FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 2443/10

Inquest into the Death of SHERYL YVONNE MARTELL

Delivered On:	5th September, 2011
Delivered At:	Coroners Court of Victoria at Melbourne Level 11, 222 Exhibition Street, Melbourne, Victoria 3000
Hearing Dates:	5th September, 2011
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Leading Senior Constable Amanda MAYBURY, Police Coronial Support Unit, to assist the Coroner No other appearances.

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 2443/10

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

Details of deceased:

Surname: MARTELL
First name: SHERYL
Address: 14 Ross Court, Sunbury, Victoria 3429

AND having held an inquest in relation to this death on 5th September, 2011 at Melbourne

find that the identity of the deceased was SHERYL YVONNE MARTELL also known as SHERYL MARTELL born on the 29th March, 1961

and that death occurred on the 26th June, 2010

at Western Hospital, Sunshine

from: 1(a) ASPIRATION PNEUMONIA COMPLICATING CEREBRAL PALSY

in the following circumstances:

1. Ms Martell was a forty-nine year old woman who had been residing at 14 Ross Court Sunbury since 11 December 1984. This was a group home managed by Disability Accommodation Services, part of the Department of Human Services. The staffing model for the group home provided high support needs including an "active" night staff member. Ms Martell required this level of care as she was born with cerebral palsy and a severe intelletual disability, required 24 hour care and assistance with all daily living activities.

2. Although Ms Martell was frail, she enjoyed general good health. In the period preceding her death she had been admitted to Royal Melbourne Hospital between 8-15 April 2010, for treatment of a recurrent seizures and aspiration pneumonia. On 27 April 2010, Ms Martell visited her general practitioner Dr Mansie for a general check-up. Between this date and 21 June 2010, Ms Martell had no particular health problems.

3. On the morning of 21 June 2010, staff found Ms Martell had vomited. After assisting her to clean up, staff found she was not distressed and showed no signs of further illness. However, they sought advice from her general practitioner who advised that she should be taken to hospital. An ambulance was called and after assessment at 9.40am, ambulance paramedics took her to Sunshine Hospital.

4. Ms Martell was admitted for treatment of aspiration pneumonia, initially with Benzylpenicillin and Metronidazole. When she failed to improve, her treating doctors consulted Infectious Diseases specialists and a different antibiotic, Timentin was commenced. Despite treatment, Ms Martell continued to deteriorate. After discussions between treating medical staff and her family, Ms Martell was made subject to a "not for resuscitation" order and treated palliatively. She died on 26 June 2010.

5. There was no autopsy as Senior Forensic Pathologist Dr Noel Woodford fom the Victorian Institute of Forensic Medicine (VIFM) reviewed the circumstances as reported by the police, the GP's medical records, a medical deposition from Sunshine Hospital and postmortem CT scanning of the whole body, and advised that a reasonable medical cause of death was apparent without the need for an autopsy. Dr Woodford found no evidence of significant injuries and advised that postmortem CT scanning showed marked thoracic scoliosis, marked cerebral atrophy, a left renal calculus, focal right coronary calcification and bilateral pleural fluid with lung opacities. He attributed death to "aspiration pneumonia complicating cerebral palsy."

6. As a person in care immediately she her death, Ms Martell's death was reportable to the coroner irrespective of the cause of death. In this way, the *Coroners Act 2008* extends some protection to those vulneralbe people who are in the care of the state, by requiring a coronial investigation including an inquest into their deaths, thereby providing a degree of scrutiny and accountability of the care provided to them.[1] There is no suggestion in the material before me that any want of clinical care of management caused or contriubted to Ms Martell's death.

7. I find that Ms Martell was a person placed in care who died from natural causes, namely aspiration pneumonia complicating cerebral palsy.

Signature:

Coroner: Paresa Antoniadis SPANOS
Date: 5th September, 2011

1 See definition of a "person placed in care or custody" in section 3 (d), the definition of "reportable death" in section 4(2)(c), and section 52(2)(b) of the *Coroners Act 2008.*