CITATION: *Inquest into the death of Zena Stevens* [2006] NTMC 032.

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Alice Springs
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HEARING DATE(s):	14,15 February 2006
FINDING OF:	Greg Cavanagh SM

CATCHWORDS:

Unexpected Death, Hospital treatment, Remote Area Medical Services, Coronial Investigation

REPRESENTATION:

Counsel:

Assisting:	Ms Lyn McDade
Dept. Health & Comm. Services:	Mr Kelvin Currie
AJAC:	Mr Chris Howse

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A16/2005

In the matter of an Inquest into the death of

ZENA STEVENS on 14 January 2005 at Tennant Creek Hospital

FINDINGS

(Delivered 28 April 2006)

Mr Greg Cavanagh SM:

1. Zena Stevens (hereinafter called the deceased) died at 4.45 am at Tennant Creek Hospital (TCH) on 14 January 2005.

2. A public Inquest into her death pursuant to section 15 of the *Coroner's Act* (the Act) was held in Alice Springs on 14 and 15 February 2006. Counsel Assisting me was Ms Lyn McDade. The family of the deceased was not represented. The Department of Health and Community Services was represented by Mr Currie. Mr Christopher Howse sought leave to appear for the Aboriginal Justice Advocacy Committee and I granted him leave. I thank Counsel for their assistance.

3. Eight witnesses were called to give evidence at the Inquest. Those witnesses were; Dr Stephen John Foster a District Medical Officer based at Alice Springs, Dr Michael Pearson the former Medical Superintendent of TCH, Dr George Clothier the Consultant Paediatrician at Alice Springs Hospital, Nurse Heather Zanker, Nurse Louise McMillan, Constable Andrew Taylor, Senior Constable Bruce Hosking and Senior Sergeant Donald Eaton. Acting Sergeant Carmen Butcher investigated the death on my behalf but she was not called to give evidence at the Inquest. She had recently suffered serious injuries in a bus accident in Egypt and was not fit to attend the inquest. Nonetheless I had the benefit of her thorough investigation and

report which was tendered to me. In addition to their evidence I also admitted into evidence a number of statements from other witnesses, the post mortem report, and the deceased's medical records. I also received a report from Dr Tors Clothier the Consultant Paediatrician at Alice Springs Hospital dated 27 January 2006.

FORMAL FINDINGS

(i) The deceased was Zena Stevens, a Aboriginal female born on 16 May 2002 at Alice Springs Hospital.

(ii) The deceased died at 4.45 a.m. on 14 January 2005 at Tennant Creek Hospital.

(iii) The cause of death was septicaemia.

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

a. The deceased was female.

b. The deceased was Zena Stevens.

c. The death was reported to the Coroner.

d. The cause of death was not confirmed by post mortem examination.

e. The cause of death was septicaemia.

f. A pathologist did not view the body after death.

g. The father of the deceased was Quincey Stafford Jabaldjari Stevens and the mother of the deceased was Griselda Beasley.

h. The deceased's usual place of residence was Epenarra Community.

i. The deceased was a young child.

RELEVANT CIRCUMSTANCES SURROUNDING DEATH

4. The deceased was a young child who during her short life suffered ill health. She was regularly treated by nurses at the Epenarra and Ali Curung Clinics for various medical conditions including skin infections, respiratory difficulties, ear and eye infections and closer to her death a large boil on the back of her neck. The deceased was often prescribed oral antibiotics and it is apparent that despite her age it was difficult to administer oral antibiotics to her. She was admitted to Tennant Creek Hospital (TCH) on a number of occasions.

5. The first admission to TCH was between 21 January 2004 and 23 January 2004. The deceased was evacuated by air from Epenarra Community and presented with a fever and cough and infected scabies. After treatment involving the administration of intravenous antibiotics she was discharged back to her community. On 26 December 2004 she was again evacuated by air from Epenarra Community to TCH with a fever and large boil on the back of her neck. In hospital she was again administered antibiotics intravenously and the boil was lanced and drained under anaesthesia on 30 December 2004. She was discharged with oral antibiotics on 31 December 2004.

6. On 4 January 2005 the deceased was taken to the Ali Curung Clinic suffering respiratory difficulties (thought to be pneumonia)and infected ears. The deceased was taken to TCH by ambulance and presented as unhappy, lethargic and “clingy”. Again she was treated with intravenous antibiotics and fluids. An xray examination of her chest did not find any evidence of pneumonia.

7. The deceased's father, Quincey, accompanied her to TCH on this occasion as her mother had been admitted to Alice Springs Hospital with difficulties relating to her current confinement. (Greselda gave birth to a son shortly after the deceased's death). He remained with the deceased throughout her

admission. On the 8th of January 2005 Quincey bathed and dressed the deceased, and then left the hospital with her and returned to Epenarra. He understood that she was to be discharged but he did not wait for her to be reviewed by medical staff nor did he take any discharge medications with him. It is clear that the medical staff at TCH were surprised that the deceased had left as evidenced by the notation in the deceased's clinical notes; "Where is the Child?". However, no one appears to have taken any action to locate the child or make contact with clinic staff at either Epenarra or Ali Curung. The deceased was formally discharged in absentia from TCH.

