FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 3685/09

Inquest into the Death of ASHLEY WILLIAM SEEDSMAN

Delivered On: 21 June 2010
Delivered At: Melbourne
Hearing Dates: 21 June 2010
Findings of: JANE HENDTLASS
Representation: S/C Kelly Ramsay
Place of death/Suspected death: Box Hill Hospital

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 3685/09

In the Coroners Court of Victoria at Southbank
I, JANE HENDTLASS, Coroner

having investigated the death of:

Details of deceased:

Surname: SEEDSMAN
First name: ASHLEY
Address: 20 Neville Street, Box Hill 3128

AND having held an inquest in relation to this death on 21 June 2010
at Melbourne
find that the identity of the deceased was ASHLEY WILLIAM SEEDSMAN
and death occurred on 30th July, 2009

at Box Hill Hospital, 16 Arnold Street, Box Hill 3128

from

1a. SEPTIC SHOCK ASPIRATION PNEUMONIA
1b. CEREBRAL PALSY
2. DIABETES MELLITUS

in the following circumstances:

1. Ashley Seedsman was 34 years old when he died. He lived in supported accommodation run by the Department of Human Services st 20 Neville Street in Box Hill South.

2. Mr Seedsman suffered from severe cerebral palsy, epilepy, diabetes, scoliosis of his spine and a profound intellectual disability. He was not able to walk and was dependent on carers in all facets of daily living. Ashley had a pacemaker fitted and was fed through a PEG tube.

3. On 15 July 2009, Mr Seedsman twice and Dr Lee assessed him. He was tentatively diagnosed with gastroenteritis and and referred him to the Emergency Department at Box Hill Hospital if the vomiting continued.

4. At 8.30pm on 15 July 2009, Mr Seedsman began vomiting laerge amounts and aspirating through his PEG tube. His breathing also became laboured.

5. At 9.07pm oon 15 July 2009, Mr Seedsman presented in an ambulance the Emergency Department of the Box Hill Hospital. He was diagnosed with aspiration pneumonia and commenced on intravenous antibiotics.

6. Despite treatment, Mr Seedsman's condition continued to deteriorate with continued hypotension and episodes of hypoglycaemia. On 19 July, feeding via the PEG tube was recommenced but his cough continued and he required suctioning which seemed to have little effect.

7. On 22 July 2009, Mr Seedsman's prognosis was assessed as poor and active management was withdrawn.

8. At 5.55am on 30 July 2009, Mr Seedsman died.

10. A recommendation that the medical investigation proceed by way of inspection was accepted by the Coroner. The forensic pathologist who inspected the body and the medical records formed the opinion that the cause of death was septic shock arising from aspiration pneumonia and cerebral palsy. Diabetes mellitus was a contributing factor.

11. Accordingly, I find that Ashley Seedsman died from aspiration pneumonia and cerebral palsy.

Signature:

Dr. Jane Hendlass
Coroner
21 June 2010