IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2005 1625

REDACTED FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: TH

Delivered On:	19 August 2013
Delivered At:	Level 11, 222 Exhibition Street Melbourne 3000
Hearing Date:	Friday 7 June 2013
Findings of:	JUDGE IAN L GRAY, STATE CORONER
Representation:	Mr D Glynn on behalf of Ms JL Ms M Tittensor on behalf of Mr MD
Police Coronial Support Unit	Leading Senior Constable K Taylor

I, JUDGE IAN L GRAY, State Coroner having investigated the death of TH

AND having held an inquest in relation to this death on Friday 7 June 2013
at MELBOURNE
find that the identity of the deceased was TH
born on 30 September 2002
and the death occurred 13 May 2005
at Millennium Medical Centre, Corner Paisley and Albert Street, Footscray
from:

1 (a) BLUNT FORCE INJURY TO THE ABDOMEN

in the following circumstances:

Background

1. The deceased TH was born in Melbourne on 30 September 2002. At the time of her death, she was two years old, her natural mother JL, 27 years of age and her natural father, TTH, 29 years of age. TH was one of three siblings resulting from the relationship between JL and TTH. TH had one older brother AL, aged 4 at the time and one younger sister, KH, aged one.

2. JL and TTH separated on 26 May 2004 and JL retained custody of the three children, residing alone with them in a two bedroom flat situated in Maidstone.

3. TH had not seen her natural father for approximately one year before her death. During the last few months of her life, she saw her mother in a number of different relationships with other men.

4. According to family and friends, TH was the most outgoing of the three children and was generally a very happy little girl who loved eating and dancing. TH was 'clingy' with her mother and constantly craved her mother's attention. She was a very active child, often staying awake until late at night.

5. At the time of her death, TH was walking fully and was in the process of being toilet trained.

6. On the evening of Thursday 12 May 2005, JL and her three young children stayed with Mr MD at his one-bedroom flat in Hyde Street, Footscray. MD was the boyfriend of JL at the time and they had been in a relationship for only a number of weeks.

7. At approximately 1.00pm on Friday 13 May 2005 JL and MD walked the children to a nearby coffee shop in Footscray. Whilst walking JL and MD noticed that TH appeared unwell and

that she was unable to walk. After arriving, JL and her children sat at a table outside the coffee shop for a number of hours. TH remained unwell and appeared to be asleep in her mother's arm. MD spent some time seated with JL and the children, occasionally getting up and moving away from the table.

8. Between 3.00pm and 3.30pm, after being alerted by a number of associates, JL noticed that TH was not breathing. JL and MD attempted to splash water on TH's face in an attempt to revive her. They were unsuccessful and JL carried TH to the nearby Millennium Medical Centre, situated at the corner of Paisley and Albert Streets, Footscray.

9. At approximately 3.30pm JL arrived at the medical centre and TH was taken to a consulting room where two doctors attempted to resuscitate her. The attempts were unsuccessful and TH was pronounced dead approximately 15 minutes later.

The Autopsy Report

10. Dr David Ranson performed an autopsy on TH on 13 May 2005 at 22.30pm. In his very thorough report he made the following "comments"[1]:-

    1. The autopsy revealed no evidence of any significant natural disease which might be expected to have contributed directly or indirectly to the death.

    2. The body showed signs of widespread soft tissue injuries to the head, neck, arms, legs, abdomen, chest and back.

    3. Toxicological analysis of post-mortem blood samples did not reveal the presence of drugs or poisons.

    4. Neuropathological examination of the brain showed some brain swelling and some axonal injury in the corpus callosum, but no additional evidence of traumatic brain injury in the form of haemorrhage or contusions or lacerations. Apart from the features noted above, the brain was anatomically normal.

    5. Examination of the internal structures of the body revealed widespread injury to the region of the abdomen with evidence of haemorrhage tracking in the retroperitoneal tissues down to the levis and up into the mediastinum. The damage comprised rupture of the pancreas and proximal jejunum together with lacerations to the mesentery and lacerations of the liver. The appearances were in keeping with blunt force having been

[1] Autopsy report by Dr David Ranson, Coronial Inquest Brief of Evidence, page 15.

applied to the front of the abdomen squeezing the abdominal contents between the object applying the force and the vertebral column at the back of the abdomen.

