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Case Report

Fall or homicide...? The imbroglio answered at autopsy...!

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ABSTRACT

Homicide is one of the most dreaded consequences of interpersonal conflicts, culminating in ending the life of a person. Cases involving attempts to camouflage homicidal incidents with the accidental ones are not entirely unknown in forensic medicine. Most of the time however, neither medical science nor the law gain expected success in either curbing or unearthing such incidents, so there remains a great possibility of perpetrators escaping a meticulously planned homicide that has been disguised either as a suicide or as an accidental death. In such cases, the role of a scrupulous autopsy is of paramount importance to surface the truth. A careful observation and interpretation of the injuries in dubious circumstances may occasionally reveal an entirely unprecedented story and thereby the cause and manner of death. A case related to a young adult male is herein presented who was initially brought dead to the emergency dept. with an alleged history of assault leading to a blow over his head. In the inquest papers, however, his acquaintances stated the injury to be sustained from an accidental fall in the street. At autopsy, a discrepant location and form of the scalp injury and the additional findings suggestive of manual strangulation and kicking and/or stomping resulted eventually into an opinion of homicide. The characteristic postmortem findings and attempted circumstantial and crime scene alterations by the possible perpetrators are highlighted. The results of a modeled wound-weapon profiling that was carried out later to link the alleged crime weapon with the injury profile, are shown.

1. Introduction

In cases of homicides, sharp force injury, blunt force injury and asphyxia are the predominant methods of killing. The head is a common target of choice in assaults with blunt objects while other frequent causes of head injuries being traffic accidents, falls from height and falls from standing position.[1] In homicidal asphyxial deaths, strangulation is the leading method of killing. In cases of combined homicides, strangulation and blunt head injury frequently coexist.[2]

Forensically, it is not uncommon for the homicidal incidents to be masqueraded as suicidal, accidental or natural events. Few examples are simulation of homicidal strangulation as suicidal hanging,[3] non-vehicular homicides disguised as traffic accidents,[4] and homicidal gunshot wounds staged as suicides.[5] Similarly, cases of suicides disguised as homicides have been reported sporadically.[6]

It is also well-known that a great domain of such cases remains largely hidden or unsolved either due to lack of a fair and intensive police investigation or from poor medical understanding of mechanism of injury. The role of a scrupulous forensic autopsy in such cases cannot be overemphasized.

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The present case belongs to a young adult male who was initially brought dead to the emergency room (ER) with an alleged history of physical assault, leading to a blow over his head. Later on, however, attempts were made to simulate his death as an accidental fall under the influence of alcohol. A complete autopsy, however, contradicted the alleged alibi, culminating finally into an opinion of homicide.

2. Case Report

2.1. History

During one night, a 32 years old male was brought dead to the ER by his father with an alleged history of physical assault resulting in a hit over his head (written by the EMO over his admission card). Death information was sent to the police and the dead body was brought for autopsy the next morning. In the police papers, however, the circumstances entailed an entirely different story. The deceased's wife, a leading eye witness, stated that during previous night, her husband was drinking heavily along with his father at latter's residence. As he walked in the street, on the way back to their home, he suddenly lost his balance and fell directly backward on the tiled floor of a street and sustained a bleeding injury over the back of his head (i.e., occiput; pointed-out specifically by the witness), becoming unconscious thereafter (Figure 1). The deceased's father also narrated the same story while, at the same time, refuting any history of assault given by him in the ER.

The deceased arrived in the hospital after about an hour of incident. In the police papers, a scalp injury without any site-specification was mentioned while the apparent cause of death was mentioned as 'sudden death due to fall on the ground under alcohol intoxication'.

The apparent discrepancy in the narratives (i.e., physical assault versus accidental fall) raised suspicion over the case's circumstances. No resuscitation procedures were carried out. Any transportation or handling-related injury was ruled out. The autopsy was carried out after about 15 hours of the incident.