8. Quincey returned to Epenarra where he also had responsibility for his other two children. Greselda was still in Alice Springs Hospital. He did receive assistance from family members, in particular Graham Beasley and Sabrina Haywood to look after the deceased and other children. However it appears that the deceased was difficult to care for as she remained unwell and unhappy. It is also likely that the deceased was not at this time receiving any medication.

9. On the 10th of January 2005 the deceased was taken to the Epenarra Clinic. Nurse Zanker was informed by her carers that the deceased had been in TCH for pneumonia. She rang TCH and spoke with a nurse who informed her that the deceased had been in hospital for an abscess (Boil), and not pneumonia. In her evidence Nurse Zanker said (T79):

> "And did you check Zena's history with Tennant Creek Hospital?---Well, I mean, I asked why the child had been in hospital. That was my call I didn't - - -
>
> And what were you told by Tennant Creek Hospital as to why the child had been in hospital?---Yes, they told me why she had been in hospital.
>
> And what was that?---Because she had an abscess behind her ear.

Yes, and did that assist you in treating Zena when she presented on the 10th?---Well, my observations said that she – that that had cleared up and it was quite obvious there was no more swelling in there.

So what did you do for Zena on the 10th?---I assessed the child and all it's observations were in order, although I had a gut feeling (inaudible) that's the next day, sorry). No, I didn't really do anything for her on the 10th. All her observations were all within the call, then reasonable."

10. The child reattended at the clinic on 11 January 2005 shortly before 9a.m. and nurse Zanker took observations and then called the District Medical Officer, Dr Stephen Foster ("DMO"). In her evidence Nurse Zanker said this:

"Event thought the observations were okay for the child, I just felt – I didn't feel happy with the child because of its history of not being well at times and I rang to DMO just to pass it by him and after consulting with the DMO he said to me he felt that the observations were all in order and there wasn't really a lot that we were going to do with her at that time.

Now just there you indicated Zena's history. What in fact did you know about this young child's history, medically speaking?---Well, not a real lot because she had not been living in the community where I was working.

But she had been to the Epenarra Community - or the clinic on 22 December 2004. Were you not there then?---No, I may not have been, no. (Inaudible).

And she had been there in June of that year, so this was the first time you had actually consulted with Zena?---That's correct.

So you ring the DMO and you give him some observations?---Yes.

Did you tell the DMO that you wanted Zena to go to hospital?---Yes. I did.

And how did you tell him that?---Well, I just said to him that I felt that the child should go to hospital, it's just a gut feeling and (inaudible) but he said to me, 'Well, let's look at the observations again', which we did, and he said to me, 'Well, no, the child is not that unwell at this stage', which I then agreed with.

You then agreed with?---Yes.

Tell me, were you aware at any time - was there one or two telephone calls between you and the DMO at that stage?---No, there was only one DMO call.

In the morning, only one call?---Yes.

You don't recall being contacted by the DMO after you called him in the morning?

---No.

Are you aware that the DMO – or to your knowledge did the DMO consult Dr Pearson in Tennant Creek?---Yes. They always do that if we are thinking of sending somebody up there.

Are you aware then, to your knowledge, the DMO would have consulted Dr Pearson?---I should think he would have, yes.

But what I'm getting at, you ring him firstly, don't you?---Yes, always ring the DMO in Alice Springs first.

Yes, and you give the history of the child to him and the observations?---Yes.

What I'm suggesting is could it have been that the DMO then finished the conversation with you and then spoke to Dr Pearson and then got back to you?---He may well have, I don't recall it.

And I'm also going to ask you that - Dr Foster has told us that when you suggested the child should go to Tennant Creek, he agreed with you?---Yes.

Do you recall that?---No, I don't."

11. Nurse Zanker did not recall the DMO asking her to take further observations of the deceased during the afternoon of the 11th of January, nor was she sure whether the DMO called her back in the morning. She indicated that she went looking for the deceased to check that she was receiving medication but couldn't find her. In her evidence she went further and said that the deceased's carers informed her that the deceased was at the swimming lake.

Nurse Zanker never actually saw the deceased that afternoon and took no further observations of her.

12. The DMO Dr Foster gave the following evidence of his dealings with Nurse Zanker and Dr Pearson on the 11th January, (T23):

> "And does that indicate a note of a telephone discussion you had with Nurse Zanker concerning a sick child at Epenarra?---It does.
>
> And you were given a history of that child?---A brief history which is taken by our receptionist and then handed to me.
>
> And what was the brief history that you were given by the receptionist?---That this little girl was a two and a half year old, sorry a 21-month old baby who'd been discharged from Tennant Creek Hospital on the previous Saturday with a lump on the back of her head which had been IND which means incised and drained and that today there was an infection, she had pusy ears and she was unwell and the note also states that Nurse Zanker felt that she needed to be readmitted to Tennant Creek Hospital.
>
> So you had that information before you spoke to Nurse Zanker?---I did.
>
> What assessment did you make of that information?---I agreed with that, that the child was infected. I put down here, sepsis, so the child was sick had a temperature of 39 which is a high fever. The other observations suggested that apart from the high fever she was not that unwell. She hadn't passed urine, she was breathing well, but she – I believed that she needed to go back to hospital.
>
> And you and Nurse Zanker were ad idem on that at that stage – you and Nurse Zanker agreed?---Yes, I agreed with Nurse Zanker that this child should ideally go back to hospital.
>
> So what did you do, having made that determination that she should go back to hospital?---The protocol from the DMO office is that a child from Epenarra would be transferred to Tennant Creek Hospital.
>
> And what means would be used to transfer the child usually?---It could be by road or it could be by air. There's a plane in Tennant Creek which can do retrieval services if the airstrips are open.