6. An injury of this type causing rupture of bowel and bleeding from a variety of structures within the abdomen will be likely to cause significant pain and with the loss of blood into the abdominal tissue and abdominal cavity, the individual so affected would gradually become faint, weak and drowsy.

7. The internal damage seen to the abdomen could have been caused as a result of one application of significant force or by several applications of force. An individual receiving these injuries might be expected to live for a period of time which could amount to several hours.

11. He concluded his report with a specific finding of the medical cause of death as "Blunt force injury to the abdomen".

12. Paediatric surgeon Mr Keith Stokes also prepared a report, dated 31 March 2006. In his medical report[2] he answered a series of specific questions. He stated in his conclusion as follows:- "My conclusion from close scrutiny of the documents as described above and the photographs supplied is that this child showed evidence of extensive soft tissue injuries in the form of bruising, abrasions and lacerations involving the head and neck, chest, abdomen and four limbs. These soft tissue injuries appeared to have been sustained at different times, based on various stages of healing and scarring. Undoubtedly the injuries, which proved to be fatal, were those involving abdominal organs as a result of blunt trauma to the abdomen. Major injuries included liver trauma, ruptured jejunum with associated lacerations to the small bowel mesentery and rupture of the pancreas. There was a relatively large volume of blood in the peritoneal cavity. The measured volume of blood evacuated at the time of autopsy was 300mls. This volume of blood represents more than 25% of this child's circulating blood volume."

13. As to the timing of the injuries he stated "It is likely that the major abdominal injuries outlined previously occurred only a short period prior to death. The timing of fatal injury is likely to have been several hours prior to presentation at the Millenium Medical Centre on the afternoon of 13 May 2005. It is likely that the major cause of death was intra-abdominal haemorrhage associated with liver trauma and the intestinal and mesenteric lacerations. As

[2] Mr Keith B Stokes, Paediatric Surgeon, above n 1, page 64.

indicated previously these injuries were associated with significant blood loss which would have resulted in development of shock and circulatory failure."[3]

14. On the question of what symptoms would have been exhibited prior to her death, he stated "TH would have undoubtedly developed abdominal pain following major blunt trauma to her abdomen and this pain would have been steadily increasing in severity. She would have likely have suffered associated vomiting. TH would quickly have developed pallor and become increasingly lethargic and difficult to rouse. These clinical features would reflect the blood loss and increasingly compromised circulation."[4]

15. He then stated that the clinical features in this case confirm that it would have become "clearly evident to caregivers that TH was seriously ill."[5]

16. He next dealt with the question of whether the injuries could have been caused by accidental means. He stated:- "It is extremely unlikely that the injuries sustained by TH were caused by accident. In my report I have indicated that the extensive soft tissues injuries in this girl were in various stages or repair, indicating multiple episodes of trauma sustained at different times in the past. Some bruising and abrasions appear relatively recent whilst others show evidence of mature healing. As described in the autopsy report there were numerous bruises on the anterior abdominal wall and one of these was situated towards the right upper quadrant on the abdomen and is likely to have been associated with the severe injury resulting in crushing of the liver, jejunum and pancreas against the vertebral column.

    It is very unlikely that the injuries could have been sustained from a fall from a height. The magnitude of the intra abdominal injuries would reflect a fall from a great height and would almost certainly have been associated with significant injuries to other parts of the body such as the brain, thorax and the bones of the limbs."[6]

17. On the question of whether the injuries were consistent with being on a hard floor and being stood on or stomped on by an adult he said:- "As mentioned previously, the severe fatal intra abdominal injuries were sustained by a severe blunt force to the abdomen. One means of inflicting such force would be an adult standing or stomping on this child's abdomen".[7]

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[3] Mr Keith B Stokes, Paediatric Surgeon, above n 1, page 65.

[4] Mr Keith B Stokes, Paediatric Surgeon, above n 1, page 65.

[5] Mr Keith B Stokes, Paediatric Surgeon, above n 1, page 66.

[6] Mr Keith B Stokes, Paediatric Surgeon, above n 1, page 66.

[7] Mr Keith B Stokes, Paediatric Surgeon, above n 1, page 66.