2.2. Autopsy findings

The supine dead body of a well-built young adult male, bearing a body weight of 80.5 kg and stature of 187 cm. It had a wheatish complexion and was clad in a white sleeveless vest, yellow pants, blue underpants and a metallic bracelet around the right wrist. The clothes were stained with blood and blackish greasy stains, predominantly over the front (important details are described vide infra). The head was lying in a disk-shaped puddle of blood over the autopsy table. The nostrils were bleeding while clotted blood adhered over front of ears and around the lips. Rigor mortis was fully developed all over the body. Purplish-blue PM hypostasis with contact pallor zones in line with the supine posture, but without hypostatic petechiae. Symmetrical fronto-temporal baldness was present. No head deformity seen.

A careful inspection did not reveal any external injury over the occipital or subjacent regions of the scalp or anywhere else over back of the body. The following injuries were present however:

2.2.1. Scalp

1. A triradiate split laceration over vertex (bregma) of the scalp, placed nearly symmetrically across the midline (Figure 2). A cylindrical profiled-abrasion of 6.5 x 1.5 cm around the impact area, pinkish-red and parch brown, chiefly over anterior and slight posterior margin. An abrasion-free split radiated for a cm from each wound's end. Tissues beveled over superior and inferior right margin. Margins were crushed and irregular. Tissue bridging and haematoma over the floor.

On dissection, thick and dark subgaleal haematoma along with bright periosteal bleeding overmajority of the right frontal scalp caused by a long curvilinear fracture of the underlying frontal bone, continued up to the right orbital plate over skull's base, but sparing ethmoids. The fracture followed a typical course, as defined for similar impact previously.[7] Right upper eyelid diffusely ecchymosed and swollen (Black eye),

Additional subcutaneous injuries included:

1. One 3 x 2.5 cm bruise slightly left and lateral to the scalp laceration.
2. One small temporal bruise just above left ear's helix, with associated haematoma temporalis. Another tiny haematoma over top of the temporalis but without associated scalp injury.
3. A 2 x 1 cm bruise recessed between left frontal eminence and supraorbital ridge. Beneath it, an indented bluish skull bruise with an overlaid shallow vertical fissure, confined to the outer table of skull. Upon sectioning, sharply delineated haematoma of the corresponding skull diploë appreciated.

2.2.2. Face

1. Paired bruised punctiform abrasions over middle of the forehead.
2. A small purplish bruise over upper labial mucosa across the frenulum.
3. Three crescentic reddish nail impressions and a punctiform abrasion over lower right cheek, body of mandible and near right nasolabial angle (Figure 3).
4. Two adjacent bruised nail impressions over the left angle of mandible.
5. One reddish punctiform abrasion within left auditory meatus with an adjacent small bruise.

6. A nail abrasion over left ear's back with detached epidermis (claw-like). A small purplish bruise just below it.
7. A punctiform abrasion over left mastoid process.

2.2.3. Chest

1. Dark greasy-muddy stains smudged the left front chest of the vest. Upon closer scrutiny, at least two different footwear-tread patterns were placed one above the other (Figure 4). The patterns consisted of serial-parallel ridges, limited over the periphery by arc-like contours. The ridges of superior (smaller) pattern ran obliquely (Figure 4a), while of lower (larger) pattern were directed principally in two axes: nearly three vertical and parallel ridges medially and a diffuse elliptical pattern laterally, having an oblique tram-like ridge near its base (Figure 4b). Corresponding alternate stain-free areas, representing grooves, were present in-between. Vest's striations created a (pseudo)simulation effect in-between that was dealt with care.

In the vicinity, a coin-sized purplish bruise over the chest, medial to axilla, with doughy-pulpy surrounding skin (Figure 5a). Underneath subcutis and muscles were ecchymosed over a relatively larger area chiefly involving the first intercostal space. Partly crushed and pulpified soft tissues with muscles detached laterally below the clavicle (Figure 5b). Thoracic cage and clavicles were, however, unremarkable.