So what did you physically do in relation to putting into effect an evacuation of Zena at that time?---I rang the medical superintendent at Tennant Creek Hospital, Dr Mike Pearson.

So you spoke with Dr Pearson?---I spoke to Dr Pearson.

And can you tell us what was the nature of your conversation with Dr Pearson?---I explained who the patient was and what my assessment of the patient was and – and asked him if there was a possibility of evacuation by air and said that currently the airstrip at Epenarra was being checked.

Now can I just ask you to be more particular, if you can, in relation to your conversation with Dr Pearson. When you said you identified the child, did you name her?---I did.

And in relation to your other discussions with him, can you remember what you actually said to him about her condition, as it had been painted to you from Epenarra at that stage?---I – I asked him if he was aware of the child and what his advice would be in terms of managing the child because my feeling was that the child should be back in hospital and after discussion he felt that we should wait and see how the child settled in Epenarra.

Did he give you any reason for that or did you ask him for any reason why you should wait and see?---I respected his – his understanding and knowledge of that child and that situation.

Is it the case that he indicated a prior knowledge of Zena's history to you?---I believe so, but I didn't write that down.

And is it the case that you deferred to his knowledge of the child?---I did.

So therefore the evacuation didn't take place?---Yes.

Essentially it didn't take place because you deferred to Dr Pearson's knowledge of the child and his advice to wait and see?---That's correct.

Did you convey that to Nurse Zanker?---I did.

And how did you do that?---I rang her back at 9:15.

And did you inform her as to why it was the evacuation was off, effectively?---Yes.

What did you say to her?---Having discussed it with Mike Pearson and because the child's temperature had come down and that it was reasonable to wait and see.

Now when you say to somebody in a community, wait and see, what do you expect they do in relation to the child, do you expect they keep the child with them or give the child back to its carers?

THE CORONER: This is the nurse?---Yeah, the clinical responsibility in Epenarra was – would be with the nursing sister there.

MS McDADE: Having given that advice?---Yep.

Bear in mind you've got a child you consider at first blush should be taken to hospital?---Yes.

You defer to the greater knowledge of Dr Pearson who knows the child and say no, you tell Sister Zanker to wait out?---Mm mm.

Can you tell me whether you had any expectation of how she would conduct that wait out, would she keep the child or not?---The child - I have written down the child was in the care of the family, an auntie. That I would have expected the – the child to be reviewed later that day and if – and if Nurse Zanker had been concerned she may have asked the child to stay in clinic, but if she was happy to review the child later that day because that's the way she felt that was safe, then she would have done that and probably asked to see the child later. So either way would be appropriate.

What about medication, during your discussion with Nurse Zanker was there any discussion about giving her any medications?---Not at that stage, no.

Now did you have further contact with Epenarra community about Zena that day?---I rang back at 1500 hours.

You rang back?---I rang back which is the protocol to check and see anything – lose ends that are left I would make a note in my – in my book to ring back and see how things were. So I spoke to Nurse Zanker then at 1500 hours.

And what were you informed at that stage?---I asked her to do another set of obs and that if they were okay then I would make no further contact, but if she was concerned that she would obviously return my phone call.

And did you get any further contact from Epenarra?---I did – I heard no more on that day.

And what about subsequently did you hear anything?---I personally didn't hear but I believe there were further contacts later. I didn't have any more contact.

So you left it on the basis, do some further observations?---Yes."

13. Dr Pearson says the following about the discussions on the 11th January (T48):

"Thank you for that, doctor. Now you had some contact with the DMO relating to Zena on 11 January, do you remember that?---Yes, I believe I had a conversation with him on the phone.

And do you recall that that was Dr Foster the District Medical Officer at the time?---It was a district medical officer, I don't remember the name.

And we've heard from Dr Foster today and I will tell you what he says, he indicates that he got a call from Nurse Zanker at Epenarra in relation to Zena and he had a discussion with her in which he was told her observations, naturally enough, and he says he formed the view, given the child's temperature and other vital signs, that the child should be evacuated to Tennant Creek Hospital. He then says he rang you and you, amongst other things, informed him that you were aware of the child's history, which I take it you were?---Yes.

And that it would be best to take a wait and see attitude rather than have her evacuated into Tennant Creek Hospital, do you remember that?

Well, that's what he says, is that your memory of the events?---I don't remember saying that to him.