18. On the question of whether early medical intervention would have increased TH's chances of survival, he said that it would. He went on to say:- "Urgent medical intervention would have been necessary to save this child. Such intervention would have included intravenous fluid resuscitation including blood replacement and other supportive measures. After resuscitation this child would have then required abdominal surgery to deal with any ongoing haemorrhage and repair the ruptured jejunum and deal appropriately with the pancreatic injury."[8]

19. A comprehensive brief of evidence was prepared by Leading Senior Constable Warren Chapman. The full brief was tendered at the inquest.

Evidence about the circumstances

20. On 24 February 2005, TH's mother JL commenced a relationship with MD. JL spent large amounts of time with MD, regularly leaving the children in the care of her babysitter.

21. Approximately two weeks before the death of TH, MD lost his job and JL began to spend more time with him. During this period JL and the children frequently stayed overnight at MD's small one bedroom flat. AL and TH were left in the lounge of the flat to watch television and sleep on small couches. KH spent almost all of this time in her pram. Whilst the children were in the lounge, JL and MD spent the evening together in the bedroom with the door closed.

22. The evidence discloses that during this time injuries began appearing on KH. It further discloses that in the month before TH died, JL "expressed to a number of friends that she was concerned about the way MD treated the children (especially KH and the TH) and how they were all scared of him."[9]

23. Investigating police interviewed JL, MD, AL (the brother of TH aged 4 at the time) and other witnesses. The evidence in the brief included a transcript of all recorded interviews.

Application pursuant to s.57 *Coroners Act 2008*

24. At the commencement of the inquest Leading Senior Constable King Taylor, Coroner's Assistant, indicated that he intended to call JL and MD. Counsel for both objected to their clients being called and being required to give evidence. Each expressed their objection on the proposition that doing so may tend to prove that each had committed a criminal offence. In MD's case the offences of murder or manslaughter of TH and in JL's case murder,

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[8] Mr Keith B Stokes, Paediatric Surgeon, above n 1, page 66

[9] Summary of Circumstances, above on page 6.

manslaughter or negligent manslaughter by omission, namely failing to promptly obtain medical assistance for her daughter during the morning of 13 May 2005.

25. Each submitted that they should be excused absolutely from giving evidence and should also not be compelled to give evidence under the protection of a s.57 certificate.

26. Each relied on the decision of *Correll v Attorney General of NSW*[10] and the decision of the then State Coroner Judge Coate in her s.57 ruling on the application of Mr Duncan Tang in the inquest in to the death of Kwai (Patricia) Chan.

27. In this case, the material tendered included correspondence from the Director of Public Prosecutions expressing his opinion that the evidence against JL and MD was insufficient "to enable a jury to determine, to the required standard, which of the two suspects killed TH and injured KH."[11] Neither has been charged with any criminal offence in relation to the death of TH.

28. However their counsel submitted, and I accept, that each remains at risk of being charged.

29. The s.57(1) ground for objection on behalf of each is a reasonable ground as each confronts a potentially extremely serious criminal charge.

30. By reference to s.57(4) the question is whether "the interests of justice" require either or both to give evidence under the protection of a certificate. Each objected to giving evidence in that way. I accept the submission made on behalf of each and will not require either to give evidence under the protection of a certificate. While I am not satisfied that to require either to give evidence with the protection of a s.57(4) certificate would be likely to prejudice their interests or rights, nonetheless I am satisfied that nothing would be achieved by requiring them to give evidence in such a way. Each will be excused from doing so.

31. To satisfy the requirements of s.67C of the Act, I must be satisfied on the balance of probabilities as to identity, cause of death and the circumstances in which the death occurred and to make findings accordingly.

32. I am satisfied that the death occurred from the effects of a blunt force impact to the abdomen of TH as a result of one or more applications of significant force applied by a person in one of the rooms (probably the kitchen or the lounge room) of MD's flat in, Footscray sometime during the evening or night of 12 May 2005, or the early morning of 13 May 2005. I am

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[10] [2007] NSWSC 1385

[11] Letter from Office of Public Prosecutions dated 9 October 2008.

satisfied that the impact/impacts on the child were not the result of accidental falling. I am satisfied that the persons in the flat at the time were MD, JL, AL, TH and KH.