*2.2.4. **Extremities***

1. The pants just below the right inner knee across the seam line bear tan-colored stains, highlighting shoe-tread profile(s) (Figure 6a). The pattern was composed of serial-parallel ridges with alternating stain-free zones, converging in a V-like manner. The corresponding right upper shin bears an 8.5 x 1 cm area of oblique and indented brownish excoriations (like chafing) along with intermittent and surrounding reddish cutaneous hue (a1). An oval parch-abrasion present above. Regional skin was doughy and freely gliding.

Dissection reveals ecchymosed and ripped-off subcutis along with formation of blood-filled cavern (closed décollement) (a2). Crushed and pulpified fat had been almost separated into fronds while muscular fascia was patchily ecchymosed throughout (a3). Tibial periosteum had been sheared off along with subperiosteal ecchymoses. No bone injury was present however.

The pants seam line almost a feet above (1) bears subtle horizontally-placed alternating ridges and stain-free areas, possibly an incomplete shoe-profile (Figure 6b). Correspondingly, three confluent tiny purplish bruises in the center of a faint roundish bruise of approx. an inch diameter, over middle-medial right thigh (b1). Regional skin was doughy-pulpy that upon dissection reveals confluent punctiform extravasations in the dermis and subcutis (b2),

Additional small injuries included: crescentic nail impression, one each over middle of the left deltoid, left forearm medial upper front and left ulnar styloid, (with reddish base and heaped-up epidermis distally); a discoid finger-pad bruise over medial-middle of each arm with subcutaneous haematoma.

Additionally, large map-like and round to satellite-shaped confluent blood stains smudged pants upper front right and left thigh, respectively (suggesting victim being seated at some point of time, shedding blood drops (from top) vertically down over the thighs).

2.2.5. Organ findings

1. Brain (Weight: 1634 gms). A thin film of fresh subarachnoid haemorrhage over dorsolateral aspects of the brain. Massive subdural and subarachnoid haemorrhages over the base, esp. thick film of subarachnoid haematoma around brainstem, cerebellum and interpeduncular fossa. A gentle and careful removal of the haematoma reveals acute tearing and stretching of the arteries belonging to Circle of Willis (Figure 7). Few arteries were torn nearly to lace-like threads. Multiple confluent punctate cerebral contusions over bilateral gyri recti, inferior temporal gyri, left lateral parietal and right basal-occipital lobe. Salient brain swelling but without any evidence of herniation. Unremarkable brain parenchyma in coronal slices. No evidence of significant cerebral vascular pathology, esp. saccular or Berry aneurysm.
2. Two left interlobar pulmonary contusions. Few Tardieu's spots in each lung.
3. Layered and bloodless dissection of the neck reveals the following:

   (a) Few superficial, streaky haemorrhages in the strap muscles, just below the hyoid area. Subfascial hematoma of the left sternothyroid muscle near its origin (Figure 8). Patchy soft tissue haematoma over left inner clavicular end.
   (b) Localised subcapsular bleeding of the thyroid gland over right lobe superior, near isthmus.
   (c) Bruised and haemorrhagic left sided tip of the tongue with slight mucosal laceration (Figure 9). On dissection, corresponding and spot-like haematomas of lingual musculature. No dental or jaw injury.
   (d) Circumscribed haematoma of the left vocalis (upon sagittal sections of vocal folds).
   (e) A purplish-red oval bruise with spotty haemorrhages over middle-posterior oesophageal wall (Figure 10). Focal submucosal haemorrhage upon dissection.

Serial long incisions over the inner scalp did not reveal any ecchymoses in the occipital or nearby regions. No additional skull fracture, esp. of the occipital bone and petrous ridges. Throat skeleton was unossified and intact. No facial congestion or conjunctival petechiae seen. Skin and subcutis of ventral and dorsal neck were unremarkable.

Histopathology: slight pulmonary congestion and oedema. Hepatic mild fatty changes. Heart (334 gms): devoid of any significant myocardial or coronary arterial pathology.

