CITATION: *An inquest into the death of Ronald Smallwood* [2000] NTMC 45

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO:	A0039/2000
DELIVERED ON:	13 December 2000
DELIVERED AT:	Alice Springs
HEARING DATE(s):	13 December 2000
JUDGMENT OF:	Greg Cavanagh SM

CATCHWORDS:

REPRESENTATION:

Counsel:

Assisting	Elizabeth Morris
Territory Health:	Mr Stirk

Solicitors:

Judgment category classification:	A
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NORTHERN TERRITORY OF AUSTRALIA

CORONERS COURT

No A0039/2000

AN INQUEST INTO THE DEATH
OF
RONALD SMALLWOOD

MR G. CAVANAGH, Coroner

TRANSCRIPT OF PROCEEDINGS

AT ALICE SPRINGS ON WEDNESDAY 13 DECEMBER 2000

Certified true transcript of
a record produced out of the
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MS MORRIS: Your Worship, this is an inquest into the death of Mr Ronald Smallwood. It's an inquest that we must have under the Act under section 15 because as the evidence will show Ronald Smallwood had an order keeping him in care under the Mental Health and Related Services Act.

THE CORONER: Mr Stirk, you appear, do you?

MR STIRK: Yes, Your Worship, I'd be seeking leave under section 40(3) to appear on behalf of the Northern Territory and in particular Territory Health Services in as far given the events that occurred that are in the coronial material it's possible that Your Worship may be commenting upon the administration of the Public Health System.

THE CORONER: Okay, thank you. Yes, you have my leave.

MS MORRIS: And I'll be appearing as counsel assisting you in this matter, Your Worship.

THE CORONER: Thought so. Yes.

MS MORRIS: Basically, sir, Mr Smallwood was an elderly man. He was born on 9 October 1925. He had fairly serious health problems. The first of those was chronic paranoid schizophrenia. He lived, normally, in a small flat, number 9, 40 Head Street, Alice Springs. But on 19 July 1999 he was admitted to Ward 1, as you'd be aware that's the mental illness ward at Alice Springs Hospital, suffering from chronic paranoid schizophrenia.

At that stage it was determined that an application for adult guardianship should be made and that was initiated by Community Health on 7 September 1999. A temporary order was made on 10 November 1999. As you would be aware this allows the public guardian to make decisions on his behalf in relation to his accommodation, health care, finances and access to support services. He was released from the hospital on 20 December 1999 and returned to his home.

Adult guardianship supported him throughout that period. However, his health and physical and mental health were failing at the time that he was at home. He lost some 20 kilograms of weight in a 2 month period. So he was admitted back to Alice Springs Hospital on 10/5 of this year as an involuntary patient. Subsequent to that an order was made under the Mental Health and Related Services Act. And an order was made that he be detained as involuntary patient on the grounds of mental of illness for a period of 3 months.

That order was made in May, on 24 May in the year 2000 and a review of the order was set for 24 August 2000. However, because even in hospital his physical condition was still deteriorating, he was moved from Ward 1 to Ward 6, which is a medical ward and that was on 24 May for medical intensive care.

He was found on conducting an examination to have cancer of the right kidney and his health continued to go downhill. Consideration was given to transferring him to the Renal Unit in Adelaide, but because of his age and his ailing health it was considered it was not suitable for such an operation to remove the cancer.

He subsequently died in Ward 6 at 2.45 in the morning on Sunday 4 June 2000. A discussion at that time occurred between the attending medical staff. It was agreed amongst them that because he died in a general ward and the cause of death was obviously known to them it was not a reportable coroner's death. A medical certificate was signed by Dr Hiremagalur on 8 June and the cause of death was given as haemorrhage into tumour and cause (inaudible) was a right renal tumour. That had been diagnosed by an ultra sound scan.

On Wednesday 28 June Mr Grant Oaklands, who was the adult guardian for the deceased contacted the coroners constable in Alice Springs, indicating that Mr Smallwood was being buried that morning at 10 o'clock. He rang them at 9.45. He further advised them a post-mortem hadn't been carried out and been a medical certificate, but that there was a mental health order that he'd been under care of the Minister. It was ascertained by the coroners constable that an order was (inaudible).

Arrangements were then made to have the body returned to the Alice Springs Hospital mortuary, after the funeral was complete. The funeral was done at the grave-side and the coffin was in the grave at the time that the coroner's constable found out about this matter. In any event the body was returned, a post-mortem was completed and the matter was commenced as a coronial investigation.

THE CORONER: Have we got a post-mortem report?

MS MORRIS: I do, Your Worship. I'll just call Coroner's Constable Allan Duncan to tender the brief.

THE CORONER: Before he's sworn in have you got a copy of the PM report. Swear the constable in, please.

ALLAN GEOFFREY DUNCAN, sworn:

MS MORRIS: Please tell the coroner your full name, rank and station?---Your Worship, my name is Senior Constable Allan Geoffrey Duncan, stationed at Alice Springs. I am the coroners constable for the Southern Division.

You became aware of the death of Ronald Smallwood and subsequently commenced a coronial investigation into that death?---I did so.

And is this a copy of the brief that you prepared for the coroner in relation to that matter?---It is, yes.

I tender that, Your Worship.

THE CORONER: I'll assume there's no objection, unless you hop up and tell me so?

MR STIRK: That's correct, Your Worship.

EXHIBIT 1 Brief

MS MORRIS: You were also present when a post-mortem was conducted by Dr Michael Zillman(?)?---I was, yes.

And is this - was this report obtained as a result of that autopsy?---It was, yes.

I tender the autopsy report, Your Worship.

