of March 2. He was thereafter likely seen by local resident Jade Carter as she was walking home.

She estimated that she saw him at around 2:10 am - 2:15 am. She described him as being well dressed, not appearing to have any injuries and his clothes being neat and tidy.

2. Mr Miller's body was found within the compound of Patrick Stevedores Wharf 4 at Darling Harbour on 3 March. His body was located on asphalt at the base of a cliff.
3. Entry to that area is controlled via security gates. Whilst blood staining was present on the ground around Mr Miller's body, there was no evidence of blood staining or droplets elsewhere in the machinery yard.
4. Scene photographs demonstrate body of a well-built adult male lying prone adjacent to a drain at the base of a cliff (said to be 7 meters high). A large pool of apparent blood staining is present in the region of the deceased's face and upper torso. Blood staining is noted to the sleeve of the deceased's right upper garment as well as the shoulder area in the top right back. There is a distinct directionality to the blood staining over the top of the right shoulder. Scattered flecks of blood are noted about the deceased's right cheek and ear. Thin blood staining is also noted about the top of the left shoulder of the garment. Subsequent DNA analysis indicated blood stains came from Mr Miller.
5. It is understood that there was no evidence of disruption to the foliage at the top of the cliff, or physical evidence of anyone climbing the fence at the top of the cliff. It is however noted that a portion of ivy, which was present at the top of the cliff, was present adjacent to Mr Miller's left leg.
6. Mr Miller's wallet was located in his right back pocket.

Autopsy Findings

7. Autopsy conducted by Dr Duflou on 3 March 1997, and associated neuropathological examination, demonstrated the following:
 - a. The body was that of a well-built young adult male, 87 kilograms and 80 cm in height (BMI 26.8).
 - b. Clothed in brown shoes, multicoloured socks, blue jeans, brown belt and two white t-shirts.

- c. Predominantly abraded injuries over the front of the face. These are described as being predominantly in a vertical plane.
- d. 9.5 x 6.5 cm area of abrasion to the anterior surface of the neck with lines of abrasion passing predominantly vertically as well as to a more limited extent to the right.
- e. Variably developed bilateral periorbital haematomas.
- f. Abrasions over the right clavicle, superior surface of the right shoulder and right shoulder blade.
- g. 16 x 5 cm area of red petechial haemorrhage over the anterior trunk.
- h. Ant abrasions about the right anterolateral abdominal wall.
- i. 4.5 x 1 cm transverse abrasion at the ventral aspect of the left wrist.
- j. 10 x 3.2 cm area of interrupted non-confluent abrasion and bruising to the dorsal aspect of the right hand and wrist.
- k. Scattered superficial lacerations/abrasions to the fingers.
- l. Small abrasions and superficial lacerations to the dorsal surface of the fingers of the right hand.
- m. Scattered punctate abrasions on the medial surface of the left calf (likely post mortem ant activity).
- n. Complex fracturing of the frontal bones with semi-circular concentric fracture lines radiating from reported impact point, approximately the level of the glabella along with linear radiating fractures.
- o. "Massively" fractured anterior cranial fossa.
- p. Bilateral orbital and maxillary fractures; nasal fracture.
- q. Midline mandibular fracture.
- r. Dural laceration.
- s. Scanty subarachnoid haemorrhage.
- t. Coup-type contusions at the anterior and inferior surfaces of the frontal lobes.
- u. Mucosal lacerations to the upper lip.
- v. Teeth intact.
- w. Bruising to the anterior aspect of the strap muscles of the neck.
- x. Laryngeal skeleton intact.
- y. No intrathoracic haemorrhage.

- z. Bronchi containing blood-stained fluid.
- aa. Extensive disruption of the naso- and oropharynx.
- bb. Superficial bruising on the inferior surface of the right lung (approximately 4 cm in diameter). No rib fractures. No thoracic or lumbar spine fractures.
- cc. Findings consistent with previous sternal fracture.
- dd. Estimated 1.5 litres of blood within the peritoneum and retroperitoneal space.
- ee. Avulsion of the right kidney from the right renal artery and vein.
- ff. Extensive fragmentation of the right lobe of the liver with a near complete tear of the right lobe.
- gg. No evidence of anogenital injury.
- hh. Radiographic examination demonstrated fractures of the right radius and ulna distally at the level of the wrist and fractures of the left radius and ulna distally at the level of the wrist (direction of displacement not described). Associated with minimal haemorrhage on dissection.
- ii. Previously healed proximal left tibial fracture with surgical screws in situ.

