CITATION: *Inquest into the death of Shareya Shannon* [2005] NTMC 064

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0012/2005
DELIVERED ON:	12 October 2005
DELIVERED AT:	Alice Springs
HEARING DATE(s):	12 October 2005
FINDING OF:	Mr G Cavanagh

CATCHWORDS:

Death of a Child in Care
Coroners Act 1993 (NT) s12(1)(a), s15(1)(a)

REPRESENTATION:

Counsel:	Ms Helen Roberts
Assisting:	

Judgment category classification:	A
Judgement ID number:	[2005] NTMC 064
Number of paragraphs:	15
Number of pages:	5

IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0012/2005

In the matter of an Inquest into the death of

SHAREYA SHANNON
ON 26 FEBRUARY 2005
AT ALICE SPRINGS HOSPITAL

FINDINGS

(Delivered 12 October 2005)

Mr GREG CAVANAGH:

1. Shareya Shannon ("the deceased") died at Alice Springs Hospital on 26 February 2005.

2. Section 12(1) (a) of the *Coroners Act* ("the *Act*") defines a "reportable death" to include a death:

> (vii) of a person who, immediately before death, was a person held in care or custody:"

3. At the time of her death, the deceased was held in "care" as defined by s12(1)(a) of the *Act*. Consequently this Inquest was mandatory, as required by s15(1)(a) of the *Act*.

4. Section 34(1) of the *Act* details the matters that an investigating Coroner is required to find during the course of an Inquest into a death. That section provides:

> "(1) A coroner investigating -
>
> (a) a death shall, if possible, find -
>
> (i) the identity of the deceased person;

(ii) the time and place of death;

(ii) the cause of death;

(iii) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

(iv) any relevant circumstances concerning the death."

5. The evidence tendered at the Inquest enables me to make the following formal findings as required by the *Act*.

FORMAL FINDINGS

(a) The identity of the deceased was Shareya Shannon, an Aboriginal female born on 18 September 1999 at Alice Springs hospital in the Northern Territory.

(b) The time and place of death was 26 February 2005 at 2:15pm at Alice Springs hospital.

(c) The cause of death was pneumonia as a complication of septo-optic cerebral dysplasia.

(d) The particulars required to register the death are:

1. The deceased was a female.

2. The deceased was of Aboriginal Australian origin.

3. The death was reported to the Coroner.

4. The cause of death was confirmed by post-mortem examination.

5. The death was caused in the manner described in paragraph (c) above.

7. The pathologist who viewed the body after death was Dr Terence John Sinton.

8. The father of the deceased is Dale Jabaldjari Shannon born 4 July 1975 and the mother of the deceased is Gail Nabangardi Rankine born 27 May 1975.

9. The usual address of the deceased was 52 Erumba St Alice Springs Northern Territory.

Circumstances

6. The deceased child was born in Alice Springs on 18 September 1999. Until she was around 10 months of age, she lived with her parents, Dale Shannon and Gail Rankine in Ali Curung and Tennant Creek.

7. She was diagnosed with Septo-optic dysplasia (SOD). SOD is a rare congenital abnormality which results in structural malformation of the brain and subsequent intellectual and motor disfunction. As set out in the report of her treating paediatrician, Dr Tors Clothier, this child had *septo-optic dysplasia with associated profound global developmental delay, spastic quadriparesis, poorly controlled epilepsy, sensorineural hearing loss, visual impairment and diabetes insipidus* [report dated 28 February 2005].

8. Her loving family struggled to support her and provide the necessary care for her complex medical problems. In May 2001 the deceased was placed under a 2 month care order, which was extended until joint guardianship was ordered on 22 January 2002. The child lived with carer Noeline Wright initially in Tennant Creek, and then in Alice Springs.

9. She underwent some medical procedures to assist in feeding and reduce reflux problems. Over the 18 months prior to her death she had recurrent chest infections with increasing frequency.

10. As reported by Dr Clothier, it was discussed and agreed between her extended family and her carers that if the deceased developed respiratory or ventilatory failure, she would not be resuscitated.

11. The deceased was admitted to Alice Springs hospital on 15 February 2005 with respiratory infection. A number of antibiotics were tried with no improvement and a chest x-ray indicated a recurrence of left lower lobe pneumonia. Blood gases on 19 and 20 February 2005 indicated ventilatory failure. Medical treatment continued, with a focus upon palliative care and the prevention of seizures in her last few days.

12. The deceased's mother, maternal grandparents and other family members, as well as her carers, were present for the last few days of her life.

13. The postmortem examination was carried out by Dr Terence Sinton. His significant findings were summarised as follows, in his report dated 14 June 2005:

    (i) confirmation of the pathological abnormalities manifested in septo-optic dysplasia in the brain.

    (ii) a twisted spine (scoliosis) due to prolonged immobilisation and chronic muscle weakness resulting from the brain damage, and producing anatomical distortion of the chest cavity.

    (iii) purulent mucus blocking the peripheral airways in the lungs.

    (iv) pus in the lungs consistent with pnuemonia.

    (v) a feeding tube passing through the skin and thence directly in the stomach.

14. Dr Sinton found that the deceased died from pneumonia, a recognised complication of her septo-optic cerebral dysplasia.

15. The investigation into this death was carried out by Senior Constable Robert Bruce Hosking. He identifies no matters concerning this child's care which would warrant any comment by me. She was loved by her family and well cared for by her doctors and carers. She died from complications of her serious medical condition which she had from birth. Consequently, I have no recommendations to make or other comments in relation to this death.

Dated this 12 day of October 2005.

_____

GREG CAVANAGH
TERRITORY CORONER