CORONERS ACT, 1980

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

Name: Simon Blair WARK (E35722) **PM Number: 90/61**

I, **Peter Graham Bradhurst**, 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 5.30 in the after noon, on the 14th day of January, 1990 at Sydney in the said State, I made an internal examination of the dead body of a male identified to me by Dr Duflou of the Division of Forensic Medicine, in the State aforesaid, as that of Simon Blair WARK aged about 28 years.

I opened the three cavities of the body.

Upon such examination I found:

External appearances:

Body weight 78 kg. Body length 1.81 m.
The body was that of a well-built young adult male of about stated age.
Postmortem lividity was present on the back except for pressure points.
Rigor mortis was absent in the chin but was present in the upper and lower limbs, although subsiding.

There was an 80 mm old surgical scar in the right iliac fossa.

The conjuctivae were suffused.
There were no conjuctival or facial petechial haemorrhages.
There were no marks about the anterior or antero-lateral aspects of the neck.

There was a small number of relatively minor external injuries and there were multiple severe internal injuries.

Description of external injuries:

There was a 15 x 12 mm faint crimson bruise on the left side of the face just lateral to the left eye.

There were three small superficial crimson bruises on the right scalp lying in a coronal plane in line with the superior attachment of each ear.
One bruise measured 10 x 4 mm and was 10 mm to the right of the midline.
The middle bruise measured 6 x 6 mm and was 25 mm from the midline.
The third bruise measured 12 x 3 mm and was 45 mm to the right of the midline.
There was no underlying scalp haemorrhage.

There was a 20 x 15 mm crimson bruise on the back of the left upper neck, 65 mm directly posterior to the inferior attachment of the left ear.
There was a small amount of underlying haemorrhage in the subcutaneous tissue.

There was a 60 x 30 mm crimson bruise on the back of the right upper arm, 110 mm above the right elbow.

There were two faint crimson bruises on the inner aspect of the right arm, each measuring about 15 x 8 mm.
One of these was on the medial aspect of the right elbow and the other one was 35 mm above the right elbow.

There was a 12 x 12 mm faint crimson bruise on the lateral aspect of the right upper thigh.

There was a 30 x 15 mm crimson bruise between the 1st and 2nd right toes on the dorsum of the right foot.

Description of internal injuries:

On dissection of the neck there was a 90 x 40 mm area of dark red haemorrhage over the right submandibular gland.
There was a 30 x 30 mm haemorrhage over the left submandibular gland.
These areas of haemorrhage could be traced to haemorrhage around the 1st cervical vertebra. There was no evidence of any fracture to the 1st cervical vertebra.

There were fractures to the bodies of the 6th and 7th cervical vertebrae.
The laminae of the 4th and 5th cervical vertebrae were cracked.
There was haemorrhage in the soft tissue over the surface of the clavicular end of the sterno-clavicular muscle on each side.
This haemorrhage had tracked around from the fractures to the 6th and 7th cervical vertebrae.

There was haemorrhage on the lateral aspect of the left lobe of the thyroid gland.
The hyoid bone and the thyroid and cricoid cartilages were dissected. There was no evidence of any fractures to these structures.

There were fractures to the bodies of the 3rd, 8th and 11th thoracic vertebrae.
There was haemorrhage over the vertebral column in association with these fractures.
There was extradural haemorrhage over the spinal cord in the vicinity of these fractures.

There were fractures to each of the 1st to 12th left ribs posteriorly along the paravertebral gutter. As well, the 5th left rib was fractured laterally.

There was considerable haemorrhage into the mediastinal tissues.

There were lacerations to the upper and lower lobes of the left lung posteriorly.
750 ml of blood was present in the left pleural cavity and 300 ml

of blood was present in the right pleural cavity.
There was a tear in the hilar region of the right lung.
The right parietal pleura in the region of the fractured 8th thoracic vertebral body was torn.

There was a fracture dislocation of the left sacro-iliac joint and a fracture to the superior ramus of the left pubic bone.

There was a severe laceration to the liver along the anterior surface between the left and right lobes in the vicinity of the insertion of the ligamentum teres.
There were several lacerations to the lateral surface of the right lobe of the liver.
There was no macroscopic haemorrhage in the substance of the liver in association with these lacerations.

There was a small tear in the hilar region of the spleen.

100 ml of red blood was present in the abdominal cavity.

Skull, scalp and dura:

There was the bruising to the scalp as described above.
There was no periosteal haemorrhage.
There was no temporal muscle haemorrhage.
There was no skull fracture.
There was no extradural or subdural haemorrhage.

Brain:

Weight 1600 g.
There was no subarachnoid haemorrhage.
The brain and spinal cord were fixed whole in formalin for examination at a later date.

Thyroid:

The thyroid gland showed no evidence of disease.
There was recent haemorrhage on the lateral aspect of the left lobe of the thyroid.

Larynx, trachea, main bronchi:

No abnormality detected.

Lungs:

Weight - left 400 g, right 570 g.
Both lungs showed moderate carbon deposition.
There were the lacerations to the left lung and the tear to the hilar region of the right lung as described above.
Multiple contusions were present in the substance of each lung.

Pleura and pleural cavities:

750 ml of blood was present in the left pleural cavity and 300 ml of blood was present in the right pleural cavity.