You in fact say, 'The District Medical Officer phoned me to organise' – I'm looking at page 4 of your statement – 'to pick up the child and I said the child had been in hospital and had been well and discharged. I started to arrange the plane, then I got a call from the

District Medical Officer again to say since speaking to me he'd spoken to the nurse out at Epenarra, who reassessed the child and the child's original observations, had the present observations different she was – the recollection I have is that the District Medical Officer was told the nurse was happy with the child's condition. Yep, happy to observe the child and the District Medical Officer made the decision that the child didn't require transfer at that stage and had asked me to cancel the plane.' Is that your recollection of your interaction with the DMO?---That was the recollection at the time and it's obviously a long while ago now, but I – that's pretty much the way it happened from my memory.

So from your memory it wasn't the case that you said, look I know this child, let's just wait and see what happens to her?---I'm sorry, I can't remember the – the details of the conversation on the phone now with the DMO. I can't remember having said that, no.

But you actually indicate in your statement that it was the DMOs call to cancel the transfer not yours?---That is my understanding of the system that the DMO has control of the – of who comes in and who goes out.

Yes, I appreciate that?---He's the one who actually speaks with – speaks with the staff looking after the patient.

Yes. Who organises the plane you or him?---If he's using the RFDS plane he organises that at his end. If they're using the Tennant Creek Hospital plane the procedure is to call the doctor at Tennant Creek Hospital and organise it through him or her.

Now on this occasion I understand, looking at your statement again, that you started to organise the plane, so was that the Tennant Creek Hospital plane?---Yes, I did it by asking, by memory - I think I was in – I think I was in the emergency department when I received the call and I, having finished the call, I spoke to the senior nurse there and asked if there would be a nurse available for the evacuation. (Inaudible) recollection of what happened next.

But ultimately you stood the plane down on the advice of the DMO, is that what you're telling us?---Well, I received another phone call and my memory is that he had spoken to the nurse, that the – there was a set of observations which were normal and that he had decided that the child didn't need to go at that stage. That's what I remember from that second call.

Can I ask you, Dr Pearson, given your knowledge of Zena and her recent history did you form a view as to whether or not she should be evacuated from Epenarra on 11 January?---I – I was – I remember being a little bit surprised that he had called back and said that he didn't need the plane but he – I also remember that the observations that he gave me were quite normal for a child that age, and I thought well, I suppose that's a reasonable decision and there would be a nurse there to look after – keep an eye on the child, so it didn't appear to me I needed to question that decision.

But you would also have known, correct me if I'm wrong, at that time that Zena had left the hospital on the 8th without being reviewed and without medications?---I'm – I'm not certain I was – knew of that or not, but the child left, I believe, on a weekend while I would have been off so I'm not sure if I knew all the details of the discharge, I understood perhaps from talking to the doctor or whatever that she'd been fairly well when she left.

So when you had the discussion with DMO about evacuating the child from Epenarra is it the case you didn't access the medical files?---No, I didn't have the medical files in front of me.

Is that usual practice, just to simply talk from memory or is it usual practice to obtain the medical files when you're talking about evacuation?---Usually the - the call is - the call is to arrange a plane. I was uncertain of the details or the DMO had asked for details about the patient and if I wasn't certain I may access the notes on occasions but that was not a usual case.

But in relation to Zena you'd actually treated her, hadn't you?---I had treated her in the past, yes.

And you were aware - you may not have been aware that she'd been discharged early but you were aware that she'd been in the hospital quite recently, in fact discharged that last Saturday?---Yes, I knew she'd been in hospital.

And as I say, Dr Foster indicates to us that you conveyed to him a knowledge of Zena and a knowledge of her history such that he deferred to your knowledge of her in the decision not to evacuate?---I haven't spoken to him so I'll to - not sure.

> But you don't recall having that conversation with him, is that what you're saying?---I recall having a conversation with him but I certainly don't recall the details of it.
>
> But you don't recall the net result of that conversation being that he deferred to your greater knowledge of the patient in determining not to evacuate Zena?---No, I don't remember.
>
> I have to ask you again, given your knowledge of Zena why was it that you deferred to the DMO and didn't go ahead with the evacuation of Zena?---Because in my mind it wasn't my decision to make.
>
> It wasn't your decision to make, you believed it was his decision to make, is that right?---They did have a change in the system. Previously the calls were handled by hospital doctors and I'm not sure exactly when it happened, I think it was fairly recently that it changed, such that the Remote Health had taken over taking those communications and my understanding of the new system was that the DMO who was the one who was speaking to the - to the staff - the staff member who was looking after the patient had the final decision on whether to evacuate the patient. I was happy to discuss with him from the experience I had with the bush, but when he - when he did call - as I remember I said that the plane (inaudible). The reasons that he gave me seemed - seemed reasonable."

14. The deceased was not evacuated from Epenarra on the 11th of January 2005, notwithstanding that the family appears to have wanted the deceased to go back to hospital. The decision not to evacuate was made by medical personnel based on the information they had at the time. There was some evidence suggesting that the deceased was not evacuated because TCH was very busy. Having heard the evidence, I do not accept that the decision not to evacuate her at this time was because the hospital was too busy.

