Crispin DYE

PM 93/2466 (TG)

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CORONERS ACT, 1980

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

Name: Crispin DYE

PM Number: 93/2466

I, Liliana Schwartz, a registered medical practitioner, practising my profession at the New South Wales Institute of Forensic Medicine in the State of New South Wales, do hereby certify as follows:-

At 10.00, on the 27th day of December, 1993 at Sydney in the said State, I made a post mortem examination of Crispin DYE.

The body was identified to Mr. W. Howard of the New South Wales Institute of Forensic Medicine by Const Portlock of Kogarah Police Station, as that of Crispin DYE aged about 41 years.

The body was identified to me by the wristband marked E46613.

The forensic assistant in this case was Mr. S. McLeod.

Upon such examination I found:-

The body was that of a well nourished adult male whose appearances were consistent with the stated age.

Body weight 73 kg. Body length 171 cm.

Rigor mortis was present.
Lividity had developed on the back.

Evidence of medical intervention:

1. One E.C.G. dot.
2. A urinary catheter.
3. Intravenous lines into the right antecubital fossa, right wrist and anterior aspect of the left forearm.
4. The endotracheal tube was removed at the hospital, the chest x-rayed showed the endotracheal tube placed in the trachea.

Evidence of injury:

Head and neck:

No petechial haemorrhages or bruising were noted on the sclera or conjunctiva of both eyes.

1. A deep blue bruise measuring 65 x 35 mm was noted on the upper and lower eyelids of the left eye.
2. An area of superficial scratching measuring 15 x 5 mm was noted on the base of the bridge of the nose.
3. An abrasion measuring 10 x 15 mm was noted on the naso-labial region, to the left of the midline.
4. An area of abrasion measuring 10 x 10 mm was noted on the chin.

5. A scratch measuring 8 mm was noted on the left angle of the jaw.

6. A blue bruise measuring 40 x 50 mm was noted on the upper lip of the mouth to the left of the midline.

7. An abrasion measuring 30 x 10 mm was noted on the lower lip of the mouth.

8. A rectangular shaped area of abrasions measuring 82 x 50 mm was noted on the left temple.

9. On the left temple, adjacent to the outer angle of the left eye, there was a healing wound measuring 40 mm in length.

10. An abrasion measuring 5 x 5 mm was noted on the left cheek.

The scalp was reflected and a bruise measuring 120 x 80 mm was noted on the inner surface of the scalp and periostium overlying the left side of the head.

Fractures of the left zygoma and of the left mandibular condyle were noted.

The skull was opened. Linear fractures of both orbital plates and crysta galea were seen. The linera fracture on the left orbital plate extended towards the left frontal bone of the calvarium.

The brain weighed 1820 g, was extremely swollen and was kept in formalin for further investigation.

Neck:

A blood less V-shaped dissection of the neck was performed. Bruising of the right sternocleidomastoid muscle was noted.

There was bruising of the soft tissue overlying the cricoid cartilage (on the midline and left side).

A fracture of the right greater horn of the thyroid cartilage associated with bruising of the soft tissues was noted.

Bruising of the laryngeal mucosa was noted (due to intubation).

Trunk:

No abnormality detected.

Right arm:

A dot sized bruise surrounding an intravenous line was noted on the right antecubital fossa (due to medical treatment).

A scratch measuring 3 mm in length was noted on the posterior aspect of the right hand.

Left arm:

A blue bruise surrounding an intravenous line measuring 110 x 50 mm was noted on the left antecubital fossa (due to medical treatment).

A pale bruise measuring 25 x 25 mm was noted on the radial aspect of the left wrist.

An abrasion measuring 30 x 35 mm was noted on the left elbow.

An area of bruising and abrasions measuring 40 x 40 mm was noted on the posterior aspect of the left wrist.

An area of abrasion and discolouration of the skin measuring 60 x 20 mm was noted on the ulna aspect of the left hand.

A red bruise measuring 20 x 15 mm was noted on the ulna aspect of the left forearm.

Right leg:

An abrasion measuring 5 x 5 mm was noted on the external aspect of the right shin.

Left leg:

An area of discolouration of the skin measuring 45 x 15 mm was noted on the left shin.