Blunt craniocerebral trauma was the cause of death. The manner of death was homicidal. Chemical analysis report of viscera reads positive for ethyl alcohol with strength of 63.25 mg%, 69 mg% and 74.75 mg% in the blood, urine and bile samples respectively.

2.3. Further investigation into the case

From the hearsay evidence, it was later transpired that a spade (kassi, Indian agricultural model) at its peen area had been blown over the victim's head. The victim had been beaten and killed out of some long-running domestic dispute by his own acquaintances.

According to the police, however, no FIR has been yet lodged in this case, as no person has yet come forward as a complainant. Allegedly, the matter has been compromised on a mutual basis. No further legal investigations have been initiated. No subsequent opinion regarding any weapon or otherwise were sought from the forensic doctors.

2.4. Wound-weapon profiling

After knowing the likely crime weapon, an effort was subsequently made by the forensic doctors for a possible wound-weapon profiling. A model similar to the alleged spade and an adult human skull were fetched from the forensic museum. Upon comparison, the cylindrical shaped-abrasion around scalp laceration matched consistently with the peen-head (esp. anterolaterally) (Figure 11). After considering complete injury morphology, a blow over the vertex seemed highly likely (Figure 12). However, exact instrument's dimensions and relative victim's-assailant's positions cannot be absolutely defined.

3. Discussion

Blunt head injuries are often associated with the cause of death which makes their examination of vital importance in the medicolegal investigation of death. Globally, the incidence of fatal head injuries due to assault is greater than the non-fatal cases.[8] The chances of survival in such cases depend chiefly upon the type of weapon used, type and site of skull fracture, intracranial haemorrhage and the brain injury.[8] In homicidal asphyxias, strangulation is the leading cause of death and is often found associated with other methods of killing, esp. head injury.[2,9]

Fig. 1: Alleged site of accidental occipital fall (encircled, hard tiled floor of the street). No suspicious blood stains or debris is visible anywhere. [Note: Crime scene photograph taken next day morning]

Fig. 2: Split-laceration (triradiate) over vertex of the scalp with surrounding cylindrical shaped-abrasion. Abrasion-free splits radiating from each of the three wound's end. Bevelled soft-tissues and haematoma over the floor. [Scalp shaved at autopsy]

Keeping in view the presented circumstances of the case, it would be prudent to discuss the autopsy findings sequentially, in the light of available literature.

4. Head injury (Fall Vs Blow)

The discrimination of ground-level falls (from standing height onto a flat floor) from blows over the head is often achieved through Hat Brim Line (HBL) rule (HBL: line representing the greatest horizontal circumference of the

Fig. 3: Multiplecrescent to punctate nail impressions around right side mouth and mandibular body. Bruised-abrasions visible over the forehead's middle. Right black eye. [Hairs shaven at autopsy]

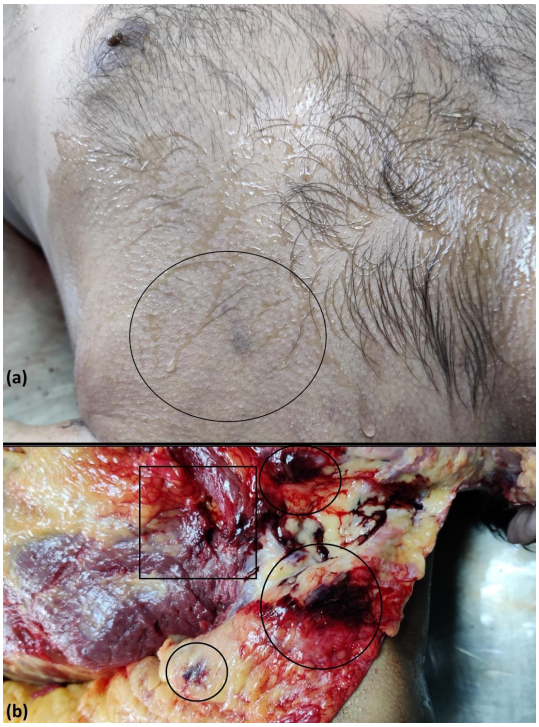

Fig. 5: Chest wall findings near kicking traces. (**a**) Bruised and doughy-pulpy cutaneous zone near left clavicle (encircled), (**b**) Subcutaneous and muscular ecchymoses (encircled). Detached-off muscles and haematoma below lateral clavicle (within block)

