IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2908

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MICHELLE HODGSON, CORONER**
Deceased:	**BEVAN JAMES MURROWOOD**
Date of birth:	29 August 1960
Date of death:	20 June 2017
Cause of death:	1(a) COMPLICATIONS OF A SMALL BOWEL OBSTRUCTION
Place of death:	Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria

HER HONOUR:

Background

1. Bevan James Murrowood was born on 29 August 1960. He was 56 years old when he died on 20 June 2017 following a bowel obstruction.

2. Mr Murrowood lived in Templestowe in Department of Health and Human Services accommodation with four other gentlemen. The residents, each of whom have a disability, are supported by 24-hour care.

3. Mr Murrowood was born with a severe intellectual impairment. He lived with his family until he was approximately eight years of age, before moving to the Kew Cottages, where he remained until 1996. He thereafter moved to Balwyn and subsequently to the Templestowe home.

4. Mr Murrowood was able to communicate with his carers and was receptive to their instructions and directions. He was also able to dress and eat independently, however required support for other daily activities. He attended a day service five days a week.

5. Mr Murrowood's medical history included hypertension, visual impairment, constipation, agitation and depression, and a previous stroke. He was on a number of medications to treat these conditions.

6. Mr Murrowood last saw his general practitioner, Dr Alan McCleary, on 30 May 2017 for a routine check-up. At this time, Mr Murrowood appeared well and had almost fully recovered from the transient ischaemic attack he suffered in December 2016.

The coronial investigation

7. Mr Murrowood's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Mr Murrowood's death was reportable because he was in the care of the State immediately before the time of his death.[1] Deaths of persons in the care of the State are reportable to ensure independent scrutiny of the circumstances surrounding their deaths. If such deaths occur as a result of natural causes, a coronial investigation must take place but the holding of an inquest is not mandatory.

[1] See section 4(2)(c) of the *Coroners Act* 2008 (Vic).

8. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[2]

9. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

10. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

11. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Murrowood's death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence.

12. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

13. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Identity of the deceased

14. Mr Murrowood was visually identified by his brother, Peter John Murrowood, on 23 June 2017. Identity was not in issue and required no further investigation.

[2] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

Medical cause of death

15. On 21 June 2017, Dr Victoria Francis, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of the body of Mr Murrowood and reviewed a post mortem computed tomography (**CT**) scan.

16. The CT scan revealed air-fluid levels in the small bowel with a transition point in the pelvis. No hernias were identified. These features were in keeping with a small bowel obstruction, however the cause of the obstruction could not be seen. Common causes of obstructions include adhesions and hernias.

17. Dr Francis completed a report, dated 5 July 2017, in which she formulated the cause of death as "*1(a) Complications of a small bowel obstruction*". Dr Francis opined that the cause of death was natural causes. I accept Dr Francis's opinion as to the medical cause of death.

Circumstances in which the death occurred

18. In the days preceding his death, Mr Murrowood showed signs of constipation. He was treated with Movicol and was able to open his bowels.

19. On 19 June 2017, Kevin Lowe, the Operations Manager of Mr Murrowood's residence, was notified that Mr Murrowood appeared unwell. He had been coughing and vomiting since returning from his day service at approximately 3.00pm.

20. Paramedics subsequently transported Mr Murrowood to Box Hill Hospital, where he was initially treated for aspiration pneumonia and non-ST-elevation myocardial infarction. During the night, Mr Murrowood deteriorated and developed tachypnoea and tachycardia.

21. The next morning, Mr Murrowood's brother attended the hospital and remained by Mr Murrowood's bedside until he passed away at 6.18am.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was Bevan James Murrowood, born 29 August 2018;

(b) Mr Murrowood died on 20 June 2017 at Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, from complications of a small bowel obstruction; and

(c) the death occurred in the circumstances described above.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet in accordance with the rules.

I convey my sincere condolences to Mr Murrowood's family.

I direct that a copy of this finding be provided to the following:

Peter Murrowood, Senior Next of Kin

Eastern Health

Senior Constable Luke Galley, Coroner's Investigator, Victoria Police

Signature:

MICHELLE HODGSON
CORONER
Date: 27 August 2018.