15. The deceased was taken to nurse Zanker's home at 0430hrs on the 13th of January 2005 because her family and carers were concerned about her. They were told by nurse Zanker to bring her to the Clinic at 0800hrs. They duly did so and on this occasion nurse Zanker commenced the deceased on

procaine penicillin. In her evidence she said of this presentation the following (T82):

> "About 8 o'clock?---Yes, I commenced the child on Procaine penicillin because I wasn't happy that she was actually getting the medication that she was supposed to?
>
> What exactly in your mind were you treating the child for at that stage?---I was treating the child with pneumonia at that stage.
>
> But hadn't you already ascertained from Tennant Creek Hospital, when you rang them on the 10th that in fact she did not have pneumonia?---Yes. But it doesn't take long for them to get it either.
>
> I see. So you thought she'd developed pneumonia?---Yes, (inaudible) in her lungs so that's why I started her on that, also covering the ear problem as well.
>
> So you believed her main problem at that stage was respiratory?---Yes and not complying with taking her medication.
>
> And the medication of course being the antibiotics?---That's correct.
>
> And that's why you gave the intramuscular injection?---Yes.
>
> Did you at any stage believe, apart from the pusy ears, that she may have been having any difficulties from the incised boil in the sense of infection?---Well, I've been asked that before that I felt the area where she'd had the incision and there was no swelling, but that's not to say that it hadn't gone inwards, but the observations were saying to me no, it was okay and that's all I can go on.
>
> So you thought that it had essentially resolved?—I had, yes."

16. It is clear that Nurse Zanker at this time believed that the deceased was not compromised by the redevelopment of the abscess.

17. The deceased was brought to the clinic again at 6.30p.m. At this time she had puffy feet and was clearly unwell. The family are adamant that they wanted the deceased to be evacuated by air to TCH, but Nurse Zanker in her evidence says she was not asked to arrange an aero medical evacuation. Nurse Zanker did speak with a nurse at TCH who also offered the medical

evacuation plane but this was declined by nurse Zanker. The deceased was taken to TCH by her grandfather who drove her in the Clinic ambulance. The journey was just over 200kms along dirt roads and should normally have taken about 2 hours, however given his concern for the deceased Graham Beasley drove carefully and the journey took just over three hours.

18. The deceased arrived at TCH and was clearly very sick and was immediately ventilated and intensive life support procedures commenced. The paediatrician from Alice Springs Hospital who had been informed of the deceased's impending arrival, flew to TCH. By the time she arrived, there was little that could be done for the deceased. She was declared life extinct at 4.45 a.m. Dr Pearson in his evidence said this (T50):

> "So your last attendance on Zena of course was at the time of her death. You became involved in the attempts to resuscitate her?---Yes.
>
> Tell me, doctor, by the time you became involved is it fair to say that Zena was in dire straits?---Yes, the child was very sick.
>
> Now were you surprised to see Zena in that state a couple of days after you've been discussing her evacuation?---Yes.
>
> Why?---Because she was very sick an it was very unexpected that she would be so.
>
> Because she'd become very sick - you were quite happy with her observations on the 11th you're telling me, is that right?---From memory they were a normal set of observations, yes.
>
> So she's become very sick between the 11th and the 13th or earlier or later?---Say that again?
>
> Sorry, she's become very sick certainly from the 11th?---Sorry, could you say that again?
>
> She has become very sick from the last time you had observations of her, correct, on the 11th?---Between - between the 11th and the 13th it does appear so, yes.

Now I guess you're not able to tell me as to whether or not, given those observations you're aware of on the 11th, whether or not she was in decline then and it was just a continuum or whether or not her condition worsened sometime later, are you able to say that or not?---I can only say that from the history given there seemed to have been a gradual deterioration, there'd been some deterioration on the 13th with the information that's come with the patient.

So on the face of the documentation she's getting slowly, on the 11th and 12th, unwell more progressively, would you agree?---That's what appears on the documentation.

And on the 13th she's still becoming unwell, but suddenly later in the afternoon of the 13th there's a progressive decline?---I don't remember reading exactly what - what time of day it was, but yeah, it appears on the day of the 13th she became much sicker than she had been.

Now you had - you arranged for the paediatrician to come from Alice Springs?---Yes.

And of course by the time she arrived there wasn't much to be done for Zena?---The child was definitely very sick, but was ventilated, had low oxygen saturations and I guess the prognosis was poor but we're always hopeful that something could be done, in fact I guess I was hopeful enough to have actually written a letter expecting the child would be able to be stablised and be transferred to Alice Springs Hospital.

But of course that didn't - - -?---That wasn't to be.

Can I ask you, given your involvement with Zena, what part if any you can attribute - what part, if any, to her death can you attribute the boil or abscess on the back of her neck?---That's hard to say.

I appreciate that?---Staphylococcus is a very common bacteria in all of us, including Aboriginal children. It may well be that that particular infection was the one - the puss from that had got into her blood and may have indirectly related to her death or it may have been coincidental.

She could well have had other infections?---That's certainly possible.