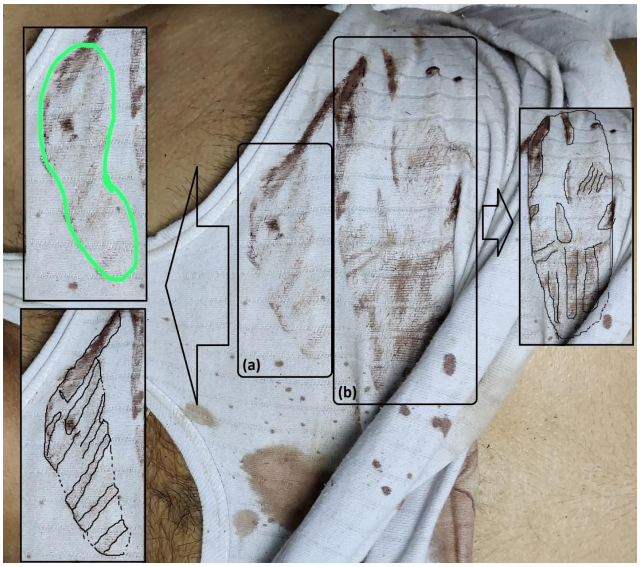

Fig. 4: Two adjacent footwear-traces over the vest (in thecentre): Smaller pattern (**a**) shows alternate and oblique ridges and stain-free grooves. Left Side Insets: Above- General footwear's contour delimited, Below: Ridge-groove pattern specifications. A suspicious shoe-slip-like trace on the top. Larger footwear trace (**b**) showing a different pattern. Right Inset: delimited complete pattern with individual zones highlighted.

Fig. 6: Right lower limb showing: (**a**) shoe-traces over pants below right inner knee with converging ridge-groove patterns.Insets: (**a**1) correspond indented excoriations and reddish cutis across right upper shin. Individual ridges appreciable. An oval parch above, (**a**2) bleeding cavity and subcutaneous soft-tissue avulsion (closed décollement), (**a**3) ecchymosed fat separated into fronds. Patchy haemorrhagic muscle fascia, (**b**) horizontally placed subtle partial shoe-trace, showing alternate ridges and gaps. Inset: (**b**1) corresponding medial right thigh with faintly bruised-doughy skin and central tiny bruises (encircled), inset (**b**2) confluent punctate dermal and subcutaneous extravasations. [Note: Corpse head towards the right]