An area of discolouration of the skin measuring 10 x 10 mm was noted on the anterior aspect of the left foot.

INTERNAL EXAMINATION:

Head and neck:

Except as noted, no other abnormalities seen.
The brain was kept in formalin for further investigation.

Body cavities:

No abnormalities seen.

Cardio-vascular system:

The heart weighed 430 g.
The cardiac chambers and valves were normal and the coronary arteries were free of atheromatous plaques.
The myocardium was normal.
The aorta and branches, inferior and superior vena cava, pulmonary vessels and portal system were normal.

Respiratory system:

Except as noted, the following abnormalities were also seen:-
The left lung weighed 820 g and the right lung weighed 800 g. Both lungs were very oedematous, congested and friable and purulent material flowed from the small bronchioli.

The diaphragm was normal.

The airways had no contents.

Gastro-intestinal system:

The oesophagus was normal.
The stomach contained digested food and bile. The gastric mucosa was normal.
The small and large bowel were normal.
The liver weighed 2300 g and had no abnormalities.
The gallbladder and bile duct were normal.
The pancreas was normal.

Haemopoietic system:

The spleen weighed 240 g and was congested, but otherwise, normal.
Lymphadenopathy was noted on the neck (reactive).

Urinary system:

The left kidney weighed 220 g and the right weighed 200 g.
The capsules stripped easily.
The cortex was congested and on sectioning the calyces, pelvis, ureters and urinary bladder were normal.
The urinary bladder was empty.
The prostate was normal.

Endocrine system:

The thyroid and adrenal glands were normal.

Musculoskeletal system:

Except as noted above, no other abnormalities seen.

Tissue for histology. (brain retained in formalin for further examination).
Stomach contents were taken for toxicologic analysis.
Blood for grouping and head hair for serologic studies.

MICROSCOPIC EXAMINATION:

Carotid artery: Arteriosclerotic changes noted. No other abnormalities detected.

Lymph node: Sinus histiocytosis.

Lung: Oedema, congestion and severe acute bronchopneumonia. Numerous bacterial colonies were noted in the inflammatory process.

Pancreas: There was a large necrotic area; at the periphery of this area there was a dense leucocytic infiltrate. Acute pancreatitis.

Liver: The tissue was congested. Leucocytes were seen in the sinusoids. A golden pigment was noted in an occasional hepatocyte of the central zone (lipofucsin pigment??).

Thyroid: Normal.

Parathyroid: Normal.

Prostate: Normal.

Heart: The tissue was oedematous and a scanty number of polymorphs and plasma cells was noted in the stroma. This finding is most likely due to sepsis.

Testes: Normal.

Adrenal: Normal.

Spleen: Congestion. The architecture was effaced and numerous polymorphs were seen in the red pulp.

Kidney: Normal.

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Macroscopic and Microscopic Description of Brain:

See attached report.

Toxicology:

See attached report.

PATHOLOGY SUMMARY

1. HEAD INJURY

   a) FRACTURES OF BOTH ORBITAL PLATES AND PART OF LEFT FRONTAL BONE.
   b) DIFFUSE BRAIN DAMAGE (SEE MEDICAL RECORDS).
   c) FRACTURE OF LEFT MANDIBULAR CONDYLE
   d) FRACTURE OF LEFT ZYGOMA

2. BRUISING OF THE SOFT TISSUES OF THE NECK WITH ASSOCIATED FRACTURE OF THE RIGHT GREATER HORN OF THE THYROID CARTILAGE.

3. OEDEMA, CONGESTION OF THE LUNGS.

4. ACUTE BRONCHOPNEUMONIA.

5. ACUTE PANCREATITIS.

6. SEPTIC FEATURES IN LIVER, SPLEEN AND HEART.

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In my opinion, based on what I have observed myself, my experience and training, and the information supplied to me:

COMMENT:

The injuries described above are those caused by a blunt instrument. The fracture of the mandibule and zygoma are most likely due to a direct impact.

A. Time and date of death: 6.30 pm on 25/12/93

B. Place of death: St. George Hospital, Kogarah

C. Cause of death:

1. DIRECT CAUSE:
Disease or condition directly leading to death:

(a) HEAD INJURY

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,

SYDNEY

(Signature) .....

(Date) 27 April, 1994