> Now but you actually did some analysis, did you not, on the puss drained from that abscess?---Yes.
>
> And it's quite certain that that showed - - -?---It was definitely staph".

19. Dr Tors Clothier the senior Paediatrician at Alice Springs Hospital provided a report and gave evidence at the Inquest as the quality and appropriateness of the deceased's management prior to her death. I accept his evidence and note his comment that there are legimate concerns "that Zena should have been transferred to Tennant Creek on the 11th given the concerns of her carers and lack of compliance with medication. The reason for this failure of transfer begs further explanation."

20. After hearing from the medical personnel involved with the deceased on the 11th of January, it is not clear why the deceased was not transferred, or who in fact made the actual decision. I do find however, that the deceased should have been transferred on the 11th of January to TCH. I accept the opinion of Dr Clothier and find that the decision not to transfer the deceased that day was, having regard to the evidence, a mistake. The deceased was eventually transferred to TCH by ambulance on the 13th of January. On the available evidence the deceased could have been transferred by air, however even if this had occurred it is unlikely that her chances of survival would have been enhanced, given her condition at the time. The outcome may have been very different if she had been evacuated by air on the morning of the 11th of January.

21. Dr. Pearson informed Tennant Creek Police of the death at about 4.50 a.m. and spoke with a Constable Taylor. In his statement to police Dr Pearson said this; "Okay yes at 4.55 I notified the Tennant Creek Police of the child's death and agreed to pass on the information to the Coroner though its not recorded here I received a call back some time later that morning and as the cause of death to us appeared fairly clear we were happy to write a certificate for the cause of death. I did that later in the day with what I

understood was permission from the Coroner or the Coroners Constable." He was referring to a phone call from Tennant Creek Police apparently informing him that a death certificate could be written. At the inquest Dr Pearson resiled from that evidence saying (T36):

> "THE CORONER: Doctor, we're especially concerned to ascertain that what you've said to the police in that statement is correct in terms of your memory in relation to the telephone calls to the police station and backwards and forwards, do you understand?---I understand.
>
> So if there's anything that you say is wrong with that statement concerning those telephone calls, even if they're typos, I'd like to know?---Certainly. I'll have a look at that – at that again. I'm just having trouble finding that on the page that I've looked through. When I try and remember now, as you know this was quite a while ago when the statement was made I've written here that – or I've said that I proceeded to call back the Tennant Creek Police.
>
> MS McDADE: Yes.
>
> THE CORONER: What page is it?---It's on page 4 at the top and I – when I look at this again just today and yesterday, I – I really honestly can't remember now receiving that call. I know that I had a certain system that involved the police or Coroner's Constable calling back, but I don't specifically remember that call coming through and I – looking through the notes I haven't recorded the substance of the call, so that would be a difference to what I recollected at the time of the statement or this conversation took place.
>
> MS McDADE: So what are you saying to us, doctor, that you in fact don't recall getting that – a telephone call from Tennant Creek Police?---I tried to remember it having gone through the statement in the last couple of days and I – I couldn't remember that call specifically, that's correct.
>
> THE CORONER: Doctor, is that the call that you say in that statement that came back from the police to say to you that it was okay to write a death certificate?
>
> ---That's correct.

I think it's appropriate to tell you and fair to tell you, that the Tennant Creek Police say whatever else happened between you and them, they deny that there was a telephone call back from them to you saying it was okay to write a death certificate. And they say there's no record of any telephone call in the telephone records which show such a telephone call. So on the statements as taken by the coronial investigators that are now in writing before me, we've got the Tennant Creek Police effectively agreeing with the conversations the first couple of times, but their response to you saying that you got a third telephone call authorising you to sign a death certificate or words to that effect is denied by the police. Do you understand?

---I understand.

Now Ms McDade will deal with that area then. I invite you to deal with it.

MS McDADE: Now doctor, as I understand what you're telling us now as we go through this statement that you made on 29 June 2005, is it the case that you're now agreeing that or at least you accept that call was not made, telling you to write a death certificate?---That's not what I'm saying. I'm saying that I don't recall receiving the call. It may have happened.

It may have happened, but now you don't recall it?---It may have happened but I don't recall it.

But you'd accept looking at that statement that's before you on the occasion you made that you actually say you did get a call?---It – it's certainly what I had said to the police.

It's certainly what you said to the police?---It certainly – the – the transcription presumably is correct and presumably that's what I thought at the time."

22. Dr Pearson apparently believed the death of the deceased was a reportable death and he did inform Tennant Creek Police. However, he then wrote a death certificate and I refer to his evidence; (T40):

"No, it's not confusing. But you agree with me that you did believe that Zena's was a reportable death?---Yes.

But what you're saying is if someone had got back to you and said, well, how about you write a certificate you would have done it?---I

had discussed the case with a paediatrician, the cause of death seemed fairly clear. No – no other reasons why not to do one, I talked to the - I received back from the Coroner that that's what they would like to happen.