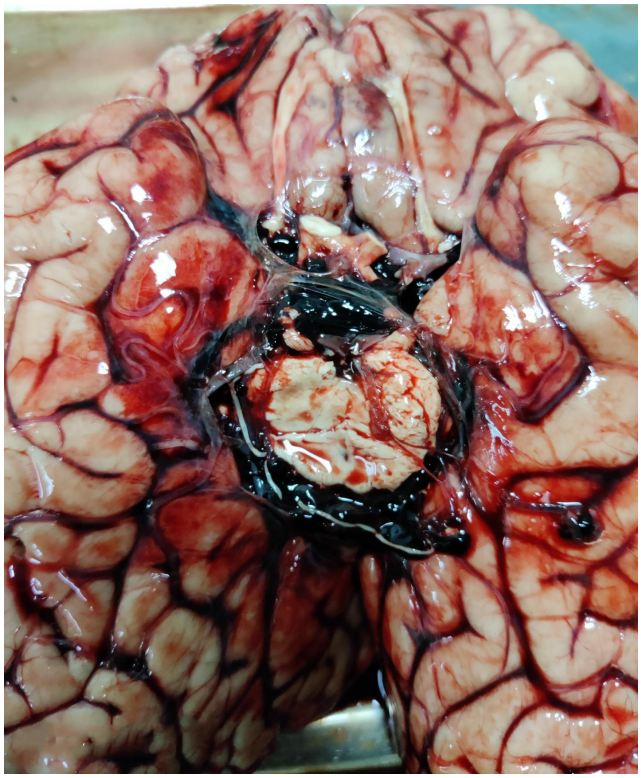

Fig. 7: Subarachnoid bleeding andhaematoma over base of the brain. Acute tearing and stretching of the arteries belonging to Circle of Willis. [Brainstem has been dissected away and most of the haematoma gently cleaned at autopsy].

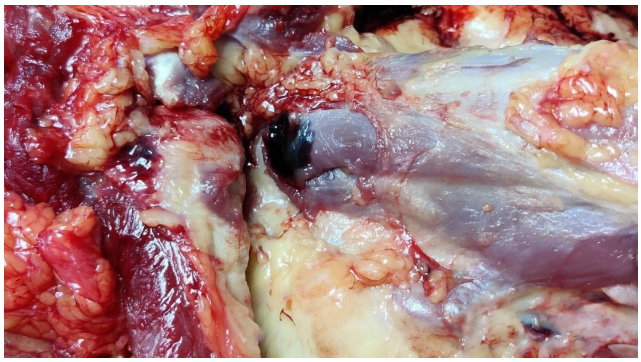

Fig. 8: Subfascial haematoma of left sternothyroid muscle near its origin. Patchy haematoma just above inner clavicle is also visible.

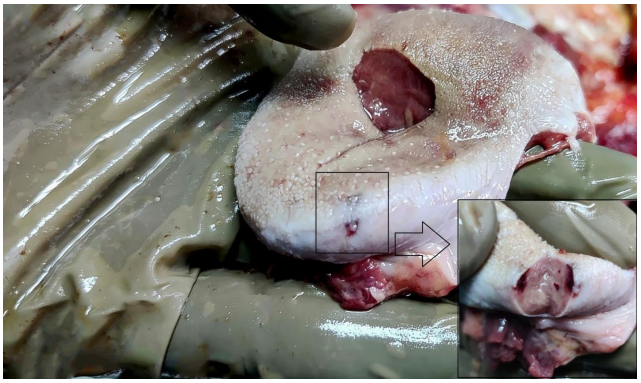

Fig. 9: Bruised andhaemorrhagic left sided tip of the tongue across anterior margin (within block). Corresponding intramuscular and spotty haematomas upon dissection (inset). [Note: Tissue defect in tongue's middle is an autopsy-related artifact]

Fig. 10: Irregular bruise withpatchy haemorrhage over posterior middle oesophageal wall (encircled).

skull),[10] which was prudently made in this case. This discrimination was perhaps the foremost priority in the prevailing circumstances. The exceptions to the rule were duly considered before incorporating it into the case.[11] A comparative study based upon cases of blows with relatively long instruments, falls from stairs and falls from standing height lead to the following verifications over this rule:[10] (1) only the scalp injuries located over "top of the head" region (limited by dorsal-lateral frontal and parietal regions) are quite uncommon in falls from standing height, (2) a scalp laceration of more than 6 cm length is indicative of a blow rather than a fall, (3) In falls from a standing position, only exceptionally more than one scalp injury is found.[10]

Another study comparing cases of homicides and falls from low-level height (sudden death associated and accidental) concluded that the simultaneous presence of at least one scalp laceration (of length more than 4 cm), of one deep (scalp) bruise, and of neuropathological injuries (in the form of subdural and subarachnoid haemorrhages) indicates a strong presumption for homicidal rather than a non-homicidal death.[12] Based upon these observations, the possibility of a homicidal blow in the present case was strongly supported. Additionally, the presence of multiple skull lesions favored a homicidal rather than an accidental

