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CORONERS ACT, 1960

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30 JUN
Coroners Court

Medical report upon the examination of the dead body of–

Name: Paul Edward RATH 77/1302

I Peter Russell 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 7.45 in the fore noon, on the 18 day of June, 1977 at Sydney in the said State, I made an internal examination of the dead body of a male identified to me by Dr. Fletcher of Division of Forensic Medicine in the State aforesaid, as that of Paul Edward RATH aged about 27 years.

2. I opened the three cavities of the body.

3. Upon such examination I found.
The body was that of an adult male whose appearances were consistent with stated age. Body weight 82 kg. Length 170 cm.
External examination revealed lividity of the anterior surfaces of the body. Rigor mortis was well established. There were numerous externally obvious injuries. There was a large contusion with a good deal of superficial oedema overlying the right eye and cheek with old blood issuing from both nostrils. There was also a small amount of blood present in the right ear but this appeared to be passive in nature and not associated with skull fracture. There was bruising of the right upper arm. There were bilateral compound comminuted fractures of the lower ends of the tibia and fibula and there was extensive bruising of the anterior chest wall.
Internal examination:
Tongue, pharynx, larynx and trachea were normal.
Thyroid: Was normal in size and appearance.
Pleural cavities: Were clear.
There was obvious fracturing of the sternum and right 4th, 5th and 6th ribs adjacent to the costochondral junctions.
Lungs (right 425 g, left 561 g): Both lungs were slightly congested posteriorly, but otherwise normal.
Pericardial cavity: Was clear.
Heart (350 g): Was normal. There was no evidence of coronary artery disease or myocardial ischaemia.
Peritoneal cavity: Was clear.
Alimentary tract: Was normal in site and general appearance.
Liver (1398 g): Was normal.
Gallbladder was present and the bile ducts were patent.

(For continuation–see over

4. In my opinion death had taken place about 2½ 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) Peter Russell
(Date) 30-6-77

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Pancreas: Normal.
Spleen (120 g): Normal.
Kidneys (right 139 g, left 128 g):
Both capsules stripped with ease. Ureters were not dilated and the renal vessels were patent.
Adrenal glands: Were normal.
Bladder and genitalia:
Showed no unusual features.
There was fracturing of the spine at the C7 level and again at the L1 level with considerable dislocation.
Skull: Showed no evidence of injury.
There was peculiar yellow staining of the internal periosteum which was not anthracomic in nature and its cause was not obvious.
Brain (1490 g): Was congested posteriorly but otherwise within normal limits.

Blood sent for estimation of alcohol via Const. Stengelis.

Body identified to Dr. Fletcher by Sen. Const. Parry of No. 14 Division.

Report noted

EXHIBIT "3"
Inquest touching the death
of Rath
Coroners Court, 44-46
Parramatta Road, Glebe
(Date) 16/9/77
(Dep. Clerk)