CITATION: *Inquest into the death of Alena Rankine* [2005] NTMC 053

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0084/2005
DELIVERED ON:	4 May 2006
DELIVERED AT:	Alice Springs
HEARING DATE(s):	6 March, 2 May 2006
FINDING OF:	Mr G Cavanagh

CATCHWORDS:

Death of a Child in Care
Coroners Act 1993 (NT) s12(1)(a), s15(1)(a)

REPRESENTATION:

Counsel:	Ms Helen Roberts
Assisting:	

Judgment category classification:	B
Judgement ID number:	[2005] NTMC
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IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0084/2005

In the matter of an Inquest into the death of

ALENA RANKINE
ON 19 OCTOBER 2005
AT ALICE SPRINGS HOSPITAL

FINDINGS

(Delivered 4 May 2006)

Mr GREG CAVANAGH:

1. Alena Rankine ("the deceased") died in the Children's Ward at Alice Springs Hospital on 19 October 2005.

2. Section 12(1) (a) of the *Coroners Act* ("the *Act*") defines a "reportable death" to include a death:

> (vii) of a person who, immediately before death, was a person held in care or custody:"

3. At the time of her death, the deceased was held in "care" as defined by s12(1)(a) of the *Act*. Consequently, despite the fact that this child's death was not unexpected due to her serious medical conditions, holding a public Inquest was mandatory, as required by s15(1)(a) of the *Act*.

4. Section 34(1) of the *Act* details the matters that an investigating Coroner is required to find during the course of an Inquest into a death. That section provides:

> "(1) A coroner investigating -
>
> (a) a death shall, if possible, find -

(i) the identity of the deceased person;

(ii) the time and place of death;

(ii) the cause of death;

(iii) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

(iv) any relevant circumstances concerning the death."

5. The death of this child was investigated on my behalf by Senior Constable Bruce Hosking. The brief of evidence was tendered as Exhibit 1. The autopsy report and toxicology report were tendered as Exhibit 2. The evidence obtained and tendered at the Inquest enables me to make the following formal findings as required by the *Act*.

FORMAL FINDINGS

(a) The identity of the deceased was Alena-Lisa Walker known as Alena Rankine, an Aboriginal female born on 9th June 2003 at Tennant Creek in the Northern Territory.

(b) The time and place of death was 19 October 2005 at 7:43am at Alice Springs hospital.

(c) The cause of death was chronic organic brain damage as a consequence of Murray Valley encephalitis.

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

1. The deceased was a female.

2. The deceased was of Aboriginal Australian origin.

3. The death was reported to the Coroner.

4. The cause of death was confirmed by post-mortem examination.

5. The death was caused in the manner described in paragraph (c) above.

7. The pathologist who viewed the body after death was Dr Terence John Sinton.

8. The father of the deceased is Norbert Jakamarra Walker born 16 February 1983 and the mother of the deceased is Patricia Rankine born 17 December 1982.

9. The usual address of the deceased was 64 Lyndavale Drive, Alice Springs.

Circumstances

6. The deceased child was born in Tennant Creek on 9th June 2003. In April 2004, while living with her mother, she contracted Murray Valley Encephalitis. As a result of this illness, she sustained severe brain damage. As set out in the report of Dr Tors Clothier, this caused *profound global developmental delay, poorly controlled epilepsy, spastic quadriparesis, bulbar palsy and also visual and hearing deficits*.

7. Her mother found it difficult to provide the extensive care and medical attention that she needed and consequently an order that she be placed in care of the Minister was made in August 2004. That order was most recently continued on 8 September 2005 and was therefore in place at the time of the child's death.

8. She lived with carer Noeline Wright in Alice Springs. Ms Wright had the care of this deceased and another young boy. The deceased received regular check ups with her paediatrician, Dr Tors Clothier.

9. On Tuesday 18th October, the deceased had suffered vomiting and diarrhoea, as well as increased seizure activity. Ms Wright settled her to bed at about 9pm with plans to take her to the hospital the next morning if she had not improved. At about 4am on 19th October, Ms Wright went to check on the deceased who was sweaty, with shallow and rapid breathing. She was conscious but non-responsive. Ms Wright called an ambulance which arrived a short time later and took the deceased to the Accident and Emergency ward at Alice Springs hospital.

10. In his report to the Coroner dated 19 October 2005, Dr Clothier says that in hospital she was found to be *tachycardic, diaphoretic and peripherally shut down with a pulse rate of 230, respiratory rate of 80 and temperature of 40*C .

11. She died about 3 hours after arrival at hospital after all efforts were made for her. Her death was certified by Dr Dede at 7:43am on 19th October 2005. An autopsy was carried out by Dr Sinton on 25th October 2005. In his report, dated 26th March 2006, he made the following comments (inter alia):

> 2. At autopsy, the only significant pathological findings was of marked scarring of the cerebellum at the base of the brain, this area of the brain being responsible for coordination of muscular movement.
>
> 3. The skull and remaining bony skeleton were intact, with no evidence of any recent trauma. There was no evidence of any recent significant soft tissue injury.
>
> 4. Sample of blood and liver were taken at autopsy for toxicological analysis. This analysis reported the detection, at therapeutic concentrations, of the therapeutic drugs, promethazine, diazepam, nordiazepam, valproic acid, and paracetamol in the blood samples, along with the detection of promethazine, nordiazepam, and paracetamol in the liver samples.
>
> 5. The chemical compound tris-(2-chloropropyl)-phosphate (TCPP) was detected in the blood samples, but not in the liver samples. This substance is reportedly used as a flame retardant. It is most likely the

case that it was present as a contaminant in the blood collection tubes, for reasons unknown.

6. There was no autopsy evidence for the direct involvement of another party in this girl's death.

7. Given the history and autopsy findings, she died as a result of the chronic organic brain damage suffered following infection with Murray Valley encephalitis virus.

12. With respect to point 5 quoted above, I note that the TCCP was described as a 'high unusual' finding in terms of post mortem toxicology. It is a compound used in manufacture of various industrial items. Its presence only in the blood sample, and not in the liver sample is particularly significant, indicating to Dr Sinton that it was very probably a contaminant of the sample, or the container. Although the source of the contamination has not been able to be identified, I am satisfied based on the available evidence, that the compound was not present in the body of the child.

13. Senior Constable Hosking has carried out this investigation, which included obtaining a statement from the deceased's carer, and from Dr Tors Clothier. I accept Senior Constable Hosking's opinion, based upon his investigation, that the deceased child has received constant medical care and loving care from her carer during her life and there are no matters that would warrant any comment from me with respect to that care.

Dated this 4th day of May 2006.

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GREG CAVANAGH
TERRITORY CORONER