Fig. 11: Possible wound-weapon profiling with a museum model of the alleged weapon used to hit the head (agriculturalkassi). The cylindrical shaped-abrasion around scalp laceration (inset) corresponds with the peen head (rectangled at two possible places). [Instrument main parts labeled]

Fig. 12: The ideal presumptive situation of blow (by a right hand dominant person). The complete injury pattern is consistent with the peen's head (inset). [Museum Specimens: Skull and Spade]

mode of death.[8]

The splits of laceration were free of any concomitant blunt injury because of a possible wedge-like effect and lack of direct tissue crushing.[1,13] The effective impact area was thus confined to the patterned-abrasion zone only (so called an 'abraded-laceration'). Detachment of the nasal mucosa due to a heavy vertical blow most likely lead to the nasal bleeding.[14] A congestive mode of this bleeding was, however, unlikely.

Furthermore, in the absence of concomitant surface injuries to the facial prominences (such as nose, chin, cheeks, orbital rims, etc.) and lateral arms, a fall-related mechanism could not be supported for any scalp injury.[13,14] A recessed location of left frontal injury thus supported a blow rather than a flat-surface fall.[13]The corresponding frontal skull bruise, being another (independent) marker of the impact site, has been reported in only few forensic studies.[15] Interestingly, one study did not find any evidence of associated falls in 31 cases of homicides.[12]

Nonetheless, the results of wound-weapon profiling resulted in a possible match between the instrument and abrasion's profile, thereby attesting the hearsay story of homicide. Although, it is admissible that the abrasion's texture was not typical of a smooth-edged impact,[1] yet the responsible agent (peen-head) is well known for its rough textured surface that possibly lead a variegated abrasion profile. Such patterned abrasions have been of leading forensic interest whereby they assist in linking the suspected crime weapon with the corresponding injury profile.[13,16]

The locations of cerebral contusions and massive bleeding over the base of the brain (esp. around the brainstem and cerebellum) also favored a heavy blow over the vertex, causing thrusting of the basal brain and tearing of basal vessels, simultaneously, against a rough and bumpy skull's base.[1,17,18]

4.1. Manual strangulation and smothering

The presence of injury marks over the face esp. around the mouth, left ear and forehead, along with bruising over upper labial frenulum indicated attempts of either smothering or restraining the victim from shouting. Bruised nail impressions over left angle of mandible, and bruising with intramuscular haematoma of tip of the tongue and deeper neck structures (esp. thyroid, oesophagus and vocalis) suggested a violent attack over the neck.[19–21] As the processes of manual strangulation and smothering are not infrequently associated, thereby presence of such injuries over the victim's body was customary.[22,23]

The characteristic haematoma near origin of the left sternothyroid muscle possibly originated from the violent tensile strains put on the neck structures, thereby causing a strain-induced bleeding at the muscle's origin site. Similar haematomas have been previously reported at the origin of sternocleidomastoid muscles in two manual strangulation

cases.[24] Along with local bleeding into deeper neck structures at nearly same level, an event of upwardly directed mid-neck pressure could be suggested.

Nevertheless, it is also well-known that the applied pressure during manual strangulation may spread even down up to the inner ends of clavicles,[17] thereby regional haematomas in that area were customary. The superficial, streaky bleeding in the strap muscles (defined as 'sprain bleeding'), located just below the hyoid area, also supported a possible manual strangulation.[21] The classical discoid and deep 'pressure bruising' of the throttled strap muscles was, however, not seen.

Another important aspect of the case was lack of any cutaneous or subcutaneous injuries over the ventral neck or a throat skeleton fracture, despite the presence of deeper neck injuries. Observations derived previously from multiple fatal strangulations have unanimously concluded that despite prominent cutaneous and deeper neck injuries, unossified throat skeleton of the young may not show any evidence of laryngeal or hyoid bone fracture/injury.[25,26] The lack of cutaneous injuries in this regard has been similarly well documented.[18,27] An important reason behind such variations may be that a subset other variables such as victim's intoxication levels, interposition of clothes/hairs/padded hands, victim's constitution and struggle, incapacitation/obtundation, amount and duration of pressure applied and/or (sudden) nature of attack, also affect the outcome of findings significantly, so that one may occasionally be strangled with little, if any, evidence of external and/or internal neck injury.[9,27,28] Manual strangulation may also be an ultimate event in a multiphase incident, thereby affecting the neck findings accordingly.

