CITATION: *Inquest into the death of Lee Shaun Wurramarrba* [2008] NTMC 041	
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0181/2007
DELIVERED ON:	3 June 2008
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HEARING DATE(s):	3 June 2008
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Death in care, Severely disabled young boy, Exceptional and dedicated care by carers

REPRESENTATION:

Counsel:

Assisting:	Dr Celia Kemp

Judgment category classification:	A
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0181/2007

In the matter of an Inquest into the death of

LEE SHAUN WURRAMARRBA
ON 25 OCTOBER 2007
AT 10 PALMER COURT, MALAK

FINDINGS

(3 June 2008)

Mr Greg Cavanagh SM:

1. This inquest inquired into the death of Lee Shaun Wurramarrba (the deceased), a 15 year old boy who died from bronchopneumonia on 25 October 2007. In 2001 he was placed in sole Guardianship under the Minister pursuant to s 43(5)(d) *Community Welfare Act.* He was placed in the care of Julie and Daryl Kempster in April 2001 and he remained with them until his death. The deceased was severely disabled and needed a high level of care. The Kempster's provided him with a loving and caring environment and deserve the highest commendation for the love with which they cared for the deceased. His condition meant he was prone to chest infections, and he had nearly died in 2005 from a similar infection. His treating doctor said he was not expected to reach adulthood. His death was not in any way a result of a lack of care, rather he lived as long as he did because of the high quality of the care he received.

2. His death was reportable under s 12(1)(a) *Coroner's Act* which requires the death of a 'person held in care' be reported. The definition of a person held in care' includes 'a child who, pursuant to the *Community Welfare Act*, is under control or care of a person'.

3. The holding of a public inquest was mandatory pursuant to s 15(1) of the Act.

4. Section 34 of the *Coroners Act* sets out the matters that a Coroner investigating a death shall find, if possible:

> "(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;
>
> (iii) the cause of death;
>
> (iv) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act*; and
>
> (v) any relevant circumstances concerning the death"

5. Section 34(2) of the Act operates to extend my function as follows:

> "A Coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

6. The material tendered before me consisted of the investigation brief prepared by Detective Acting Sergeant Vicki Koum. The brief was of a particularly high standard and I thank Detective Koum for her work in this matter. Detective Koum was called to tender the brief. I did not hear evidence from any other witnesses and am relying on the evidence contained in the brief.

FORMAL FINDINGS

7. Pursuant to s. 34 of the *Act*, I find, as a result of evidence adduced at the public Inquest as follows:

(a) The identity of the deceased person was Lee Shaun Wurramarrba born on 30 September 1992 at Gove District Hospital in the Northern Territory of Australia.

(b) The time and place of death was approximately 5:45 am on 25 October 2007 at 10 Palmer Court, Malak.

(c) The cause of death was bronchopneumonia secondary to chronic chest dysmorphology caused by congenital brain disease.

(d) Particulars required to register death:

1. The deceased was a male.

2. The deceased's name was Lee Shaun Wurramarrba.

3. The deceased was Aboriginal Australian.

4. The death was reported to the Coroner

5. The cause of death was confirmed by post-mortem examination and was bronchopneumonia secondary to chronic chest dysmorphology caused by congenital brain disease.

6. The pathologist was Dr Terry Sinton.

7. The deceased's mother is Joan Maminyamanja and his father is Harry Nunggarrgalu.

8. The deceased lived at 10 Palmer Court, Malak.

9. The deceased was born on 30 September 1992 at Gove District Hospital.

BACKGROUND AND CIRCUMSTANCES OF DEATH

8. The deceased was born with cerebral palsy. The brain damage affected his ability to think, move his arms and legs, talk and swallow and resulted in 'global developmental delay'. The deceased was able to hear and see and communicated with his carers using three different noises to demonstrate wanting attention, displeasure and pain or need. He had difficulty swallowing which presented a risk that he would breathe in liquids or foods, and because of this a feeding PEG was placed in his stomach and from 2003 all foods were given through this PEG. Because he was unable to move his own muscles, his body was unable to grow normally and he developed a severe twisting of his spine (kyphoscoliosis) and a dislocation of both hips. Most of his joints were very limited in the extent to which they could be moved. His condition was complicated by epilepsy, which resulted in convulsions that threatened his ability to breathe. He had inflammation of his ear canals (chronic otitis externa) and a pressure problem with both eyes (glaucoma). He spent most of his day in a special wheelchair. He occasionally developed pressure sores, which were treated. He required full nursing care, that is feeding, washing, bathing and toileting.