Autopsy Photographs

- 8. Autopsy photographs demonstrate the following:
 - a. Directional abrasions in a single plane at the front of the face and neck.
 - b. Abrasion volar aspect of the left wrist; apparent dirt staining on the palm.
 - c. Ill-defined abrasions dorsal aspect of the fingers of the left hand.
 - d. Abrasions consistent with ant activity back of the left upper arm.
 - e. Back of the right wrist, ill-defined areas of abrasion associated with a deformity.
 - f. Back of the right hand and fingers, patchy areas of abrasion; apparent dirt staining.
 - g. Variably developed petechial bruising about the trunk.
 - h. Abrasion top of the right shoulder medial aspect of the right clavicle.
 - i. Predominantly vertically oriented abrasions over the chin and neck; abrasions to the nose and forehead, notably in a single plane.
 - j. Ant type abrasions present about the trunk.
 - k. Patchy abrasion, possibly ant activity leg (side not evident).
 - l. No evidence of cutaneous injury to the back.

- m. Bilateral comminuted anterior cranial fossa fractures apparently extending into the middle cranial fossa.
 - n. Radiating ring like fractures as well as a linear fracture frontal bone in the midline.
 - o. Large laceration and fragmentation right lobe of the liver.
9. In his autopsy report, Dr Duflou was of the view that the deceased's injuries may have been sustained in one of three ways:
- i. Inflicted by one or more persons. The head injury in particular may represent an impact with a heavy object swung against the forehead eg. a length of timber. The injury to the liver and kidney may have been similarly inflicted by one or more persons with either kicking the deceased or hitting him with an object. Wrist injuries in this scenario may be an indication of defensive injury.
 - ii. Injuries sustained during a fall from a height, however the head injury and abdominal injuries, were somewhat atypical for a fall from a height. There was no evidence of disturbance of vegetation at the top of the cliff. Considering the severity of the injuries, it is extremely unlikely that the deceased moved any distance following the fall and he would not have fallen from that part of the cliff assuming he was not moved at a later stage.
 - iii. A combination of the aforementioned scenarios, i.e. injuries sustained in an assault followed by a fall from a height. The lack of disturbance of the vegetation on the top of the cliff was noted. It could be hypothesised that the deceased fell from a cliff somewhere else and was then moved to the place where he was found.

Dr Duflou opined that the likelihood of those scenarios would depend on information obtained during the non-medical part of the investigation.

QUESTIONS AND REPONSES

- Q1. *Following review of the briefing material, please identified (a) Any additional areas of medical investigation or expert opinion you consider would assist in his honour on the issues of Mr Miller's injuries and cause of death; and (b) If relevant, appropriate experts from whom his honour may wish to seek further expert opinion.*

It would be advantageous to obtain expert opinion from a forensic biologist/blood pattern analysis expert as to mechanisms for the pattern of blood spatter observed on Mr Miller's clothing, in particular in relation of the pattern of spatter on the right side of Mr Miller's shirt and face.

Q2. *View as to the adequacy of the post mortem investigations conducted with respect to Mr Miller.*

Dr Duflou's autopsy report is comprehensive and the photodocumentation of injuries is of a relatively high standard relative to practice circa 1997. Toxicological studies have quantified alcohol in blood and screened for drugs of abuse as well as "CNS drugs". Based on Mr Miller's age and lack of significant past medical history, additional toxicological testing is unlikely to be of assistance.

X-rays have been taken of Mr Miller's forearms. Unfortunately, the type of displacement of the forearms fractures is not described.

The post mortem/autopsy investigations in my view are sufficient to form a view as to how Mr Miller's injuries were sustained.

