CITATION: *Inquest into the death of Jenissa Ryan* [2008] NTMC 073

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0010/2006
DELIVERED ON:	23 December 2008
DELIVERED AT:	Alice Springs
HEARING DATE(s):	25 & 26 September 2008
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Absconding juvenile patient, relevant hospital policy and non-compliance with it, subsequent hospital actions

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Department of Health And Families:	Kelvin Currie

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

No. A0010/2006

In the matter of an Inquest into the death of
JENISSA RYAN
ON 29 JANUARY 2006
AT THE ADELAIDE WOMEN AND CHILDREN'S HOSPITAL

FINDINGS

(Delivered at Alice Springs on 23 December 2008)

Mr Greg Cavanagh SM:

Introduction

1. Jenissa Ryan (hereinafter called "the deceased") was an Aboriginal adolescent female born on 16 December 1991 in Alice Springs in the Northern Territory. She died at approximately 2pm on 29 January 2006 at the Adelaide Women and Children's Hospital in South Australia from blunt force injury. She was admitted to the Alice Springs Hospital but left there on Friday 27 January 2006 and while absent suffered a number of injuries that led to her death. The distressing events that befell the deceased over the night after she left the Hospital have been dealt with by criminal proceedings in the Supreme Court and were not revisited before me at this Inquest. This inquest was held to examine the care she received at the Alice Springs Hospital, and in particular the circumstances of her leaving the Hospital and how this was dealt with.

2. Ms Jodi Truman appeared as Counsel assisting. The Department of Health and Families ("the Department") was represented by Mr Kelvin Currie. Although publicly advertised, the family of the deceased was not represented, nor were any family members present. I thank both Counsel for their assistance during this inquiry.

3. There were 10 witnesses called to give evidence at the inquest. Sergeant Derek Maurice, a member of the Northern Territory Police Service, investigated the death of the deceased. This contained numerous statements from other witnesses, a post mortem report, the deceased's medical records and a large amount of material relating to the criminal proceedings that flowed as a result of the death of the deceased. He produced a thorough and comprehensive brief that was tendered before me. I also heard evidence from Dr Lloyd Einsiedel, Nurse Fleur Spencer, Nurse Damien Bond, Nurse Susan Prentice, Nurse Dianne Cornell, Nurse Jo Hanak, Nurse Alvin Cheam, Nurse Emma Secombe and Vicki Taylor (who was called by the Department).

4. Pursuant to section 34 of the *Coroners Act*, I am required to make the following findings:

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

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. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

> "(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.

(2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

(3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

Relevant circumstances surrounding the death

7. The deceased was 14 years old. She was a student. Her mother had died when she was very young and she was cared for by her aunt, Carmel Ryan. They were living at Room 11 of the Ayiparinya Hostel in Alice Springs.

8. On Sunday 22 January 2006 the deceased's nose began to bleed. She reported this to Carmel. Attempts were made by them both to try and stop the bleeding, but it was to no avail. As a result, Carmel contacted the on-call Congress Medical Officer, Dr Arman Yazdani. Dr Yazdani attended at the Hostel and examined the deceased there. He found that the deceased had a temperature and a slight persistant nosebleed. At about 9pm that evening he took the deceased and Carmel to the Alice Springs Hospital Emergency Department for examination and testing.

9. At the Emergency Department blood was taken for analysis, however the analysis could not be conducted that night, as the blood machine was not working. A nasal pack was inserted and the deceased was permitted to return home with her aunt that evening. An appointment was made for the following morning with the Ear, Nose and Throat specialist at the hospital. The deceased then left the hospital in the company of her aunt.

10. On Monday 23 January 2006, the blood tests were able to be conducted and revealed that the deceased had a blood platelet count of 5,000 per cubic millimetres. This is extremely low; the normal range is 140,000 to 400,000 per cubic millimetres. Dr Lloyd Einsiedel, an infectious disease physician

from the Alice Springs Hospital, gave evidence that in a 14 year old adolescent female he would expect, at the very least, a blood platelet count of approximately 120,000 per cubic millimetres.

