CITATION:	*Inquest into the death of Alison Rose Woods* [2005] NTMC 031.
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0111/2004
DELIVERED ON:	6 June 2005
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HEARING DATE(s):	6 June 2005
FINDING OF:	GREG CAVANAGH SM
CATCHWORDS:	Death in Care – Natural Causes

REPRESENTATION:

Counsel:

Assisting:	Helen Roberts
Department of Health:	Kelvin Currie

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

No. D0111/2004

In the matter of an Inquest into the death of

ALISON ROSE WOODS
ON 2 JULY 2004
AT 3 BURNET COURT, KATHERINE

FINDINGS

(Delivered 6th June 2005)

Mr GREG CAVANAGH SM:

1. Alison Rose Woods ("the deceased") died at home in Katherine on 2 July 2004. She was the beloved daughter of Wendy and Christopher Woods.

2. The deceased child was under a sole guardianship order granted by the Minister for Health. Therefore at the time of her death, the deceased was held in "care" as defined in s. 12(1)(a) of the *Coroners Act*. As a consequence this Inquest was mandatory pursuant to s. 15(1)(a) of the *Coroners Act.*

3. Section 34(1) of the *Coroners Act* sets out the matters that a Coroner is required to find during the course of an investigation into a death. That section provides:

> "(1) A coroner investigating –
>
> (a) death shall, if possible, find –
> (i) the identity of the deceased person;
> (ii) the time and place of death;
> (iii) the cause of death;
> (iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act; and
> (v) any relevant circumstances concerning the death;"

FORMAL FINDINGS

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

(A) The identity of the deceased was Alison Rose Woods, a Caucasian female born on 21 January 1999 at Katherine Hospital in the Northern Territory.

(B) The time and place of death was 7.30am on 2 July 2004 at 3 Burnet Court, Katherine.

(C) The cause of death was chronic hydrocephalus.

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

1. The deceased was female.
2. The deceased was Caucasian Australian.
3. The death was reported to the Coroner.
4. The cause of death was confirmed by post mortem examination.
5. The cause of death was hydrocephalus.
6. The pathologist viewed the body after death.
7. The pathologist was Doctor Terence John Sinton of Royal Darwin Hospital.
8. The father of the deceased is Christopher Lee Woods born 14 October 1967.
9. The mother of the deceased is Wendy Maree Woods born 19 March 1969.

10. The usual address of the deceased was 3 Burnet Court, Katherine, Northern Territory of Australia.

HISTORY AND CIRCUMSTANCES

5. The deceased, the daughter of Christopher and Wendy Woods, was born at Katherine Hospital on 21 January 1999. She was born with congenital brain damage and suffered from severe developmental delay and infantile seizures since birth. She required constant medication and full time care. Her level of disability at the time of her death was spastic quadriplegia. The Woods family cared for their daughter with the assistance of occasional respite care.

6. Due to the level of assistance that the family required, a guardianship order provided that the deceased was in the sole custody of the Minister, was made in December 2003. One part of the agreement between the Woods family and NT Family and Childrens Services ("FACS") was that the family could care for her at any time when requested. The deceased was much loved by her parents who cared for her as often as they could.

7. During the week commencing Monday 28 June 2004, the deceased was with her family at their request during school holidays. She was found deceased by her mother at 7.00am on Friday 2 July 2004.

8. Senior Constable Michael Murphy conducted the coronial investigation into the death of this child and I commend him for his thorough investigation.

9. During the Inquest, evidence was given by four witnesses. They were Senior Constable Murphy, Dr Russell King, the treating doctor for the deceased; Doctor Terence Sinton, the Forensic Pathologist who performed the post mortem examination and Ms Alexis Jackson, the Manager of Katherine FACS. Also before me was the entire investigation brief including statements from Wendy and Christopher Woods, FACS workers, attending police officers and ambulance officers.

10. Doctor Russell King gave evidence that he attended the home of the Woods family on Friday 2 July 2004 at about 7.00am after he received a telephone call from Wendy Woods. She indicated that she thought that her daughter had died overnight and asked if he could come over straight away. Doctor King pronounced her deceased at about 7.35am.

11. The deceased's level of disability was very severe spastic quadriplegia. As Doctor King described it, she could not talk but could communicate through crying and some sounds; she was blind and unable to walk or feed herself; she had daily seizures which varied in intensity and required anti-epileptic medications and laxatives. Doctor King was her local doctor in Katherine since her birth. He was of the opinion that she was well cared for by her parents and her carers.

12. Doctor Terence Sinton performed the post mortem examination of the deceased. I called him as a witness at this Inquest because Wendy Woods, the deceased's mother, had some questions about his autopsy findings. He explained his conclusion as to the cause of death. The deceased's hydrocephalus had increased over her life, and the resulting pressure had reduced her brain size until it was extremely thin. This ultimately caused her death. There was no evidence of any injury or any disease.

13. There is no question that the deceased's death was from natural causes. There is no question about the adequacy of care provided to the deceased by her parents, either during her lifetime or on the night and morning that she died.

14. Alexis Jackson of FACS gave a statement to police and also gave evidence at this Inquest. She detailed the involvement of FACS in the care of the deceased which commenced in about 2001. Some questions were asked about the maintenance of records in relation to the deceased's medications. I am aware that there has been in the past some dispute between the Woods family and FACS which led to a complaint to the Ombudsman.

15. As I explained to the family of the deceased, my role as Coroner is to investigate thoroughly the circumstances of reportable deaths. In addition, I have a power pursuant to s.34, to comment on matters "connected with the death being investigated". It is not part of the function of the Coroner to mediate disputes between families and Government agencies where the subject matter of those disputes do not in any way bear on the death.

16. Ms Jackson was asked some questions about the keeping of communication books, or diaries. I do not propose to make any findings in relation to that subject for the reasons I have explained above, and because they are properly the province of the Ombudsman

17. The deceased child, known as Ally, was very much loved by her parents. I find that she received a very good standard of care from her carers and from her parents. She died from natural causes, complications of her severe disabilities which she had had since birth. I have no recommendations or other comments in relation to this death.

Dated this sixth day of June 2005.

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GREG CAVANAGH
TERRITORY CORONER