CORONERS ACT. 1980

Medical report upon the examination of the dead body of:-

Name: John Peter **HUGHES** **PM Number: 89/726**

I Liliana Schwartz a legally qualified medical practitioner, carrying on my profession at the Division of Forensic Medicine, in the State of New South Wales, do hereby certify as follows:

At 4.00 in the after noon, on the 9 day of May, 1989 at Sydney in the said State, I made an external examination of the dead body of a male identified to me by Det. Sen. Const. Scullion of Kings Cross in the State aforesaid, as that of John Peter HUGHES aged about 40 years.

EXTERNAL EXAMINATION ONLY:

Examination of the body at the scene:

On the 6th May 1989, about 7.30 pm, I was at the address of the deceased, at 311/3 Greenknowe Avenue, Kings Cross.
The body was lying on the bed, face down, dressed, with the hands and foot tied at the back and the head was covered by a pillow case tied around the neck with a belt.
There was a minimal amount of blood around the head.

Preliminary examination of the body at the City Morgue, Glebe:

On the 6th of May, 1989 at 11 pm I examined the body further.

There was well developed rigor and livor mortis, which was present on the anterior surface of the body.
Early stages of decomposition were observed.
The rectal temperature was 28 degrees C at 11 pm.

Preliminary testing of serum was positive for Hepatitis B surface antigen.
Because of the highly infectious nature of this condition and with authorisation of the Coroner, an external examination only was performed.

External examination on the 9 May, 1989:

The body was that of a middle-aged Caucasian male of medium build whose appearance was consistent with the stated age.
The body was in a moderately advanced state of decomposition with green discolouration of the skin, marbling of the venous network and disappearance of the rigor mortis.
Body weight 50 kg. Body length 175 cm.
There were lesions on the shins in different stages of healing from recent ones with ulcerations of the skin, those showing scabs and those completely healed.
These lesions measured up to 1.5 cm in diameter.

A) ABRASIONS

1. There was an horizontal ligature mark around the neck, 0.3 cm in width on the right side and 0.5 cm in width on the left side of the neck.
The ligature mark was 153.1 cm distant from the left heal and 8 cm distant from both external auditory meatus.
There was a band shape area of pallor on the neck, immediately inferior to the ligature mark. This area had a width of (including the ligature mark), 3.5 cm at the left side; 5.7 cm at the right side and 4.0 cm in the posterior aspect of the neck.

2. On the left side of the neck, just inferior to the angle of the mandible and immediately inferior to the ligature mark was an abrasion measuring 3.0 x 0.2 cm.

B. PETECHIAL HAEMORRHAGES

There were numerous petechial haemorrhages on the face, on the nose, on the sclera and conjunctiva of both eyes.
Petechial haemorrhages were seen within the pale area of the neck inferior to the left angle of the jaw, and inferior to the abrasion described previously in A(2); in an area of 2.0 x 7 cm.

C. BRUISES

1. There was a bruise 0.3 x 6.0 cm at the left side of the neck, at the angle of the jaw superiorly to the abrasion described in A(2).

2. There was a bruise 0.5 cm in diameter in the left posterior aspect of the neck just above the ligature mark.

The head was shaved.

3. There was a bruised area of 5 x 3.5 cm in the occipital region.

4. A bruise 2 x 0.7 cm was seen posterior and superior to the left ear.

5. There was a bruise 1.3 x 2.0 cm over the left temporo-parieto-occipital region.

6. There was a bruise 2.5 x 1.5 cm in the occipital area.

D. LACERATIONS

There were numerous lacerations at the head, in the occipital region in an area of 6 x 6.5 cm; near these lacerations were bruises described in C(3) and C(6).

The depth of the lacerations were from superficial up to the periosteum.

1. Two lacerations measuring 0.5 cm in length.
2. 0.2 cm in length.
3. 0.8 cm in length.
4. 0.4 cm in length.

5. 1 cm in length.
6. 1.4 cm in length.
7. 1.9 cm in length.
8. Two lacerations of 2.4 cm in length.

There were no other abnormalities in the rest of the body. The trunk and the extremities were normal in appearance apart from the lesions described in the skin.

The whole body was x-rayed.
No injuries to bones or bullet fragments were observed.

Blood for grouping.

Hairs for matching.

Fingernails.

Blood sent for the estimation of alcohol and blood for chemical analysis.

In my opinion death had taken place about 3 to 4 days previously and cause of death was:

1. DIRECT CAUSE:
   Disease or condition directly leading to death:
   (a) ASPHYXIA due to

   ANTECEDENT CAUSES:
   Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last:
   (b) STRANGULATION WITH A LIGATURE

   (c)

2. Other significant conditions contributing to the death but not relating to the disease or condition causing it:
   BLUNT OBJECT INJURY TO THE HEAD

TO THE CITY CORONER, (Signature) .....

SYDNEY (Date) 23 June, 1989

ANALYST REPORT SEEN