11. Alice Springs Hospital immediately asked the Congress Medical Centre to assist in the locating of the deceased and her return to the hospital. Those arrangements were made and the Congress Medical Centre returned the deceased to the hospital Emergency Department.

12. At the Emergency Department a repeat full blood count revealed that the deceased was still showing marked thrombocytopenia (the medical terms for a low peripheral blood platelet count) and anaemia. It was determined that the most likely cause of the thrombocytopenia was "Idiopathic Thrombocytopenic Purpura", referred to as "ITP" for short.

13. ITP is generally caused by the spontaneous production of antibodies, which are directed at parts of platelets, resulting in their removal from the circulation by the spleen and their subsequent destruction. Sometimes ITP may follow a viral infection, but often no cause is discovered. The condition can cause life-threatening bleeding if it is severe, such as bleeding within the brain. In addition traumatic events may cause excessive or prolonged bleeding if the peripheral blood platelet count is very low, that is below 50,000 per cubic millimetres.

14. The deceased was admitted to the Alice Springs Hospital. The paediatric ward does not generally admit patients over 13 years of age. The documents before me describe the deceased as a 'well built' 14-year-old female adolescent. A decision was made that the deceased would be admitted to the adult medical ward.

15. The deceased's condition was considered serious because of her low blood platelet count. The treating plan on admission was to confirm the diagnosis

of ITP and improve the blood platelet count with the use of intravenous Intragam Infusions.

16. Dr Einsiedel became responsible for the care of the deceased from Tuesday 24 January 2006. He met with the deceased and her aunt on that day and spoke with them briefly about the deceased's condition and the treatment that she would be undergoing. Dr Einsiedel said that he had some concerns about the placement of an adolescent in the adult medical ward, but given that she had already been in the adult ward for over 24 hours when he took over her care, and she had settled in, he did not seek to have her transferred to the paediatric ward.

17. On 25 January 2006 medical notes record Dr Einsiedel's plan that if the deceased's blood platelet count did not rise in the next 24 to 36 hours then they would need to consider transferring her to Adelaide.

18. As the week progressed the deceased became more mobile and began walking about the hospital from time to time. A number of witnesses at the inquest gave evidence that the deceased was regularly 'going in and out' of the adult ward. During this period the deceased left the hospital at least twice, in the company of her cousin, Delvina Boko.

19. The deceased continued to undergo a course of Intragam Infusions in the hope of increasing her blood platelet count. Unfortunately her blood platelet count was not rising and Dr Einsiedel gave evidence that he was becoming increasingly concerned about the deceased's condition and the capacity of the Alice Springs Hospital to provide adequate care for her.

20. On Thursday 26 January 2006 deceased was noted to be absent from the ward from11 pm. At that stage steps were put in place to locate the deceased including a search of the ward, the hospital and the grounds. The deceased was found back in her bed at 11:30 pm and was spoken to about not leaving the hospital grounds and staying where it was safe.

21. The prompt efforts to find deceased on this occasion were in compliance with the Alice Springs Hospital policy statement in relation to patients taking their own leave (that is leaving the hospital without official discharge) that was in place at that time.

22. There was evidence presented before the inquest that in relation to each hospital day there are generally 3 nursing shifts:

    i. An early or morning shift commencing at 7am and ending at 3.30pm;

    ii. A late or afternoon shift commencing at 1pm and ending at 9.30pm; and

    iii. A night or evening shift commencing at 9pm and ending at 7.30am.

23. Within each shift each patient has a registered nurse who is noted as his or her primary carer. The registered nurse or primary carer then reports to the Team Leader. There is also a Nursing Coordinator for each shift to whom the Team Leader reports, particularly after hours and on weekends, if something out of the ordinary occurs or there is an emergency in relation to a patient.