Q3. *Your view as to the medical cause of Mr Miller's death (including if relevant any reasons for taking a different view to that formed by Dr Duflou). Without limiting the matters which you may consider relevant to this question, please address: (a) Mr Miller's skull and brain injuries, and the possible causes of these injuries; (b) The injuries to Mr Miller's liver and right kidney, and the possible cause/causes of these injuries; (c) Mr Miller's abdominal injuries, without any associated rib or pelvic fractures; and (d) Mr Miller's blood alcohol level.*

Mr Miller's skull and brain injuries are consequent to severe blunt impact to the front of his face and forehead. It is noted that the injuries to Mr Miller's face are located in a single plane, and they have a vertically oriented abraded component most obvious on the neck and chin. These injuries are entirely in keeping with high magnitude force impact to the front of Mr Miller's face, as may occur consequent to a fall from a height onto his face. The injury to his neck and chin indicated a directional component in of a single impact, or a directional component to an injury occurring prior to head impact.

Mr Miller's liver and right kidney injuries and associated intraperitoneal and retroperitoneal haemorrhage are the result of significant disruption to the liver and right

renal hilar region. No associated bony injury or cutaneous injuries accompanying these injuries. These are in keeping with deceleration injuries that may be observed consequent to a fall from a height. The absence of associated rib or pelvic fractures may be accounted for by the primary impact being to Mr Miller's head and face with deceleration injury to abdominal viscera.

A similar pattern of craniofacial injuries can be observed in other high-energy scenarios (e.g., pedestrians, cyclists in motor vehicle incidents). However, the absence of injuries to the torso and lower limbs, and the circumstances in which Mr Miller was found, appear to discount such a scenario.

Whilst there is no vitreous humour alcohol concentration recorded, given Mr Miller's body was not significantly decomposed, the recorded blood alcohol concentration of 0.22% likely approximates his blood alcohol concentration immediately prior to death. A blood alcohol concentration of 0.22% would render most individuals significantly intoxicated, however the degree of intoxication in any specific individual would depend on their tolerance.

Q4. Your view on whether Mr Miller likely died at the location that he was found.

Mr Miller sustained severe craniofacial injuries that would not only result in severe disruption of brain function but would result in marked difficulties in respiration given damage to his facial bones, oropharynx and nasopharynx. Dr Duflou's autopsy report does not document features of significant haemaspersion i.e., a pattern of alveolar blood dispersal is not described in lung tissue, which would be anticipated if Mr Miller had taken significant numbers of breaths following severe facial injuries with associated inhalation of blood into his distal airways. Based on these findings, it is my view that Mr Miller would not have been able to move any significant distance from the site where his craniofacial injuries were sustained.

Whether or not Mr Miller's body was moved from another location is a matter for non-medical components of the investigation. However, based on the material presented, there appears to be no scene or circumstantial evidence that would be compatible with Mr Miller's body being moved to this site. It is my view that Mr Miller's injuries were most likely sustained in a fall from a height (see point 6 below), which would be in keeping with where his body was found.

Q5. *Are you able to identify any abrasions, scratches or other injuries on Mr Miller's body which would be consistent with a person climbing a barbwire fence or pushing through ivy.*

Dr Duflou's report and the autopsy photographs demonstrate a number of areas of abrasion about the trunk, legs and arms that are in keeping with post mortem ant activity. It is noted that Mr Miller was wearing thick denim jeans, thus protecting his legs from potential injuries from foliage or barbed wire. Abrasions pictured to the back of Mr Miller's right hand and fingers may have been sustained during a fall. I cannot exclude some of these being caused by foliage or barbed wire. Less prominent abrasions are present on the backs of the fingers of the left hand. I cannot be specific as to how these small abrasions may have been sustained. There is no clear photodocumentation of the palms of the hand to exclude injury to the palmer surfaces, however none is described by Dr Duflou. Abrasions are present about the volar aspect of the left wrist and the back of the right wrist. These may represent stretch type abrasions related to underlying fractures.

Q5. *View as to whether Mr Miller's injuries are consistent with misadventure (namely an accidental fall from a cliff) or foul play (namely an assault or push over the edge of the cliff, or both). Without limiting the matters which you may consider relevant to this question, please address*

(a) The position Mr Miller was found in (i.e. face down with his body laid straight, around 1.1 meter from the cliff face). Please also consider the photograph of the fall from the Opera House scaffolding said to be similar to Mr Miller's position.

(b) The environment Mr Miller was found in including: The height of the cliff, the ivy ledge, the lack of vegetation disturbance or blood particles around the machinery yard the ivy found at Mr Miller's feet, and the lack of access to the wharf area.