Now it begs the question why did you write a certificate later on that day?---Well, I – as I explained I don't remember receiving a call back from the police but my usual procedure is to wait for a call back. If I didn't receive it then I left it as a – to see if the Coroner wanted to continue that on as a Coroner's case. If I received a call back then assuming everything was in place and no reason why the certificate couldn't be written, (inaudible) a certificate. So my assumption is that I received a call back. However, as I explained earlier on, I don't remember the call and there's no record of it in my notes.

THE CORONER: Doctor, I take it you'd agree there are cases, it's not unusual, for example, for a death to be unexpected but for – I'm now going to put my point of view as the Coroner, the Coroner's Constable sometimes ring back to a doctor and say, look there's a medical history here of some sorts, he's had some heart problems now and again, we know that he's died unexpectedly but it looks like a heart attack, are you willing to sign a death certificate that he died of a heart attack, because there doesn't appear to be any suspicious circumstances around the matter. Is that the kind of situation you're talking about?---Yes.

It still goes back to the doctor, though, it's still a professional decision of the doctor to sign the death certificate, isn't it?---Certainly.

I mean, a doctor's not going to sign such a death certificate just because he gets a telephone call, it's got to be based on some kind of history and some kind of medical cause of death, doesn't it?---Well, that's correct."

23. The evidence from Dr Pearson is essentially this, he believed the death was "reportable" and he called the Tennant Creek Police to inform them of the death. He was advised by Tennant Creek police that they would contact the coroners constable. He then wrote a death certificate in accordance with his usual practice and on the assumption that he received a call from the police (which call he now can't recall and did not record in his notes) informing him that the death was not reportable. I find that Dr Pearson erred in

writing a death certificate. This death was unexpected and as such a "reportable death" which mandated a coronial investigation by police.

24. I pause to point out that "Death Certificates" are only signed by Doctors where they believe the death is not reportable to the Coroner; in such cases there is no coronial investigation

25. It is clear from the evidence that the police did not call back Dr Pearson and inform him that the death was not reportable. However, the police did not deal with the advice of the death appropriately. Constable Taylor who took the call from Dr Pearson informed his shift supervisor Constable Kaftan of the call and he in turn contacted the watch commander in Alice Springs Senior Sergeant Eaton. He made an entry in the Police Computer Diary System (PROMIS) system of the call under the category "pass a message". A PROMIS number had already been created to record a pass a message from the Stevens family to relatives in Tennant Creek that the deceased was coming in to TCH, albeit the message wrongly referred to the deceased's mother Greselda. Constable Taylor contacted Dr Pearson and informed him that the Coroners Constable would contact him.

26. Senior Sergeant Eaton gave evidence that he was contacted by Tennant Creek police Constable Kaftan and advised of the death and further that the death was expected as the child was very ill and there were no suspicious circumstances. He says he advised Constable Kaftan to ascertain whether a certificate was being issued and if yes then there was nothing further for him to do. If a certificate was not going to issue then he advised Constable Kaftan that the death would have to be investigated and preferably by a CIB member. He went on to say that he would run it past the Coroner's Constable when he came in and if his advice was wrong the Coroners Constable would be in touch.

27. Senior Sergeant Eaton did advise the Coroner's Constable about the death, however, the Coroner's Constable Bruce Hosking thought he was having a

joke with him. Constable Hosking did however check the PROMIS system and found no reference to a death a Tennant Creek, because it had been entered by Constable Taylor under "Pass a message". I refer to his evidence at (T108):

> "THE CORONER: Yes, constable, have you got your stat dec there?---Yes, your Honour.
>
> The fifth paragraph on the first page?---Yes.
>
> Just read that out loudly?---'I recall on 13 January attending the Alice Springs Police Station at 5:30am to pick up the prosecution paperwork from the shift sergeant's office in the cells.'
>
> You were still doing your dual job that day?---I - - -
>
> Of Prosecution's constable as well as Coroner's Constable?---Yes, your Worship, I think I did it for a period of six weeks.
>
> Yes?---'It was as I left the shift sergeant's office that Senior Sergeant Eaton yelled out to me that there was a body of a child in Tennant Creek. I know Senior Sergeant Eaton very well and consider him to be a close friend. I thought at the time he was having a joke with me, being my first day officially in the position of Coroner's Constable. I think I said something like they can handle it. I then continued walking from the police station to the cells. I collected the paperwork from the cell block. I travelled to the Centrepoint building where Summary Prosecutions is positioned. I never received a phone call or read a PROMIS job entry in regards to the death of Zena Stevens'.
>
> Just stop there. You never looked in the PROMIS system about an Alice Springs' death that morning?---I did the prosecution's work, then I did a PROMIS job look.
>
> Well, wait there, that last sentence there says, 'I never received a phone call or read a PROMIS job entry in regards to the death of Zena Stevens'?---That's correct.
>
> MS McDADE: In fairness, I think that probably beggars explanation.
>
> THE CORONER: Yes. Are you saying you did look at the PROMIS system?---I did a search, right.

That's what I want to know from you. You did look?---Yes.

And you did not see any reference to a death in Tennant Creek of a child?---Not in Tennant Creek, no, or Alice, but there was no - - -

But you did look?---Yes.

