IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 1833

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: ANGELA MURRAY

Delivered On:	25th June 2012
Delivered At:	Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	29 May 2012
Findings of:	AUDREY JAMIESON, CORONER
Police Coronial Support Unit	Leading Senior Constable Amanda Maybury

I, AUDREY JAMIESON, Coroner having investigated the death of ANGELA MURRAY

AND having held an inquest in relation to this death on 29 May 2009
at MELBOURNE
find that the identity of the deceased was ANGELA FAY MURRAY
born on 8 July 1956
and the death occurred on 23 September 2008
at Monash Medical Centre, 246 Clayton Road, Clayton 3168
from:

1 (a) ASPIRATION PNEUMONIA IN A FEMALE WHO HAD UNDERGONE A LAPAROSCOPIC CHOLECYSTECOTMY FOR CHOLANGITIS AND CHOLELITHIASIS WHO ALSO SUFFERED FROM PANCREATITIS AND RECENT HAEMATEMESIS

in the following circumstances:

1. Ms Angela Fay Murray was 52 years of age at the time of her death. She had an intellectual disability and was diagnosed with cerebral palsy and epilepsy. She lived in a group home located at 1139 Dandenong Road, East Malvern, a facility under the auspices of the Department of Human Services, Disability Services.

2. On 30 August 2008, staff at the home observed that Ms Murray required greater assistance to get up and was unsteady on her feet. Further changes in her condition were noted over the following day prompting requests for attendance by her treating general practitioner, Dr Psaradellis. Investigations were subsequently performed at Cabrini Hospital. On 10 September 2008, Ms Murray vomited a large amount of fluid which was reported to Dr Psaradellis. She vomited again that evening after eating a small meal and then at approximately 9.20pm, vomited a large amount of brown coloured liquid which was also reported to Dr Psaradellis.. An ambulance was subsequently requested and Ms Murray was transported to the Monash Medical Centre with suspected aspiration.

3. On 11 Sepember 2008 Ms Murray was reviewed by the surgical registrar and was found to have a number of medical concerns including acute cholecystitis with multiple immobile stones in the gallbladder, cholangitis with a raised white cell count, pyrexia and acute pancreatitis. She subsequently underwent a laparoscopic cholecystectomy with an intraoperative cholangiogram. Postoperatively Ms Murray's condition did not substantially

improve and she experienced seizure activity and decreased oxygen saturation levels requiring MET calls on two occasions. By 23 September 2008, Ms Murray had developed significant respiratory distress. In consultation with her next of kin, it was decided that there should be no further escalation of treatment. Ms Murray died on 23 September 2008.

4. At the time of her death, Ms Murray was considered a *person in custody or care* as defined in the *Coroners Act 2008*[1] her death was *reportable*,[2] however, a death certificate was issued and this did not occur.

5. On 1 April, 2009, the Department of Human Services reported Ms Murray's death to the Coroners Court.

Investigation

6. Associate Professor (A/Prof.) and Forensic Pathologist, Dr David Ranson, was requested to review the documentary material available in relation to Ms Murray's death, including the death certificate and the medical records from Monash Medical Centre. A/Prof. Ranson commented that the medical certificate of death appeared to be correct, however, it failed to mention some of the predisposing medical conditions which led to her final period of hospitalisation. Accordingly, A/Prof. Ranson reformulated Ms Murray's cause of death to be that of aspiration pneumonia in a female who had undergone a laparoscopic cholecystectomy for cholangitis and cholelithiasis who also suffered from pancreatitis and recent haematemesis. No suspicious circumstances were identified.

7. Sergeant David Dimsey of the Police Coronial Support Unit undertook additional investigation on behalf of the coroner and obtained a statement from Ms Cathie Ceroloni, Disability Accommodation Services Manager for Disability Services for the inner part of southern region. No issues were identified as specific to the care that Ms Murray received at her group home or Monash Medical Centre.

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[1] Person placed in custody or care **"person held in care"** means—

(a) a person under the control, care or custody of the Secretary to the Department of Human Services; or the Secretary of the Department of Health

[2] **"reportable death"** means a death—

(a) a person under the control, care or custody of the Secretary to the Department of Human Services; or the Secretary of the Department of Health

8. An inquest was held in accordance with Section 52(2)(b).

Finding

I accept and adopt the medical cause of death as identified by A/Prof. David Ranson and find that Angela Fay Murray died from aspiration pneumonia in circumstances where she had undergone a laparoscopic cholecystecotmy for cholangitis and cholelithiasis on a background of pancreatitis and recent haematemesis.

AND I further find that there is no relationship between Ms Murray's cause of death and the fact that she was a *person in custody or care* as defined in the Act.

I direct that a copy of this finding be provided to the following:
Ms Carolyn Felix, sister of Ms Murray
Ms Cathie Cerolini, Department of Human Services

Signature:

AUDREY JAMIESON
CORONER
Date: 25.6.12

Coroners Court of Victoria