(c) The fact that Mr Miller's clothing was intact.

(d) The blood tracks down the right side of Mr Miller's face

(e) The position and pattern of blood on Mr Miller's t-shirt.

(f) The fracture to Mr Miller's frontal bone.

(g) Mr Miller's two broken wrists.

(h) The presence or absence of abrasions, scratches or other injuries as noted in the question 5 above.

Based on the medical findings, it is my view that Mr Miller's fatal injuries were sustained in a fall from a height with a primary impact point to the front of Mr Miller's face. Intraperitoneal and retroperitoneal haemorrhage consequent to liver laceration and disruption of the right renal pedicle are readily accounted for as deceleration injuries, particularly in the absence of any evidence of bruising to the abdomen or back, or bony fractures in these regions. The bilateral distal forearm fractures are in keeping with Mr Miller's arms being outstretched at the time of impact. Whilst it is my view that Mr Miller's injuries have been sustained in a fall from a height with a primary facial impact, I am unable to say, based on the medical evidence, how that fall occurred (i.e. I cannot discriminate Mr Miller falling from the cliff edge, crawling at the edge of the cliff and falling over, or being pushed over the cliff).

It is my view that Mr Miller's injuries in toto are not typical of an assault. The presence of a single plane of facial abrasion in the setting of severe underlying craniofacial trauma is not typical of an assault. In addition, bilateral distal forearm fractures, particularly in the absence of overlying bruising, and as stated in the autopsy report, lack of haemorrhage in the underlying soft tissues, are not at all typical of defensive injuries.

A fall from a height of around 7 meters with a primary facial impact, i.e., a headfirst fall would be in keeping with the environment and the position which Mr Miller was found. The medical findings are inconsistent with Mr Miller moving significantly from the point of impact. The injuries to Mr Miller's face would result in significant bleeding after death, in keeping with the pool of blood in which he was found. The circumstantial evidence around lack of access to the wharf area, and absence of blood particles in the machinery yard support the assertion that Mr Miller has fallen from the cliff above where he was found, and he subsequently died at that location.

I am unable to comment about the absence of disturbed foliage at the top of the cliff face, however the ivy located beside Mr Miller's left leg adds weight to the supposition that he was, at some point, at the top of the cliff.

The location of another deceased person's body after a fall from a height in a similar position is noted, and whilst this suggests that Mr Miller's body position was not unusual, it does not materially change the medical facts in this case. The positioning of

Mr Miller's body, whilst corresponding with injuries indicating an anterior (ventral) plane of impact (head and face, arms with forearm fractures), is not otherwise informative.

The presence of minor injuries in some areas (for example Mr Miller's hands) is non-specific. The absence of injuries that can definitively be ascribed to barbed wire, foliage etc, in isolation does not preclude Mr Miller traversing these areas.

Mr Miller's intact clothing does not materially change the above conclusions. However, the pattern of blood staining on Mr Miller's T-shirt and the right side of his face is of interest. Blood pattern analysis is not my area of expertise. The blood staining to the left shoulder region and the left upper arm region of Mr Miller's shirt may be accounted for by blood being absorbed into the material of the clothing from the pooling below Mr Miller's body. The apparently directional blood staining on the top right back of his shirt, and to the right side of his face and ear could possibly be accounted for by agonal expiration of air and blood from Mr Miller's heavily damaged nasopharynx, into a pool of blood on the ground. **However, this is not my area of expertise, an opinion should be sought from others.**

I cannot exclude that Mr Miller was assaulted prior to falling from a height. He does not however have injuries to indicate that this has occurred. Nor can I exclude him being pushed over the cliff. The uncertainties around the position and pattern of blood on Mr Miller's T-shirt and face notwithstanding, all of Mr Miller's physical injuries can be accounted for by a fall from a cliff face with a primary facial impact with decelerative injuries within his abdomen and bracing type injuries to his distal forearms.

Q7. Please provide any other comment within your areas of expertise regarding the likely cause of Mr Miller's death.

Based on the pattern of injuries present Mr Miller's death *may* be expressed as:

1(a) Multiple injuries sustained in a fall from a height.

I am however unable to state based on the medical findings precisely how such fall may have occurred.

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.

Dr Linda E. Iles
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