The lack of cephalic petechiae similarly may be attributed to a prior infliction of severely bleeding head injury (causing lack of required intravascular pressure for vascular ruptures) or a non-congestive pathophysiological mechanism of strangulation coming into display.[9,17]

In conclusion, alcohol intoxication, (prior) incapacitation from a severe head injury and a possible unanticipated nature of attack (e.g., lack of typical defense injuries), must have played a significant role in the presented neck findings.

4.2. Physical evidence of kicking

Kicking, in almost all homicidal cases, is a part of chain of events.[29] The sole-tread patterns of different footwear over the victim's clothing suggested multiple episodes of kicking and/or stomping during some stage of incident, possibly while he laid in a recumbent position.[29] The traces over the vest concurred well with the closed chest injury, the overall morphology of which could be easily explained based upon tangential forces of kicking.[30] The same mechanism was appreciated in the closed décollement injury of right leg whereby additional shoe-traces over pants and cutaneous chafing attested similar episode(s) of kicking. Forensically, such décollements have been frequently described in traffic-related fatalities, whereby the tangential hood strike from a motor vehicle/car commonly leads to subcutaneous avulsion of soft tissues and resultant bleeding cavities in the back, buttocks and/or lower extremities of a pedestrian or cyclist.[1,31]

Nevertheless, patterned shoe injuries, signifying kicking, are occasionally encountered on the victim's skin.[32] Morphologically, these usually take the form of bright-red intradermal extravasations that commonly represent negative- and rarely a positive-imprint of the shoe-sole, resulting from squeezing of skin folds in the grooves/reliefs located in-between-,[1] and direct impacts of the elevated ridges/projections onto the skin,[33] respectively; the positive imprints being differentiated by accompanying concomitant abrasions usually.[33]

It is also a proven fact that external stigmata of kicking may be quite subtle or non-specific, so as to easily escape detection at autopsy.[34] In a retrospective study, shaped-injuries characterizing shoe-traces on body surface or clothing were recorded merely in one-third of cases.[32] In one case, trivial looking abdominal abrasions, leading to a fatal hepatic rupture and hemoperitoneum, were later on revealed to be caused by jumping over the victim, only via some witness testimony.[29] In the present case, the slight morphological bruising over the right thigh along with the subtle shoe-traces over the pants was possibly sustained from a similar episode of kicking.

The physical findings of kicking additionally aided in establishing homicidal circumstances of the case.[29,32] The gripping bruises over the upper arms along with nail impressions over left upper extremity suggested forcibly restraining the victim.

5. Conclusion

A thorough and meticulously performed autopsy, unbiased of police history, preconceived assumptions or appealing circumstances, may be the sole way to bring out the truth.

Masquerading of homicidal incidents with the accidental ones does not connote the cause and manner of death.

The discrimination of an accidental fall from blow(s) over the head should be carefully made at autopsy. HBL rule is often helpful, keeping its limitations in mind.

The morbid findings of strangulation may be quite subtle that may appear at variable neck planes and nearby places, independently. Tongue haematomas/bites should be alarming.

Isolated strap muscles bleedings can be of varied forms forensically, anticipating a sound mechanistic evaluation.

The physical evidence of kicking traces may range from overtly subtle to quite straight forward at autopsy. In the absence of a forthcoming history or closer scrutiny, their appreciation may be escaped easily.

The present case reveals the mens rea of the (possible) perpetrators who after killing the victim tried to conceal the crime by manipulating the entire history and circumstances.

6. Conflict of Interest

The authors declare that there is no conflict of interest.

7. Source of Funding

None.

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