9. His family were from Groote Eylandt. He had been cared for by his grandmother, Dolly Wurramarrba, until her death in 1999. Her partner, Jeffrey Foster, assumed the role of carer at that stage and moved to Darwin with the deceased. The deceased came to the attention of Family and Children's Services in 1999. In July 2000 he was admitted to the Royal Darwin Hospital with malnutrition and weight loss and he nearly died. FACS applied for and were granted a holding order and then an interim custody order and finally the deceased was placed under joint guardianship of the Minister and the deceased's aunt Agnes Maminyamanja. Various care options were tried with his extended family but after a second hospital admission in October 2000 and then again in April 2001 he was placed in Sole Guardianship under the Minister. He was placed under the care of Julie

and Daryl Kempster and he lived with them and their six children until his death at 10 Palmer Court, Malak. Julie and Daryl both had qualifications and experience in caring for disabled children. They deliberately sought out contact for the deceased with his mother and his extended family. The deceased had respite care with Vern and Annette May (from Chelsea's Home and Family Care) every 3rd or 4th weekend.

10. The deceased attended Nemarluk Special School and then Henbury Special School. His main treating doctor was Dr Keith Edwards, a paediatrician, and he also saw various specialist doctors. The deceased had continuous health complications during his time with the Kempster's and he had frequent appointments with Dr Edwards, and numerous admissions to the Royal Darwin Hospital. There were many agencies involved in his care; Danila Dilba Medical Service, the Royal Darwin Hospital (both medical and dietary), the Casuarina Community Care Centre, Chelsea's Home and Family Care, the Seek team, a podiatrist, a behavioural specialist, an incontinence nurse and a wound nurse. FACS (Family and Children's Services) paid for all his care requirements. Dr Edwards states:

> "Children with Lee Shaun's condition are particularly prone to chest infections and Lee Shaun developed a chest infection in 2005 and this developed into a severe pneumonia despite treatment in the children's ward at Royal Darwin Hospital. He was admitted into the Intensive Care Ward and required ventilation on a breathing machine for a number of days. His survival from this episode was in doubt however he did recover and was discharged back into his carers' care. Because of his increased risk of chest infection I was available to be contacted by his carers at any time should he be unwell and would arrange a review by myself or another doctor, as well as antibiotics if appropriate."

11. On 1 October 2007 the deceased was admitted to the Royal Darwin Hospital to have his feeding tube replaced. He was noted to have extra airway secretions and prescribed a medication to reduce these. It was also thought reasonable that he should have airway suction and home oxygen available and these were arranged. He was sent home on 5 October 2007.

12. On 18 October 2007 the deceased was reviewed by Dr Keith Edwards. He had episodes of noisy breathing caused by certain positions he lay in, but no evidence of respiratory infection. He was referred to a respiratory paediatrician but died prior to that appointment.

13. Lee Shaun was being treated with Robinul, a medication to reduce excess saliva. It was last administered on 22 October 2007 and the Kempster's were waiting for authorisation from FACS or Danila Dilba to get more. Danila Dilba had said they couldn't pay for it, and then they gave authorisation on 24 October 2007 and the medication was sent up on 25 October 2007, the day the deceased died. Dr Edwards does not consider the lack of Robinul is likely to have affected his death.

14. On 25 October 2007 Julie Kempster checked hourly on the deceased through the night. He seemed fine at 5 am. At about 5:45 am Daryl Kempster found that he was not breathing. He immediately commenced Cardio Pulmonary Resuscitation (CPR) and St John Ambulance were called. They arrived at 6:11 am and took the deceased to the Royal Darwin Hospital whilst continuing CPR. They arrived at the hospital at 6:27 am and attempts were made to resuscitate the deceased at the hospital. The deceased was unable to be resuscitated and attempts were ceased at 7:03 am by Dr Didier Palmer in the Emergency Department. At no stage during the resuscitation did the deceased demonstrate any signs of life and I find that he had already died when he was found by Daryl.

15. The toxicology results showed therapeutic levels of lamotrigine and sodium valproate; anticonvulsants used to treat epilepsy and a sub-therapeutic concentration of clobazam.

16. Dr Sinton performed an autopsy and found that the deceased died from acute bronchopneumonia, this having occurred at least in part as a result of chronic anatomical distortion of the head and chest

17. The evidence is clear that Julie and Daryl were particularly conscientious and loving carers. Dr Edwards states:

> At all times when I reviewed Lee Shaun in the clinic or the ward I was very impressed with the level of care provided by his carers, Julie and Daryl Kempster. They would never hesitate to ring me when they had a concern for his health and were very strong advocates for his health and wellbeing."

18. Lynette Hicks had been the FACS case manager for the deceased for the six months before he died. She says:

> "He was a happy healthy…boy, he was always joking and smiling, he knew Julie's voice…and he knew Daryl's voice…and you could tell there was a bond with Julie and Daryl 'cause his eyes would follow them around the room."

19. She says that when she saw the deceased he was always clean and tidy and says that Julie and Daryl were:

> "Very happy, caring, couldn't do enough for Lee Shaun, all his needs were met."

20. It is clear that the deceased received a very high standard of care and I have no concerns at all about the care he received. Providing this high standard of care took a considerable amount of time and effort by his carers and I am moved by their loving treatment of the deceased as part of their family. I find that his death was not preventable and that those around him did everything they could in relation to it.

Dated this 3rd day of June 2008.

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GREG CAVANAGH
TERRITORY CORONER