CORONERS ACT, 1960

Medical report upon the examination of the dead body of–

Name: Mark STEWART (76/910)

I, Thomas Howard Godfrey Oettle, 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 11.00 in the fore noon, on the fourteenth day of May, 1976 at Sydney in the said State, I made an internal examination of the dead body of a male identified to me by Const. R.J.Fyson of No.14 division in the State aforesaid, as that of Mark STEWART aged about 18 years.

2. I opened the three cavities of the body.

3. Upon such examination I found. The body to be that of a young adult male of medium build whose appearances were consistent with the stated age.
Length 172 cm, weight 60 kg.
The scalp showed splitting on the left side in the parietal region and the skull showed shattering in all aspects of its dimensions.
The brain showed gross laceration. A thin extradural and subdural haemorrhage was present. There was no evidence of traumatic haemorrhages in the brain.
Numerous parchment scrape abrasions were present along the left side of the body on the postero-lateral aspect.
The left humerus showed fracturing in the midshaft, the pelvis showed bilateral fracturing of the pubic rami, the left femur showed fracturing in the midshaft and the left tibia and fibula showed fracturing immediately above the ankle.
The cervical spine showed fracturing at the level of C.3 with a small amount of surrounding haemorrhage.
Mediastinal haemorrhage was also present and the carina of the trachea showed tearing.
Extensive tearing was also present in both lung hilar regions and a small amount of free blood had been inhaled.
The pericardial sac showed tearing and blood clot was present in the pericardial sac to a small extent.
The liver showed gross tearing through the centre and extending into the left and right sides.
The spleen showed extensive tearing.
A small amount of free blood was present in the abdomen (100 ml).
450 ml of free blood was present in the left chest cavity and 100 ml in the right chest cavity.
Brain:
On section appeared healthy and weighed 1580 grm. The vessels at the

(For continuation–see over

4. In my opinion death had taken place about 3 - 4 days previously and the cause of death was.

I. DIRECT CAUSE–
Disease or condition directly leading to death .. .. (a) MULTIPLE INJURIES (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) [signature]
(Date) 3 JUN 1976

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Lungs:

The air passages contained a very small amount of fresh blood. Both lungs showed inhaled blood to a small extent together with haemorrhage within the substance of the lung. The right lung weighed 698 grm and the left lung 410 grm. No oedema was found.

Heart:

Weighed 288 grm and the myocardium showed occasional flecks of fibrous change in the left ventricular wall adjacent to the apex posteriorly and medially in the interventricular septum. The coronary arteries were free of atheroma. The valves were healthy. The pericardial sac was healthy.

Stomach: Was empty, as also was the duodenum. The lining was healthy.

Liver: Weighed 1588 grm and showed no remarkable features. The gallbladder contained bile of normal appearance.

Kidneys: Both kidneys weighed 130 grm and showed marked pallor of the cortex but otherwise appeared healthy. The bladder contained clear urine and the lining was healthy.

Spleen: Weighed 180 grm and apart from the injuries appeared healthy.

The other organs showed no remarkable features.

Blood has been sent for the estimation of alcohol via Const. Z.Stengelis.