VICTORIAN INSTITUTE OF FORENSIC MEDICINE

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

KENNETH BRENNAN
CASE NO. A00067/23

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.

AUTOPSY REPORT

Case No. A00067/23
Re : BRENNAN deceased

I have been requested by Ms Hermoine Nicholls, senior solicitor for the Special Commission of Inquiry into LGBTIQ hate crimes, to review materials related to the death of KENNETH BRENNAN, age 53 years, who died in June 1995.

MATERIALS PROVIDED

I have been provided an extensive list of statements, reports and photographs as outlined in the letter of instruction. However, with reference to the pathology relevant to the questions put to me, I have specifically reviewed the following:

- P79A Report of Death to Coroner
- Crime scene photographs
- Autopsy photographs
- Results of forensic examination by Michele Anne Franco
- Further results of forensic examination by Michele Anne Franco
- Neuropathology report of Dr W Evans
- Toxicology report of Natalie Michailidis
- Inquest findings
- Transcript of Inquest

SYNOPSIS OF MATERIALS

1. Mr Kenneth Brennan, aged 53 years, was found naked in the loungeroom of the unit that he shared with his partner NP215, late in the afternoon of 12 June 1995. Mr Brennan was last seen alive at about 6:30 pm on Sunday 11 June.

2. Forensic pathologist Dr Peter Bradhurst attended the scene of Mr Brennan's death at [redacted] Onslow Ave, Elizabeth Bay between 0010 and 0100 hours on Tuesday 13 June 1995. He observed Mr Brennan lying naked, semi supine and covered in blood on the living room floor of the unit. Stab wounds were evident to his chest. He noted rigor mortis to be present. He noted Mr Brennan's right knee was flexed and being held up against gravity.

3. There was extensive blood staining within the bedroom and on the bed, blood staining in the entranceway and on the floor of the kitchen. Two footprints and one boot print in blood are pictured and described.

4. Rectal temperature taken at 0030 hours on June 13 was 23.0 degrees C; the ambient temperature at that time was 15.1 degrees C. The maximum temperature during the day on the 12th of June was reported to be 17.8 degrees C.

5. Dr Bradhurst estimated time of death was sometime between 5:00 pm and midnight on Sunday 11 June, or possibly a little earlier or later.

6. Autopsy

Doctor Bradhurst performed an autopsy on the morning of June 13 1995. He noted the body to be that of an 88 kg, 167 cm tall middle aged man (BMI 31.6).

7. Injuries

Dr Bradhurst documented 15 stab wounds, predominantly to the chest but also involving the lower neck and back of the left shoulder and left arm. These stab wounds resulted in injuries to the ribs, diaphragm, liver, right and left lobes of lung, pericardium, right atrium, 9th thoracic vertebra and scapula, and were associated with bilateral haemothoraces, collapsed right lung, minor haemoperitoneum and haemopericardium.

8. Several stab wounds had long abrasion tails, and superficial sharp force injuries were also noted about the trunk.

9. The estimated maximum depth of the stab wounds was 17.5 cm.

10. In addition to a stab wound to the upper left forearm, superficial incised wounds to the left forearm, right middle finger, right index finger and inside of the right thumb were present and were described as defensive injuries.

11. Numerous blunt force injuries were described, including an area of fine petechial haemorrhage on the right forehead above the right eyebrow, an area of petechial haemorrhage above the left mid forehead, area of small abrasions on the upper right cheek, right side of the nose and tip of the nose, lip lacerations and associated abrasion, and a 7 x 5 cm area of faint patchy bruising admixed with abrasions on the anterior aspect of the chin below the lower lip.

12. Re-examination on June 16 demonstrated further bruising on the right side of the face, giving the impression of a patterned injury resembling a shoeprint.

13. A fracture of the second thoracic vertebral body associated with a small amount of haemorrhage was noted along with an intimal aortic tear and associated smaller ladder tears of the aortic intima in the region of the diaphragm. This was interpreted as representing perimortem hyperextension injury of the spine.

14. A small area of periosteal haemorrhage over the right frontoparietal skull was noted without associated skin bruising. There was no evidence of skull fracture, intracranial haemorrhage or brain injury. There was no evidence of facial bone fracture or damage to dentition. The laryngeal skeleton was intact. Mucosal petechial haemorrhages where noted to be absent. No anorectal or genital injury was present.

15. Incidental moderate to marked fatty liver changes were noted.

16. Dr Bradhurst also examined a knife blade that was identified at the scene. The blade length was 190 millimetres and the blade was 25 millimetres at its widest point. The blade had a single sharp edge and was noted to be bent to form a curve at the tip. Dr Bradhurst opined that the knife was capable of causing the sharp force injuries observed on the deceased.

17. **Toxicological testing** demonstrated a small concentration of alcohol in blood (0.024%); metopralol (a beta blocker) was also detected in blood.

18. Trace evidence samples for DNA analysis (blood bone and muscle), scalp and suprapubic hairs, nail clippings left and right hands, loose hairs and fibres from the hands and feet, mouth and rectal swabs and smears were taken.

19. Mr Brennan's cause of death was given as: **1a. Stab wounds to chest.**

20. **Scene photographs** demonstrate extensive blood staining within the deceased bedroom, particularly on the bed, and large numbers of blood drops across the carpeted floor and bedroom walls. Extensive blood standing is noted within the bathroom, loungeroom and entranceway, and there are appearances of dilute blood within the kitchen.