Despite you thinking your leg was being pulled, you did look?---I did look but when I had done the prosecution - - -

Well, then – I'm pleased to hear that?---Right.

At least you looked. I take it then that having looked and found nothing that just confirmed your suspicion that your mate was pulling your leg?---That's correct, yes.

I mean with the best - I must say, and I'll say it from the Bar table. Those two paragraphs are so Monty Pythonesque that you wouldn't make them up. I believe you?---Yes.

You know, your first day in your job and your mate who you've known for years who's the acting shift sergeant says there's a death of a young someone in Tennant Creek - - -?---Yes.

- - -and you said, 'Oh yeah, pull the other one?'---Well, basically that was my understanding.

But you did go and check PROMIS in the event?---Yes.

And as we know from young Constable Taylor, he's updated a 'pass on message' computer folder, rather than putting that particular call from Dr Pearson into a more appropriate place?---That's my understanding, yes.

MS McDADE: What should the folder be, in relation to – in PROMIS?---In regards to this there is a PROMIS job entry for death, either natural or non-suspicious circumstances or then you go into - - -

THE CORONER: So those folders were there at the time to be entered into on the PROMIS system?---Yes.

MS McDADE: And you found nothing?---No.

And you had no concept that you should be looking in the received message?---No. No, I - - -

I take it from that you did not get back to Tennant Creek Hospital on the 14th did you?---No.

THE CORONER: On the 13th.

MS McDADE: 13th?---13th yes.

You didn't ring them?---No.

28. I made the following observations about how this death was dealt with by police at the Inquest; (Snr. Sgt. Eaton's evidence) - (T121):

"THE CORONER: Senior sergeant, I can tell you this, that the four different statements from the four policemen involved, assuming that they're all telling the truth, and I see no reason to think they're not, indicate a bit of a shambolic miscommunication about the matter?---Well, it appears so.

It appears so, doesn't it, as you've just been told, yes?---It does.

MS McDADE: Yes. I'm not suggesting for one moment – I'm just putting it to you in fairness?---Yes.

That was what Tennant Creek Police interpreted your communication to mean. But that's not what you meant to convey is it?---That's not, no.

No. And indeed, in fairness to you, Constable Hosking says that you informed him by calling out to him, as he was walking down the hall.

THE CORONER: Now, this is not a matter for you but Hosking just told us that you yelled down the hall as you come in to pick up the Prosecution papers that – about a death in – on his first morning as Coroner's Constable, there's a death in – a body in Tennant Creek, he thought you were pulling his leg and he kept on walking. That's the impression that I got from Hosking?---Well, that's not my total recollection.

No, I accept that. I mean, I'm not here –I'm not calling you a liar at all?---I know.

I'm just saying to you that there's different recollections that, much later, indicate some miscommunication about some crucial matters.

MS McDADE: And Hosking goes on to say again that – notwithstanding what you say in your statement about having a conversation about the ins and outs of the death and what you've told Tennant Creek to do, but that never occurred?---When I spoke to Mr Hosking it wasn't in a – like it wasn't in a authority way, it was fairly casual.

THE CORONER: Thank you. You see, sergeant, and there is a superintendent down there, at the end of the day I don't think it's had any – this miscommunication has had any significant effect on the coronial process. It has had some effect in respect of the investigation inquest into this child. But it indicates a situation that I just don't want to happen again. It's embarrassing?---I understand that, your Worship.

And it's regrettable?---Yes.

And it shouldn't happen like this. And I want a big red flag going up that says, 'Don't happen again'. Death of anybody's important to the community and to the people who love that deceased, and where a person dies in an unexpected fashion, fingers might be pointed to medical practitioners or community nurses or carers. The community and grieving families want to see that the truth comes out. And when the truth doesn't come out or is held up, or it's months down the track when, 'Oh, it should have been looked at', and it turns out there was no autopsy done, so doctors are saying, 'We think it was septus or it might have been something else', it's unsatisfactory. In this occasion we had a politician who told us about it. Well, politicians do a job of work but I don't like being told by politicians about a reportable death. And that's what happened on this occasion. And I'm angry about it. But thank you for your frankness."

29. I have publicly expressed my concerns at the Inquest about the police response to news of the death. This was acknowledged by senior police at the Inquest and their Counsel, Mr Stirk. The investigation of the death of the deceased was delayed and hampered by what occurred after her death. The death certificate wrongly issued by Dr Pearson permitted the deceased to be removed from the morgue and buried. Statements were not taken by police of relevant witnesses until a considerable time after the death, and no autopsy was conducted on the body of the deceased. The investigation into the death of the deceased commenced only after the intervention of a politician who rightfully raised concerns. At that time the deceased had

been buried and no autopsy was possible (although I note that her body remained at the morgue for some time and if the police had dealt appropriately with news of the death it would have been available for autopsy).

RECOMMENDATION

30. I recommend that the Commissioner of Police review the position of the Coroners Constable in the Central Region (viz. Alice Springs and Tennant Creek) with particular regard as to whether the responsibilities of the position require more fulltime attention or an additional constable.

Dated this 28th day of April 2006.

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GREG CAVANAGH
TERRITORY CORONER