EXHIBIT 2 Autopsy report

MS MORRIS: And - - -

MR STIRK: Your Worship, I haven't got a copy of that but I don't think anything turns on it, of the actual autopsy itself. I don't think that's - - -

THE CORONER: Widespread cancer.

MR STIRK: I'm aware of the - I don't need to see it. I'm just saying I haven't seen it, but I don't object to its tender.

THE CORONER: Okay, exhibit 2.

MS MORRIS: Did you also arrange for the medical records for completeness of Mr Ronald Smallwood to be obtained?---I did, yes.

I tender those medical records, Your Worship.

EXHIBIT 3 Medical records

MS MORRIS: I'm not requesting that you read those.

THE CORONER: No. I'll just have a look though. Yes.

MS MORRIS: And constable, as a result of the information that you learned from Mr Grant Oaklands you acted quickly?---I did, yes.

And in doing so you contacted the coroner's office in Darwin and advised them of the situation?---Yes, I did.

And you made arrangements for the immediate return of the body to the mortuary so a post-mortem could be conducted?---I did, yes.

And the - during the investigation you spoke to hospital and medical staff about what is a reportable death, is that correct?---Yes, I did.

And as part of your brief of evidence you obtained copies of reports sent by Mr Len Notaras to medical - all the forensic pathology staff and all the directors of medical services throughout Territory Health?---I did, yes.

And they're contained in the brief?---Yes.

I don't have any further questions for the constable, Your Worship.

THE CORONER: Thank you. Any questions?

MR STIRK: Just a couple.

Constable, do I understand you to be saying that from your investigations it appeared that various staff in the hospital were unaware of the fact that Mr Smallwood was under an order under the Mental Health and Related Services Act?---Yes, most certainly.

And is also fair to say that most of them were unaware that that - if a person is under such an order and dies in hospital then the death has to be notified to coroner?---Yes, that's correct.

And I think, as my learned friend said, you included a letter from Mr Notaras or Dr Notaras who is the principal medical consultant with the Territory Health throughout the Territory. Were you personally aware of the information in that report being disseminated to various staff within the hospital?
---Yes, I was.

And is it fair to say that perhaps there was a bit of a rocket being placed up various people?---Yes.

And as a consequence of that are you reasonably confident that people in the hospital are now aware of their obligations?---I am certain, yes.

Thank you.

THE CORONER: Yes, thank you, constable, you can step down.

WITNESS WITHDREW

MS MORRIS: Your Worship, that's the evidence that I intend

to present in relation to this inquest. In my submission it would appear from the evidence that what was a problem has been rectified already by Territory Health and that there's no need to make a further recommendation, but for, perhaps, that as we know in health services in the Territory staff change fairly frequently, even at high levels, and there probably needs to be continued reminders to staff about their obligations under the Coroners Act.

This obviously can be done within the hospital, but the coroner's office, itself, had also offered its services to assist in training of new staff.

THE CORONER: Mr Stirk, I'm minded to hand down findings now. Perhaps, if it's okay by you, I'll let you know what my draft findings are such that you may not then wish to add anything or make any further submissions.

MR STIRK: I'd anticipate I wouldn't want to, Your Worship. As Your Worship's heard there was a problem. There needs to be ongoing education within the hospital system. I understand Dr Notaras and others are attending to that. Obviously all the help the coroner's office can provide is obviously of assistance.

THE CORONER: Yes, I had a word with Mr - Dr Notaras about this and he full well knows the importance of reporting those deaths which are required to be reported under the Coroners Act. He told me that he would ensure that there is continued reminding of that to doctors. And I note that his memo to the Medical Superintendent of the Alice Springs Hospital in that regard.

MR STIRK: That's right, Your Worship. As I've said to my friend, many bush doctors are also bush lawyers and it seemed there was a bit of discussion about this and that - - -

THE CORONER: Yes, I've found that to be so myself. In fact we're wondering what to do in respect of my findings in the death of Baby J where foetuses live and become human beings and then die and I held it to be in those circumstances for them to be - that to be a reportable death, it being unnatural or unexpected. And I think there's some dispute by doctors about whether it's reportable.

MR STIRK: They can take that up if they want to in other places.

THE CORONER: They can. Not a matter for you now.

MR STIRK: No, certainly not and I'm out of that, I think, because it's being handled out of Darwin, as I understand it.

THE CORONER: But I'm satisfied with the efforts made by the

hospital system in relation to this death in terms of reporting.

MR STIRK: May it please the court.

THE CORONER: Thank you. I find that the deceased is a male caucasian named Ronald Smallwood, born on 9 October 1925 and normally resident at flat 9, 40 Head Street, Alice Springs. The deceased died at Alice Springs Hospital at 0245 hours on Sunday 4 June 2000. The cause of death was natural causes, being a disseminated carcinoma, to the lay person otherwise called widespread cancer. I find the deceased was in care pursuant to the relevant Act and therefore, according to the Coroners Act it was reportable death.

And I note that the relevant Act for which he was placed in the care was the Mental Health and Related Services Act. I adopt the opening summary of counsel assisting as my findings in relation to the circumstances surrounding the death. I note the action taken by Territory Health to rectify the apparent ignorance of their staff at Alice Springs Hospital of the relevant provisions of the Coroners Act in relation to this kind of reportable death. And I commend this action by Dr Len Notaras.

I make no recommendations and I finally commend the actions of Senior Constable Allan Duncan in recognising the situation and taking prompt and appropriate action. Thank you. I also order a copy of these proceedings to be transcribed and forwarded to the coroner's office, Darwin, as soon as possible. Close the court.

ADJOURNED