21. A bloodstained knife along with a dented frying pan are demonstrated. Mr Brennan is observed lying on his left side on a heavily bloodstained pillow on the lounge room floor. A blue sponge is located on his right supraclavicular region.

22. **Trace evidence.** Three condoms are pictured in and about the toilet. Semen was successfully obtained from one condom. Subsequent analyses have been unable to identify the donor. A champagne glass with a fingerprint of an unknown person was identified. Underwear belonging to an unknown person was also identified.

QUESTIONS AND REPONSES

1. *Following your review of your briefing material, please identify:*

   a. *Any additional areas of medical investigation or expert opinion you consider would assist his Honour on the issues of Mr Brennan's injuries and cause of death (for example, a blood splatter analyst able to comment on the bloodstain patterns identified at the crime scene); and*

   b. *If relevant, appropriate experts from whom his Honour may wish to seek further expert opinion.*

Mr Brennan's cause of death is clear. It is also evident that he sustained both sharp and blunt force injuries, quite possibly due to implements (knife, frying pan) located at the scene, in addition to a possible stomping injury (see below bracket). Whilst a blood pattern analysis expert could review the initial interpretation of the extensive blood staining at the scene, this is unlikely to assist in addressing the questions below.

2. *Your view as to the adequacy of the post-mortem investigations conducted with respect to Mr Brennan.*

Dr Bradhurst's autopsy examination appears thorough and comprehensive. I agree with his cause of death statement. Whilst the quality and number of autopsy photographs falls significantly short of contemporary standards, these are likely represent the standard of practice at the time of this event. Nevertheless, they do limit my ability to review elements of the autopsy examination.

There is no apparent photography of the re-examination that took place on June 16. I am therefore unable to comment as to whether the patterned injuries on the right side of Mr Brennan's face possibly represent a boot print, and there is no ability to compare this

to the boot print in blood noted at the scene.

Similarly, I cannot confirm that the thoracic injury and aortic laddering are due to hyperextension injury as the spinal changes are not photodocumented.

The level of description of each stab wound, and the absence of individually photographed stab wounds, is not what would be expected in contemporary practise, however was likely considered more than adequate at the time the autopsy was performed. In my view this has had no impact on the conclusions that can be reached regarding the nature of injuries, or cause of death.

Based on the autopsy photographs and what is described in the autopsy report, following conventional sharp force wound description, I would suggest that a total of **13 stab injuries** are present. Some of the individual stab wounds described represent exit and re-entry wounds from the same knife track. Again, this represents a difference in contemporary wound description practice rather than a shortcoming.

It is not documented whether anorectal swabs were taken prior to rectal temperature assessment. Failure to take these trace evidence samples prior to probing with a rectal thermometer can potentially create difficulties in trace evidence interpretation. However, given that analysis of these swabs was negative, this has had no impact on the case.

3. Information about the crime that can be ascertained from Mr Brennan's injuries.

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

a. the likely sequence of Mr Brennan's injuries; and

b. the possibility that Mr Brennan was injured by two or more assailants.

Regarding potential blunt force injuries to Mr Brennan's head, with the possibility they were inflicted the frying pan and a shod foot being raised at autopsy and during investigations, photo documentation is inadequate for me to express an opinion. However, given that there is only minor scalp bruising described, and that there is no evidence of intracranial injury, blunt force head injuries of this nature could have occurred at any time during the incident, as there are no features to indicate that they may have been incapacitating.

It is not possible to determine an order for Mr Brennan's stab wounds. However, the

characteristics of many of the wounds (entry re-entry complexes, long tailing abrasions) imply a significant degree of movement whilst these injuries were being sustained. Scene findings suggest that Mr Brennan was moving about the unit whilst or after sustaining these sharp force injuries.

Whilst Dr Bradhurst has indicated that one of the stab wounds would be "quickly lethal" (stab wound 4, injuring the ribs, diaphragm, liver, right lung and right atrium of the heart), it is still *possible* for Mr Brennan to be active and moving for a significant number of minutes following this injury, i.e., this wound would not necessarily be immediately incapacitating.

Autopsy photographs (green label 45, 46) suggest subcutaneous bruising to the back of the hands (possible blunt force defensive injuries). Autopsy photograph green label 18 shows discoloration on the instep of the right foot, which is possibly bruising, however there are no further photographs of this area for corroboration.

There is nothing in the autopsy findings that precludes Mr Brennan's injuries being inflicted by a single individual. As per Dr Bradhurst's opinion, Mr Brennan's sharp force injuries could have been inflicted by the knife identified at the scene, or a similar bladed implement. Likewise, the wounds could have been inflicted by two or more similar bladed implements, and there is nothing that precludes more than one individual inflicting Mr Brennan's injuries.

Dr Bradhurst's estimation of time since death appears reasonable and he has been appropriately cautious about the limits of precision of this estimate.

4. *Please any other comment, within your expertise, which you consider to be relevant to the manner and cause of Mr Brennan's death.*

The manner and cause of Mr Brennan's death appear clear based on autopsy examination.

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.

Assoc. Prof. Linda E. Iles
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