33. I accept the evidence of Dr David Ranson and paediatric surgeon Mr Keith Stokes as to the medical causes of death.

34. There are a number of discreet pieces of evidence in the inquest brief relevant to reaching conclusions on the balance of probabilities about the actions of JL and MD and the causes of, and contributions to, TH's death including statements of JL's babysitter[12] and MD's friend[13].

35. Part of the conversations and records of interview that police officers Leading Senior Constable Euverard, Senior Sergeant Andersen, Sergeant Hatt and Seregeant Owen conducted with both JL and MD are relevant to the issue of how one or both responded to the TH's condition on the morning 13 May 2005, and the question whether their failure to act earlier, contributed to TH's death.

36. In relation to the cause of the internal injuries that led to the death, there are several passages from the records of interview between Police Officer Hatt and JL which appear to implicate MD[14].

37. The statement of the babysitter[15] is relevant to the issue of who caused the ultimately fatal injuries. A further passage from the same witness[16] is also relevant to this issue. In particular the second paragraph on that page of the inquest brief is relevant. The observations of the babysitter, set out in several statements are relevant to the condition of TH when she was at the flat on 13 May 2005, in particular, the final paragraph on her statement dated the 31 January 2008[17] and the reference to "her eyes rolling back in her head".

38. Things said by AL to various people are also relevant. In the statement of a family member[18] a relevant conversation is recorded. In that conversation, the family member states that AL said that "MD" hit TH, and kicked TH on her tummy. He is to have demonstrated by stabbing

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[12] Statement of Babysitter, above n 1, page 120.

[13] Statement of DA (JL's friend at coffee shop), above n 1, page 200.

[14] Above n 1, pages 698-699.

[15] Statement of Babysitter, above n 1, page 101, final paragraph.

[16] Statement of Babysitter, above n 1, page 111.

[17] Statement of Babysitter, above n 1, page 121.

[18] Statement of JL's mother, above n 1, page 268.

his foot heavily on the ground. Further in the family member's statement[19] there is reference, to AL mentioning "on a number of different occasions that he saw MD stomp on TH while they were at MD's house". Again when asked "how did TH get hurt?", AL "made a stomping motion with his foot" and said "MD does this".

39. In the statement of QVT (the fiancé of JL's sister) there are further references to conversations had with AL and it being reported that AL said "MD kicked TH"[20]. Also in Mr QVT's statement[21] there is reference again to the same proposition – "TH is a naughty girl, MD hit her" and "MD kick her"..."on her tummy". These are comments attributed to AL.

40. In the statement of LD[22] (another friend of JL) there is again a passage containing a reference to AL telling Department of Human Services staff that he had seen "MD" stepping on TH's back. Further in the statement of that witness[23] in the final paragraph he says "I have never seen MD being rough towards the children. All I could see was that the children were petrified of MD, especially KH".

41. In her statement Acting Senior Sergeant Dagmar Andersen[24] details the conduct of VATE interviews with AL.

42. For the purposes of s.67(1)(b) of the Act, I am satisfied that the death of TH was a result of the actions, and inactions, of the two adult persons with her on the night of 12 May 2005 and the morning of 13 May 2005.

43. For the purpose of s.49(1) the Act, I am satisfied that indictable offences may have been committed by JL and MD in connection with the death of TH and I intend to have the Principal Registrar of the Court notify the Director of Public Prosecutions accordingly.

On 7 June 2013, I ordered pursuant to section 73(2) of the **Coroners Act 2008** that the names of TH, JL, MD, AL and KH not be published on the basis that such publication would be contrary to the public interest.

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[19] Statement of JL's mother, above n 1, page 270, paragraph 4.

[20] Statement of QVT, above n 1, page 281.

[21] Statement of QVT, above n 1, page 283.

[22] Statement of LD, above n 1, page 358, paragraph 1.

[23] Statement of LD, above n 1, page 364.

[24] Statement of Acting Senior Sergeant Dagmar Andersen, above n 1, page 422, paragraph 47.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that the same names not be published on the internet.

I direct that a full copy of this finding be provided to the following:

Ms Megan Tittensor

Mr David Glynn

Signature:

JUDGE IAN L GRAY
STATE CORONER
Date: 20/8/13