24. On Friday 27 January 2006 Damien Bond, an enrolled nurse at the Alice Springs Hospital, was on duty for the morning shift. Nurse Bond stated that when he commenced his shift the deceased was on the ward. She appeared comfortable and alert, with no complaints and attended to her own hygiene and ate that morning. She was dressed in casual clothes.

25. Nurse Bond recalls that at approximately 10 am the deceased told him that she was going outside for a little while. She then left the ward. The late or afternoon shift then commenced at 1 pm. At that time it was noted that the deceased had not returned to the ward, not even for the lunchtime meal, which occurred around midday.

26. There was evidence before me that a hand over occurs between the shifts. This is usually between the team leaders, however the primary carers can also be involved. I heard evidence that there was also a handover that took place between the nursing coordinators.

27. Nurse Bond recalled that he was involved in the handover from the morning shift to the afternoon shift and said that he advised the afternoon shift that the deceased had been absent since 10 am. The primary carer for the afternoon shift was Nurse Kingi. Nurse Kingi could not be located to give oral evidence at this Inquest. I accept that all endeavours were made to try to locate this nurse. I did have in evidence before me the statement that was given by Nurse Kingi to the police.

28. The Team Leader for the afternoon shift was a Ms Freeman. Unfortunately since these events Ms Freeman has passed away. A statement from her was tendered. The Nursing Coordinator for the afternoon or late shift was Dianne Cornell, who gave a statement to the police and also gave evidence before me.

29. It appears from the evidence that very little was done during the morning shift on Friday 27 January 2006 to locate the deceased. I did hear evidence that various people were told that various persons had been contacted, however there is no documentation to support that such communication had in fact occurred, or to substantiate those statements. It appeared from the evidence of Nurse Bond that once handover had taken place he considered the responsibility rested with the incoming afternoon shift and nothing further was done by him as the primary carer.

30. Nurse Spencer gave evidence before me that she recalled instructing someone to contact the Aboriginal Liaison Officer after handover had occurred but she could not recall who it was that she instructed to do that. Again there is no documentation to support that this was ever done.

31. Some time after 1pm on Friday 27 January 2006, Dr Einsiedel became more concerned as to the condition of the deceased and her progress and prepared a plan that included further Intragam Infusions and arrangements for a Royal Flying Doctors Service flight out of Alice Springs to the Royal Adelaide Women and Children's Hospital on Sunday 29 January 2006. It is clear from the evidence before me that the deceased was never advised of such a plan, or of the arrangements for her transfer to Adelaide.

32. The next notation contained in the hospital file as to anything being done in relation to the deceased's absence from the ward is a notation recorded at 5.30pm on 27 January 2006 which states that at the commencement of that shift the deceased was still absent from the ward. It also states that the medical ward Aboriginal Liaison Officer had been unable to locate her. I note that there was no record of what attempts in that regard had been made. It also noted that Carmel Ryan had been telephoned and advised that the deceased had left the ward without being discharged and the hospital required her back in order to transfer her to Adelaide.

33. Carmel Ryan gave a statement to police. After receiving that call Mrs Ryan *herself* contacted the Tangentyere Night Patrol. Their records record that the first contact they received regarding the deceased was from Mrs Carmel Ryan at approximately 6.45pm. At 6.56pm the patrol attended at the Ayaparinya Hostel and spoke to Carmel and she provided them with a description of the deceased and asked them to particularly look for her at 'Hoppies' and 'Hidden Valley' Camps. The patrol did attend at the Hoppies Camp and drove around but did not get out of the vehicle. They did not go to the Hidden Valley Camp that evening.

34. Also contained in the brief tendered before me are statements from the Aboriginal Health Worker, Thelma Thomason; the assistant in nursing or AIN, Baden Chapman; and the security officers working on Friday 27 and Saturday 28 January 2006. Mrs Thomason states that she did not do

anything to locate the deceased because she was told at 11 am that people had already contacted the night patrol and the mother of the deceased. Again there is no documentation to support that that had actually been done, particularly at that time. Mr Chapman records in his statutory declaration that at no stage was he requested to look for the deceased during his shift. Only one of the security officers on duty recalls being tasked at any stage to look for the deceased, or anyone of her description, and that was not until 8.30pm on Friday 27 January 2006.

