CORONERS ACT, 1980

Medical report upon the examination of the dead body of–

Name: Samantha RAYE

I Peter Graham Bradhurst 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:

1. At 7.00 in the after noon, on the 22nd day of March, 1989 at Sydney in the said State, I made an internal examination of the dead body of a _____ identified to me by Constable B.J.Duncombe of Division No.10 in the State aforesaid, as that of Samantha RAYE aged about 30 years.

2. I opened the three cavities of the body.

3. Upon such examination I found.

External appearances:

Body weight 60 kg. Body length 177 cm.
The body was that of a thinly built young middle aged adult male to female transexual of about the stated age.
There was mild postmortem lividity on the back.
There was postmortem lividity about the feet and lower limbs.
Rigor mortis was still present to a slight degree in the knees and elbows but was subsiding.
The eyes had a sunken appearance as though the body was in a state of dehydration.
There was early blackish-green discolouration of the right side of the abdomen due to decomposition.
There were some reddish patches of skin with blistering from pressure and decomposition on each leg, the medial aspect of the left knee, on the left side of the back just below the left shoulder blade, and on the upper left lateral thigh.
These marks were consistent with pressure marks at the time of, and after, death.
There was a similar area on the right side of the scalp 6 cm above the right ear. This area was 10 x 3 cm and showed reddish purple skin discolouration with superficial blistering of the skin which was partly denuded.

(For continuation–see over

4. In my opinion death had taken place about approximately 2 - 3 days previously and the cause of death was.

I. DIRECT CAUSE–
Disease or condition directly leading to death .. ..
(a) ACUTE BILATERAL BRONCHOPNEUMONIA AND VIRAL MENINGOENCEPHALITIS

(associated with)

ANTECEDENT CAUSES–
Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last .. .. ..
(b) POSSIBLE USE OF INSULIN

(due to or following)

(c) _____

II. Other significant conditions contributing to the death but not relating to the disease or condition causing it
TRANSEXUAL, DEPRESSION

TO THE CITY CORONER,
SYDNEY

(Signature) P.G. Bradhurst PGB

(Date) 23 June, 1989.

ANALYSIS NOT REQUIRED

S.O. 2508

The facial appearance was that of a male and there was early beard growth with the male distribution of hair. The hands and feet were masculine in size and shape.
Both breasts were well developed.
There was a 2.4 x 1 x 1.5 cm "clitoral" stump.
2 cm posterior to this was a urethral orifice.
5 cm posterior to the urethral orifice there was a "vaginal" orifice. This vagina extended in depth for a distance of 8 cm and ended blindly.
There was no cervix.
The "vulval" lips were not fully developed.
2 cm posterior to the vaginal orifice there was the anus.

The deceased was wearing multiple ear studs and sleepers around the edge of each auricle.

There were no significant injuries nor were there any signs of violence.

Skull scalp, dura:

There was some pinkish to red discolouration of the under side of the scalp at the site of the discoloured and blistered skin on the right side of the head described above.
There was no evidence of any skull fracture.
There was no extradural or subdural haemorrhage.

Brain:

The brain weighed 1490 g.
The brain was fixed whole in formalin for examination at a later date.

Dissection of the neck:

There was no evidence of any external marks or bruising around the neck.
There was no haemorrhage or bruising of the soft tissues of the neck.
There was no evidence of any fracture to the hyoid bone or to the thyroid or cricoid cartilages.

Thyroid:

No abnormality detected.

Larynx, trachea, main bronchi:

No abnormality detected in the larynx or trachea.
Each main bronchus, more so the lumen of the left main bronchus, contained yellowish muco-purulent material.

Lungs:

The left lung weighed 670 g, right lung 570 g.
The left lung was heavier than normal.
Both lungs showed moderate carbon deposition.
Both lungs were congested.
From the cut surfaces of the lobes of the left lung, yellow, thick purulent material could be expressed from the cut ends of the small bronchi. These changes were more marked in the lower lobe and two sections of the lower lobe of the left lung sank in formalin.
Similar changes were noted, but not so marked, in the right lung.

