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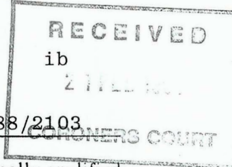
CORONERS ACT, 1980



Medical report upon the examination of the dead body of—

Name: Andrew Ronald CURRIE 88/2103

I William Harold Brighton 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:

1. At 10.30 in the fore noon, on the 17 day of December, 1988 at Sydney in the said State, I made an internal examination of the dead body of a male identified to me by Dr Hollinger of Division of Forensic Medicine in the State aforesaid, as that of Andrew Ronald CURRIE aged about 29 years.

2. I opened the three cavities of the body.

3. Upon such examination I found.

The body was that of a young adult male whose appearance was consistent with being the stated age.
Height 163 cm. Postmortem body weight 65 kg.

External and general appearance:

Average physique. Normal nutritional state. Mauve lividity over the back. Cyanosis about the ears. Suffusion of the face.
There was no significant injury on the body.
Over the right temple and forehead region there were two irregularly shaped areas of dry brown abrasion without excoriation consistent with pressure in the perimortem period.
Two areas of slight reddening of the skin present over the central forehead between the eyebrows and over the front of the nose. No frank bruising involved.
There were no needle puncture wounds present.
No congenital deformities.
No internal injury.
The body was in an unkempt state with much soiling of the feet.
The nostril region showed a mass of dark brown to dark green material similar to that present in the stomach.
Apparently this had been regurgitated and was present in the oro-pharynx.

(For continuation—see over

4. In my opinion death had taken place about 4 - 5 days previously and the cause of death was.

I. DIRECT CAUSE—
Disease or condition directly leading to death (a) POISONING BY A COMBINATION OF PENTOBARBITONE, CODEINE, METHADONE AND MORPHINE
(due to or following)

ANTECEDENT CAUSES—
Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last (b) ______
(due to or following)
(c) ______

II. Other significant conditions contributing to the death but not relating to the disease or condition causing it ______

TO THE CITY CORONER,
SYDNEY

(Signature) W. Brighton

(Date) 13 February, 1989

S.O. 2508

ANALYST REPORT SEEN

The macroscopic appearance of the organs was as follows:

Brain (1380 g):
The circle of Willis was intact. No atheroma.
Apart from passive congestion and marked cyanosis of the cortex there were no other remarkable features.

Skull, scalp and dura:
No abnormality.

Heart (400 g):
Normal in shape and size. The coronary arteries showed patchy atheroma in the proximal third of the anterior descending branch of the left artery but elsewhere the vessels were virtually free of atheroma. The myocardium was normal in colour and showed no evidence of necrosis or scarring.
No significant valve disease. The endocardial and pericardial surfaces were normal.

Aorta and branches:
Normal appearance.

Lungs and air passages (left 750 g, right 890 g):
Both organs were expanded to fill the cavities.
There were no effusions within the cavities. No adhesions between the pleural surfaces. The pleural surfaces were smooth and glistening. The lobes of both lungs were soft and showed acute oedema and marked passive congestion only.
The air passages were free of obstruction from foreign material. A small amount of the brownish green material present in the oro-pharynx was in the region of the larynx and the upper part of the trachea. This was in the form of small streaks which were adherent to the mucosal lining and not causing gross obstruction to the air passage.
The larynx and pharynx showed no gross abnormality.
The hyoid bone and thyroid cartilages were intact.

Liver (2580 g):
Normal in shape and size. The capsular surface was smooth.
On section the tissues showed no remarkable features.
Gallbladder and bile ducts, appeared normal.

Kidneys (left 200 g, right 200 g):
Normal appearance apart from intense passive congestion.
Ureters, bladder and prostate, normal.
100 ml of urine present in the bladder.

Spleen (290 g):
Normal appearance apart from congestion.

Pancreas:
Normal.

Gastro-intestinal tract:
No disease present. As stated above, the stomach contained a quantity of dark brown to dark green coloured material, mostly vegetable material and a little fluid. The stomach lining showed autolysis.

Endocrine glands:
Normal.

Lymph nodes:
There were some enlarged, soft, pale coloured nodes at the porta-hepatis. Elsewhere the nodes showed no remarkable features.

Andrew Ronald **CURRIE** 88/2103

Histology being performed.

Blood sent for the estimation of alcohol and blood, liver, stomach and contents, urine and bile for chemical analysis

Blood Chlorides

Microscopic examination:

Lungs: Marked passive congestion and oedema present only.

Heart: No evidence of myocardial pathology.

Brain:)
Kidney:) No remarkable features.

Pancreas: Undergoing autolysis, essentially normal.

Liver: Bridging fibrosis of slight degree between the portal tracts which also showed an increase in the numbers of lymphocytes present.

Lymph node:
(porta hepatis): No remarkable features.

HISTOLOGICAL SPECIMENS

Please note that the [illegible] and specimens taken from the deceased [illegible] examination will be disposed of after a [illegible] written instructions [illegible] received from the [illegible].

Blocks and slides however will be held indefinitely.

20/2/89

Director
Division of Forensic Medicine