Vertebral column, thoracic cage and pelvis:

There were the vertebral, rib and pelvic fractures as described

above.

Pericardium and pericardial cavity:

Recent haemorrhage was present on the anterior pericardium.
20 ml of blood was present in the pericardial cavity.

Heart:

Weight 320 g.
Myocardial thickness - left ventricle, 13 mm, right ventricle 3 mm.
The coronary arteries were free of atheroma and had good patency throughout.
The myocardium appeared healthy.
There was a small amount of subendocardial haemorrhage on the posterior aspect of the left ventricle.
No abnormality detected in the cardiac valves.

Great vessels:

No abnormality detected in the aorta, iliac or renal arteries, or the inferior vena cava.
There was no evidence of pulmonary embolus.

Peritoneum and abdominal cavity:

100 ml of red blood was present in the abdominal cavity.
The appendix had been removed.

Oesophagus:

No abnormality detected.

Stomach:

The wall of the stomach was showing postmortem discoloration.
The stomach contained a small volume of brownish fluid.

Small and large intestines:

No abnormality detected, except for some early postmortem discoloration.

Liver:

Weight 1540 g.
There were the lacerations to the liver as described above.
On the anterior surface of the liver there was a 12 x 8 mm cyst filled with whitish fluid.

Gallbladder:

The gallbladder contained a moderate amount of bile and the bile duct was patent.
There was no evidence of any disease.

Spleen:

Weight 160 g.
There was the small tear in the hilar region of the spleen as

described above.
The spleen showed no evidence of disease.

Pancreas:

There were several small areas of dark red haemorrhage on the anterior surface of the pancreas.
The pancreas was showing some postmortem discoloration.

Adrenals:

There was peri-adrenal haemorrhage on each side.
Neither adrenal showed evidence of disease.

Kidneys:

Weight - left 160 g, right 150 g.
The capsule of each kidney stripped easily.
Thickness of renal cortex 7 mm on each side.
There was recent haemorrhage in the hilar region of each kidney.
Neither kidney showed evidence of disease.

Ureters, bladder, prostate:

No abnormality detected.

There was no evidence of any abrasion or laceration around the anus, perineum, scrotum or penis.
There was a small amount of blood around each testis in the tunica vasculosa.

Histology being performed.(Brain and spinal cord.)

Blood was sent for the estimation of alcohol and blood, liver, stomach and contents, urine and bile for chemical analysis.
Blood from the left and right sides of the heart for specific gravity and chlorides.

Scalp and pubic hair for matching.
Nail clippings from the right and left hand.
Anal and perineal swabs and smears.

Re-examination of the body:

The body was re-examined of the 17th January, 1990.
There was a 30 x 4 mm faint red mark on the underside of the chin more on the left side.
There were three faint greyish brown marks ? decomposition ? bruising on the left side of the neck anteriorly.
One measured 8 x 3 mm, was 15 mm to the left of the midline and 46 mm above the manubrium.
Another measured 25 x 3 mm, was 35 mm to the left of the midline and 46 mm above the manubrium.
The third measured 9 x 4 mm , was 15 mm to the left of the midline and 40 mm above the manubrium.
These marks were very superficial and there was not underlying subcutaneous tissue haemorrhage.

The body was identified to Dr. Duflou by Const. Ford of the Sydney Water Police.

Microscopic Examination:

Thyroid:

Autolytic change affecting acinar epithelium, and recent haemorrhage in the adventitial layer.

Heart:

There is recent epicardial haemorrhage as well as some haemorrhage within the fibrous and adipose tissue around myocardial blod vessels.
In one block, there is a small focus of lymphocytes in the endocardium.

Lungs:

Severe contusion haemorrhages.

Liver:

Lacerations without any surrounding haemorrhage.
Some hepatocytes in a somewhat zonal distribution show fatty change.
There is a small benign surface cyst lined by columnar epithelium.

Spleen:

No evidence of pre-existing disease.

Pancreas:

Marked autolytic change.

Adrenals:

Recent peri-adrenal haemorrhage.

Kidneys:

One kidney shows recent peri-calyceal haemorrhage.
There is no evidence of pre-existing disease.

Prostate:

Numerous small calculi within acini.

Macroscopic Examination of the Brain Report:

The brain was re-examined after fixation.

The arteries at the base were free from atheroma macroscopically.
No aneuryms were found.
No abnormality was seen on the surface of the brain.
Mamillary bodies were of normal size.

The cerebrum was cut coronally.
There was moderately severe postmortem change with postmortem gas formation.
No other abnormality was seen here.

No abnormality was seen in the cut surface of the brainstem.
There was minimal postmortem change in the cerebellum.

The spinal cord was re-examined after fixation.
There was a little patchy extradural blood.
There was some artefactual damage to the spinal cord.
No other abnormality was seen.

Microscopic Examination of the Brain Report:

Attached.

In my opinion death had taken place about 4 and 1/2 - 4 and 3/4 days previously and the cause of death was:

1. DIRECT CAUSE:
Disease or condition directly leading to death:
(a) MULTIPLE INJURIES

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

(c)

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

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

SYDNEY (Date) 24 May, 1990.

ANALYST REPORT SEEN