Pleura and pleural cavities:

No abnormality detected.

Pericardium and pericardial cavity:

No abnormality detected.

Heart:

The heart weighed 330 g.
Myocardial thickness, left ventricle 1.5 cm , right ventricle 0.4 cm.
The coronary arteries were relatively free of atheroma and had good patency throughout.
The right coronary artery was smaller in calibre compared with the circumflex branch of the left coronary artery.
The myocardium was firm to flabby in consistency and light brown in colour.
The cardiac valves appeared normal.
There was no evidence of any postmortem discolouration of the endocardium.

Great vessels:

No abnormality detected in the aorta, iliac or renal arteries, or in the inferior vena cava.
There was no evidence of any postmortem intimal discolouration.
There was no evidence of pulmonary embolus.

Peritoneum and peritoneal cavity:

There was no evidence of ovaries, uterine tubes, or uterus.
There was a cord-like like ligament 0.2 to 0.3 cm in diameter extending in the peritoneum lining the lower abdominal wall above the bladder. It extended across from the pelvic rim on one side to the other.

Oesophagus:

No abnormality detected.

Stomach:

No abnormality detected apart from some postmortem marbling.
The stomach contained a small amount of brownish fluid.

Small and large intestines:

No abnormality detected.

Liver:

The liver weighed 1260 g.
The liver was firm in consistency and dark purple brown in colour.

Gallbladder:

The gallbladder was filled with bile and was thin walled.
The bile duct was patent.

Pancreas:

No abnormality detected apart from some purplish discolouration.

Spleen:

The spleen weighed 90 g.
No abnormality detected.

Adrenals:

No abnormality detected.

Kidneys:

The left kidney weighed 140 g, and the right weighed 130 g.
The capsule of each kidney stripped with slight difficulty.
Thickness of renal cortex 0.7 cm.
Both kidneys were a pale brown colour.

Ureters, bladder and prostate:

No abnormality detected in the ureters or bladder.
The prostate appeared smaller than normal and had some haemorrhagic areas within its substance.

Histology being performed (brain).

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

Microscopic examination:

Thyroid: Early autolytic change of the acinar epithelium but, otherwise, no abnormality detected.

Heart: There is congestion of the myocardium.

Lungs: Sections show an acute bronchopneumonia affecting both lungs. The changes in the left lung are florid and almost appear as a lobar pneumonia. The changes in the right lung are less marked and resemble acute bronchopneumonia.
Gram stain (left lung): Numberous Gram positive cocci in pairs, short chains or in clusters. The appearance of the bacteria suggests streptococci.

PAS stain: No fungal elements seen.

Liver: There is marked congestion.

Spleen: No abnormality detected.

Pancreas: Marked autolytic change.

Adrenals: No abnormality detected.

Kidneys: Autolysis of tubules. No evidence of disease.

Prostate: The prostatic tissue is markedly congested giving rise to the "haemorrhagic" appearance noted macroscopically. There is poor, virtually absent, development of prostatic acini.

Cord-like ligament:
This has an appearance suggestive of a vas deferens but the histology is not clearly defined. There appears to be a narrow lumen lined by autolysed epithelium. There is a lamina propria and a thick muscularis. However, the muscle layers in the muscularis are not in the normal clearly defined three layers.

Microscopic examination (contd):

NB: At autopsy, no testicular tissue could be found nor any evidence of ovaries, uterine tubes, or uterus.

Further macroscopic examination of the brain:

The brain was re-examined after fixation.
The arteries at the base were almost free of atheroma.
The right vertebral artery, external diameter 3 mm in diameter, was larger than the left, external diameter 1.5 mm.
No aneurysms were found.
The mammillary bodies were normal size.
The cerebrum was cut coronally.
No abnormality was seen in the cerebrum, cerebellum and brainstem.

Microscopic examination of the brain report attached.

HISTOLOGICAL SPECIMENS

Please note that the gross wet specimens taken from the deceased for histological examination will be disposed of after a period of six months unless written instructions are received from the Coroner to the contrary.

Blocks and slides however will be held indefinitely.

23/6/89

Director
Division of Forensic Medicine