

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 2420/10

Inquest into the Death of MARY WELSH

Delivered On:	13th July 2011
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne
Hearing Dates:	13th July 2011
Findings of:	IAIN TRELOAR WEST
Place of death/ Suspected death:	Monash Medical Centre 246 Clayton Road, Clayton, Victoria 3168
PCSU:	Leading Senior Constable King Taylor

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Section 67 of the Coroners Act 2008

Court reference: 2420/10

In the Coroners Court of Victoria at Melbourne
I, IAIN TRELOAR WEST, Deputy State Coroner

having investigated the death of:

Details of deceased:

Surname: WELSH
First name: MARY
Address: 37 Harlington Street, Clayton, Victoria 3168

AND having held an inquest in relation to this death on 13th July 2011
at Melbourne

find that the identity of the deceased was MARY WELSH

and death occurred on 27th June, 2010

at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria 3168

from

1a. PNEUMONIA COMPLICATING EPILEPSY IN A WOMAN WITH
MICROCEPHALY

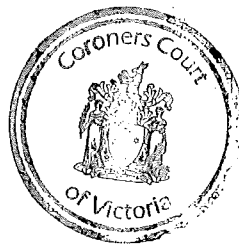
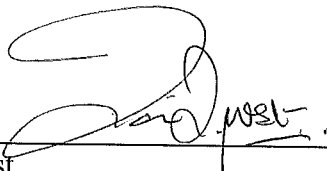
In the following circumstances:

1. Mary Welsh, aged 44 years, was of female gender and resided at the Department of Human Services high care facility, located at 37 Harlington Street, Clayton. Ms Welsh's past medical history included epilepsy, intellectual impairment, microcephaly, severe kyphoscoliosis and episodes of aspiration pneumonia.
2. On the 26th June 2010, Ms Welsh was admitted to the Monash Medical Centre with a history of being unwell for a week, with symptoms suggestive of upper respiratory tract infection. Despite having been treated by her general practitioner for her symptoms, recovery was complicated by a possible allergic reaction to her prescribed Rulide antibiotic medication, with facial and peri orbital swelling. Following admission Ms Welsh was continued on her usual medications and was treated with intravenous antibiotics for possible right sided pneumonia and a single dose of intravenous hydrocortisone for the allergic reaction.

3. On the morning of the 27th June, Ms Welsh developed a generalised seizure and was placed in a lateral position in order to recover from it. After a few minutes, she developed another partial seizure resulting in her becoming unresponsive and cyanosed at the lips. This resulted in a medical emergency code being called and cardiopulmonary resuscitation being commenced. Family were contacted and following discussion as to the poor prognosis, the decision was made for palliative management and further resuscitation was ceased. Ms Welsh subsequently died at 9:27 am on the 27th June 2010.

4. I find that Mary Welsh died of natural causes and that her care and treatment was within the parameters of reasonable health care management.

Signature:



Iain T West
Deputy State Coroner

13th July, 2011