35. Dianne Cornell was the nursing coordinator for the late or afternoon shift. Nurse Cornell gave evidence that at no stage during her shift was she advised as to the absence of the deceased from the ward. Nurse Cornell gave evidence that this was one of the matters that she *would* expect to be made aware of from her team leader if it occurred. Because of that failure Nurse Cornell took no action in relation to attempting to locate the deceased.

36. The nursing night shift for Friday 27 January 2006 commenced at approximately 9pm. The primary carer for the deceased for the night shift was Nurse Brycen Brook. The team leader was Nurse Jo Hanak and the nursing coordinator was Mr Alvin Cheam. Nurse Jo Hanak provided a statement to the police and gave evidence before me.

37. Nurse Hanak had coincidentally been responsible for the care of the deceased the evening prior, on Thursday 26 January 2006. Nurse Hanak confirmed that on 26 January 2006 she had immediately made arrangements to locate the deceased when advised as to her absence and that the deceased had simply returned to the ward of her own accord at approximately 11.30pm.

38. As a result of that earlier occurrence Nurse Hanak gave evidence before me that she had anticipated, upon being made aware of the absence of the deceased from the ward on 27 January 2006, that the deceased would simply

return to the ward of her own accord once again. She did not recall whether she had been advised as to how long the deceased had been absent from the ward. She stated that she recalled receiving information that prior to the commencement of her shift the hospital grounds had been searched, the guardian contacted, the doctor communicated with, the nursing coordinator informed, and the deceased's absence also reported to the police. She could not recall who told her this. As a result of receiving that information and also as a result of the events of the previous evening, Nurse Hanak took no further action in relation to endeavouring to locate the deceased.

39. Nurse Alvin Cheam was the nursing coordinator for the night shift. There were some differences between the information that Nurse Cheam provided to the police a few short months after these events, and the evidence that he gave before me over 2 years later and I consider it likely that some reconstruction had occurred in relation to the events of 27 January 2006. However I accept that he was endeavouring to do his best when giving his evidence.

40. Nurse Cheam stated that he had been advised that the police had been contacted when he commenced his shift. It is clear from all of the evidence however that the police were not contacted at any stage on 27 January 2006, despite what nurses Cheam and Hanak say now that they were told. Nurse Cheam gave evidence that as a result of being informed of these circumstances, he did not take any further action in relation to endeavouring to locate the deceased and did not learn anything further in relation to her whereabouts until the conclusion of his shift at 7.30am the following morning. Nurse Cheam stated in his evidence that he had provided information to the oncoming nurse coordinator for the morning shift of 28 January 2006 as to what had occurred in relation to the absence of the deceased from the ward. That person was Nurse Emma Secombe.

41. Nurse Secombe gave evidence before me, and was very clear in her recall. Importantly, her recollections accorded with the statement that she gave to the police. That recollection was that she was *not,* at any stage upon commencement of her shift, informed of the absence of the deceased.

42. In this regard, I prefer the evidence of Nurse Secombe to that of Nurse Cheam, and I find that Nurse Cheam did not advise her as to the absence of the deceased when she commenced her shift on Saturday 28 January 2006.

43. Nurse Secombe gave evidence that it wasn't until she commenced her own rounds, at approximately 9.30a m, that she realised that the deceased was off the ward. Upon discovering the absence of the deceased, Nurse Secombe made arrangements for searches to be conducted and also inspected the hospital file of the deceased. She then made contact with the doctor for the deceased and inquired as to what arrangements should be made to locate the deceased. Immediately thereafter a decision was made to contact the police and Nurse Secombe did so. I find on the evidence before me that the police were contacted for the *first* time by the hospital at approximately 10am on Saturday 28 January 2006, that is 24 hours after the deceased had absented herself from the hospital.

