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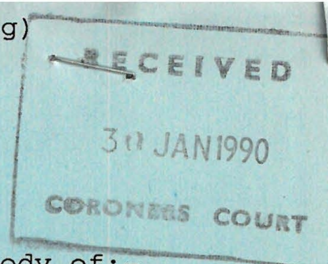

CORONERS ACT, 1980

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

Name: John Alan RUSSELL **PM Number: 89/2125**

I **Sylvia Hollinger** 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 7.30 in the fore noon, on the 29 day of November, 1989 at Sydney in the said State, I made an internal examination of the dead body of a male identified to me by Dr. Lawrence of Division of Forensic Medicine in the State aforesaid, as that of John Alan RUSSELL aged about 31 years.

I opened the three cavities of the body.

Upon such examination I found:

The body was that of a thin man consistent with his stated age.
Body weight 55 kg. Body length 175 cm.
On external examination an appendicectomy scar was present.
A little rigor mortis was present in the legs only and postmortem lividity was present on the back except for pressure points.

Pattern of injuries:

Purple bruising was present on the left side of the abdomen measuring 8 x 6 cm.
Purple bruising was present on the right side of the abdomen covered by abrasion measuring 7 x 5.5 cm.
The clavicle was fractured on the left hand side.
A laceration was present on the left side of the forehead measuring 6 x 1.4 cm.
A laceration was present on the left side of the occipital region measuring 7.5 x 1.5 cm.
A linear red abrasion was present on the back of the left shoulder measuring 13.5 x 1.5 cm.
A red abrasion was present on the front of the left knee measuring 3.5 x 3 cm.
A laceration was present of the left elbow measuring 2 cm in diameter and this was surrounded by a red abrasion.
A closed fracture was present of the lower end of the left humerus.
A closed fracture was present of the lower end of the right radius and ulna.

Internal examination:

Cranial cavity:

The cranial cavity was opened to display tearing of the dura overlying the right cerebral hemisphere.
The tear measured approximately 1 cm in greatest dimensions.
The brain weighed 1380 g.

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The dura was stripped and the following fractures noted:

Comminuted fractures were present of the right frontal, parietal and occipital bones.
Comminuted fractures were present of the left occipital bone, the left petrous temporal bone and the left frontal bones.
Fracturing extended across the midline to involve the pituitary fossa and the ethmoidal bones.
The fractures at the base of the skull showed marked displacement.
The brain showed on its inferior surface pulping, involving the inferior surfaces of the frontal lobes.
On coronal sectioning no additional pathology was noted of the cerebral hemispheres and examination of the brainstem and cerebellum showed no additional pathology.

<u>Neck and thorax:</u>

The thyroid gland and neck tissues were normal.
Heart weight 280 g.
A large tear was present in the pericardium.
Examination of the coronary arteries revealed atheroma with approximately 50% luminal narrowing of the left main coronary artery.
The branches of the left coronary artery and the right coronary artery showed no atheroma and no luminal narrowing.
The myocardium, endocardium and valves were normal.
The aorta showed a complete transection at the junction of the arch and the descending aorta.
600 ml of blood and clot were present in the right pleural cavity.
The right 3rd, 4th and 5th ribs were fractured anteriorly.
Left lung weight 360 g and right lung weight 350 g.
The left pleural cavity was clear.
The right pleural cavity contained the blood and clot as described.
The larynx, trachea and bronchi contained a moderate amount of blood and mucus.
Cross sections to the lungs revealed no obvious pathology except for a laceration of the lower lobe of the left lung.
The oesophagus was normal.

<u>Abdominal cavity:</u>

The stomach contained a moderate amount of greyish granular contents of alcoholic odour.
The stomach mucosa was normal.
Small and large intestines were normal.
Liver weight 1220 g.
The liver was normal.
The gallbladder, bile duct and pancreas were normal.
Left kidney weight 100 g and right kidney weight 100 g.
Apart from pallor the kidneys showed no obvious pathology.
Ureters, bladder and prostate were normal.
The spleen weighed 100 g.
The spleen was normal and the adrenals were normal except for the right adrenal which was surrounded by haemorrhage.

Histology being performed.

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

The body was identified to Dr. Lawrence by Const. Barrett of No. 10 Division.

Microscopic examination:

Heart:

Epicardium, myocardium and endocardium normal.

Lungs:

Section shows congestion and oedema. Intra-alveolar haemorrhage is also present.

Liver:)
Kidneys:)
Adrenals:) Section shows no obvious pathology.
Thyroid:)
Spleen:)

Brain:

Section shows intra-cerebral focal haemorrhage.

Prostate:)
) Section shows no obvious pathology.
Pancreas:)

In my opinion death had taken place about 6-7 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)

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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) 29 January, 1990.