44. It is not my intention to review the horrendous circumstances that befell the deceased during the evening of Friday 27 January 2006 and into the early hours of the morning of Saturday 28 January 2006. Facts in relation to those events have been found beyond a reasonable doubt in the Supreme Court and are set out clearly in the sentencing remarks of the Honourable Chief Justice Martin of 8 May 2008. It is not the purpose of this inquest to reinvestigate those circumstances.

45. I differ from the agreed facts on one point. I rely on the findings of the forensic pathologist, Dr Allan Cala, to find that the deceased suffered the following injuries in the lead up to her death;

- Swollen left eye
- Bruised right eye
- Laceration inside lip to the left and bruising
- Bruising to 2nd and 3rd left ribs
- Bruising to the right of the ribs
- Bruising left ear
- Closed head injury

46. It was the opinion of the forensic pathologist that the direct cause of the deceased's death was blunt force head injury. The CT scan taken of the deceased at the time of her admission to the Royal Adelaide Women and Children's Hospital showed evidence of a right subdural haemorrhage with mid-line shift, that is displacement of parts of the brain due to bleed in the brain.

47. The post mortem examination showed injuries to the facial region consistent with being caused by an assault. The forensic pathologist states in his report that the very low platelet count of the deceased would have exacerbated any bleeding around the brain following the head injury. He is of the opinion that a subdural haemorrhage is not a feature of ITP and therefore that the subdural haemorrhage was not spontaneous, but caused by a traumatic event such as an assault. I accept the findings of the forensic pathologist in this regard and find that the bleed was caused by a traumatic event and was not a spontaneous occurrence.

The Hospital Policy in 2006

48. The Alice Springs Hospital policy statement in relation to patients taking their own leave (that is leaving the hospital without official discharge) had been in place for a number of years at the relevant time. The policy had been issued in June 1998 and revised in 2002, with a review noted for 2005.

Point 2 of that provides that where a patient leaves hospital without notice, or official discharge, the following procedures shall apply:

1. When a patient is found to be absent without leave from a ward an attempt should be made to find them using available resources to search the hospital and grounds. The intensity and urgency of the search will depend on the condition of the patient.

2. The assistance of the police must be sought immediately to return a patient to hospital where the patient is :

    a. a minor, under the age of 18 years;

    b. at risk of causing injury to themselves or others;

    c. held under section 9 or 10 of the Mental Health Act;

    d. held under the Notifiable Diseases Act.

    The decision to return a patient to hospital under the above criteria must be made by a medical officer and documented in the patient's notes.

3. Where the patient is not located the following persons should be notified as soon as possible:

    a. The patient's doctor or doctor on call if a public patient;

    b. Clinical Nurse Consultant/Nursing Services co-ordinator;

    c. Patient's next of kin;

    d. The police or welfare agency if the patient is a minor or deemed to be at risk;

    e. The patient's referring agency, "home" community health clinic or other medical service provider where applicable."

49. The policy was located in "hard copy" in a manual, and also on the hospital "F Drive". I find that the policy as it existed at that time was appropriate in relation to the steps to be taken when a patient took their own leave.

50. The evidence before me however makes it clear that a large number of the staff were either unaware of the policy's existence or were not familiar enough with its terms to properly understand the requirements and obligations placed upon them when a patient did take their own leave.

51. If the policy had been complied with, police should have been called far earlier than the 24 hours that it took for them to be contacted by the hospital.

52. There was evidence given before me from a number of witnesses that in practice they would generally allow a patient to leave their bed and travel outside for a period of time, but eventually if the patient did not return then they would take action. That 'leeway' period varied from 2 to 6 hours. On occasions if a patient missed a meal, or a medication, it was at that point that steps would be taken to locate the patient.

53. Even if such a time period was allowed, and taking into account the differences in opinion as to how long it should be, it is apparent that police should have been contacted far earlier than they were. In addition I note that the deceased was only 14 and thus there should have been a heightened concern about her.

54. I find that not only were the police not contacted in accordance with Hospital policy but that there were inordinate delays in communicating with the deceased's next of kin. In addition the note taking as to what had actually been undertaken by the hospital in regards to complying with their own policy was extremely inadequate.

55. As I have noted in other findings, it makes it very difficult for family, and also the greater community, to accept that steps were undertaken by the hospital in accordance with its duty of care to a patient, when those steps are not confirmed in the documents or notes made contemporaneously. These concerns could easily be put to one side if proper note taking is undertaken.

I therefore recommend that systems are put in place to ensure that staff take proper and detailed notes are taken of the steps taken in accordance with their policy in future situations where patients take their own leave.

56. Since this death the hospital has undertaken a comprehensive Critical Incident Review. The hospital has instituted changes to their policy statement, and has educated their staff in relation to the responsibilities when patients take their own leave, particularly highlighting the requirements when the patient is a minor. Ms Vicki Taylor gave evidence before me and read onto the record her statement provided on behalf of the Department. The clear, frank and unambiguous evidence of Ms Taylor is to be commended. I commend also the hospital for their response to this death and their cooperation with this Inquest. The coronial process is all about people learning from the circumstances of a person's death. It is clear that the hospital has undertaken significant steps in this regard.

Conclusion

57. The deceased left the hospital without being formally discharged. As a result she fell to be dealt with by the hospital staff in accordance with their policy dealing with absconding patients. The staff involved comprehensively failed to comply with the hospital policy that was in place at the relevant time in a prompt and efficient manner.

58. I am simply unable to make a finding as to whether that failure to comply with the hospital policy would have made any difference to the subsequent death of the deceased; it may have resulted in her being found and returned to the hospital and thus prevented her death, but she may not have been found and her death may still have occurred.

59. That the Alice Springs Hospital continues to ensure that staff are educated as to the policies applicable to absconding patients and that such policies are

readily available so that when a patient leaves a hospital the staff can access the policy and do, in fact, comply with it.

60. That the Alice Springs Hospital provides the relevant education at regular intervals (that is not just at inducation/orientation) to keep staff up to date as to their responsibilities and obligations.

Formal Findings

61. Pursuant to section 34 of the Act, I find as a result of evidence adduced at the public inquest as follows:

i. The identity of the deceased was Jenissa Ryan, an Aboriginal female born on 16 December 1991 in Alice Springs in the Northern Territory. The deceased resided at the Ayaparinya Hostel in Alice Springs.

ii. The time and place of death was approximately 2 pm on 29 January 2006 at the Adelaide Women and Children's Hospital when tests revealed that the deceased had no brain activity. After consultation with the family the Hospital then ceased life support.

iii. The cause of death was blunt force head injury.

iv. The particulars required to register the death are:

a. The deceased was female.

b. The deceased's name was Jenissa Ryan.

c. The deceased was of Aboriginal descent.

d. The cause of death was reported to the Coroner.

e. The cause of death was confirmed by post mortem examination carried out by Dr Allan Cala.

f. The usual place of residence of the deceased was at Ayaparinya Hostel in Alice Springs.

g. The mother of the deceased was Veronica Ryan who passed away a number of years ago and the deceased was

in the care of her aunt, Carmel Ryan, for the majority of her life.

h. The deceased was a student.

Recommendations

62. That the Alice Springs Hospital puts systems in place to ensure that staff take proper and detailed notes of the steps taken in accordance with their policy in future situations where patients take their own leave.

63. That the Alice Springs Hospital continues to ensure that staff are educated as to the policies applicable to absconding patients and that such policies are readily available so that when a patient leaves a hospital the staff can access the policy and do, in fact, comply with it.

64. That the Alice Springs Hospital provides the relevant education at regular intervals (that is not just at inducation/orientation) to keep staff up to date as to their responsibilities and obligations.

Dated this day of 2008.

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GREG CAVANAGH
TERRITORY CORONER