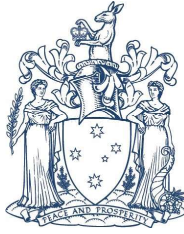

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 4026

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(1)
Section 67 of the Coroners Act 2008

Findings of:	**JOHN CAIN, STATE CORONER**
Deceased:	**Baby A**
Date of birth:	19 July 2011
Date of death:	23 October 2011
Cause of death:	I(a) Head injury
Place of death:	Royal Children's Hospital, Parkville, Victoria
Catchwords:	Suspected child homicide; family violence; unexpected; violent; not from natural causes; baby death; head injury

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HIS HONOUR:

BACKGROUND

1. **Baby A** was three months old at the time of his death. Baby A was born with his fraternal twin brother, **Baby B**, in Geelong on 19 July 2011. Baby A's parents were **Mr X**, aged 22 years, and **Ms Y**, aged 18 years at the time of Baby A's death.

2. Mr X has three children from three prior relationships and had limited contact with the other children in the proximate period prior to Baby A's death. The fraternal twins, Baby A and Baby B were Ms Y's first children.

3. Mr X and Ms Y met in August 2010 and moved in together in a unit on John Street in Colac. In November 2010, Ms Y discovered she was pregnant and was due to give birth in August 2011. The couple moved to Hearn Street, Colac shortly after discovering Ms Y was pregnant.

4. Baby A and his brother were born at Geelong Hospital on 19 July 2011, three weeks premature but otherwise healthy.

5. On 5 August 2011, Ms Y presented to Colac Area Health (**Colac Hospital**) with Baby B and reported that he had vomited blood and was pale and floppy.[1] Baby B was admitted and transferred to Geelong Hospital where he underwent a series of tests. These tests did not identify any concerns and treating professionals advised that Baby B may be being overfed.[2]

6. On 12 August 2011, Ms Y presented with Baby B to Colac Hospital after he turned pale during a feed. Upon observation, Baby B was noted as being pale but in no distress.[3]

7. On 16 September 2011, Ms Y attended Birregurra Community Health Centre with both twins to see at general practitioner (**GP**) .[4] During this appointment, Ms Y advised that she was concerned that the twins had periods where they would become floppy and unable to be roused.[5] Both twins were examined, and no issues were identified. Both twins were referred to Geelong Paediatric Group for further investigation.[6]

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[1] *Coronial Brief,* Statement of Keith Michael Kolodzej dated 16 August 2012, 47
[2] Ibid
[3] *Coronial Brief,* Statement of Nikita Cook dated 28 October 2011, 82.
[4] *Coronial Brief,* Statement of Raymond Rimantas Sarkis dated 14 November 2011, 44.
[5] Ibid .
[6] Ibid.

13 October 2011 – Colac Hospital treatment

8. In the evening of 12 October 2011, Ms Y reported that she heard Baby A scream whilst he was in the bedroom with Mr X.[7] Mr X then reportedly exited the bedroom with Baby A who was crying and screaming.[8] When Ms Y asked Mr X what had occurred, Mr X reportedly warned her not to accuse him of anything.[9]

9. On 13 October 2011 at around 4.41pm, Ms Y presented to Colac Hospital with Baby A, reporting that he was not moving his right leg and was in pain when she attempted to straighten his leg.[10] Baby A was examined by a triage nurse and doctor and a series of motion tests were conducted. No issues were observed and Baby A was discharged from hospital the same day, with a referral to see a General Practitioner (**GP**) in three days.[11]

10. Later in the evening of 13 October 2011 at around 7:48pm, Ms Y attended Colac Hospital again with Baby A, noting that he was still experiencing distress.[12] Doctors conducted further motion tests and, after examination of his legs, noted that Baby A's right hip was flexed more than his left hip, but that that he was irritable with examination of both his legs.[13] Medical staff failed to detect any issues with Baby A's leg but admitted him for overnight observation. Ms Y requested that x-rays be done on Baby A's leg but the treating medical practitioners indicated that there was no clinical indication to perform one.

11. The following morning on 14 October 2011, Baby A was reviewed by a doctor who documented that he had normal movements of his right leg. Upon discharge from hospital on 14 October 2011, staff instructed Ms Y to take Baby A to see a General Practitioner later that day for a follow up.[14]

14 October 2011 - GP follow up care

12. Ms Y presented at Birregurra Community Health Centre later on 14 October 2011.[15] The treating GP conducted a series of motion tests but determined that there were no abnormalities

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[7] *Coronial Brief,* Statement of Nikita Cook dated 28 October 2011, 84
[8] Ibid
[9] Ibid
[10] Statement of Keith Michael Kolodzej dated 16 August 2012, 47-48; Statement of Wendy Hay dated 7 June 2012, 153
[11] Ibid
[12] *Coronial Brief,* Statement of Ian Mackay dated 24 May 2012, 156; Statement of Narelle Kim Andrews dated 18 June 2012, 151
[13] *Coronial Brief*, Statement of Ian Mackay dated 24 May 2012, 156
[14] *Coronial Brief*, Statement of Janet Grace Philips dated 15 June 2012, 159; Statement of Ian Mackay dated 24 May 2012, 157; Statement of Celeste Neale dated 16 July 2012, 162
[15] *Coronial Brief,* Statement of Raymond Rimantas Sarkis dated 14 November 2011, 44-45

other than Baby A not moving his right leg as much as his left leg. Ms Y was advised to monitor Baby A's leg and a further consultation was booked for the following week.[16]

THE PURPOSE OF A CORONIAL INVESTIGATION

13. Baby A's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was violent, unexpected and not from natural causes.[17]

14. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[18] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[19]

15. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[20] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[21] or to determine disciplinary matters.

16. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

17. For coronial purposes, the phrase "*circumstances in which death occurred*,"[22] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

18. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

19. Coroners are also empowered:

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[16] Ibid
[17] Section 4 Coroners Act 2008
[18] Section 89(4) Coroners Act 2008
[19] See Preamble and s 67, *Coroners Act 2008*
[20] *Keown v Khan* (1999) 1 VR 69
[21] Section 69 (1)
[22] Section 67(1)(c)

(a) to report to the Attorney-General on a death;[23]

(b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[24] and

(c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[25] These powers are the vehicles by which the prevention role may be advanced.

20. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[26] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[27] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

21. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

22. On 24 October 2011, Ms Y visually identified the deceased to be her son, Baby A, born 19 July 2011.

23. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

24. On 24 October 2011, Dr Yeliena Baber, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the Baby A's body. Dr Baber provided a written report, dated 17 August 2012, which concluded that Baby A died from I(a) Head injuries.

25. Dr Baber commented on the following:

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[23] Section 72(1)
[24] Section 67(3)
[25] Section 72(2)
[26] Re State Coroner; ex parte Minister for Health (2009) 261 ALR 152
[27] (1938) 60 CLR 336

(a) Post mortem examination evidenced a spiral fracture of the right mid-shaft of the femur with associated haemorrhage. There was also evidence of the right 5th and 6th ribs being fractured laterally with some callus formation. Left parafalcine and subdural haemorrhage and right frontoparietal parasagittal subdural haemorrhage was also identified. Further examination also revealed a right anterior frontal cortex intraparenchymal haematoma;

(b) The external surface of the left frontal bone evidenced an area of focal haemorrhage which is likely the point of blunt impact;

(c) Histological examination of the eyes showed bilateral acute retinal haemorrhages that were consistent with non-accidental injury;

(d) No natural disease was identified and thus excluded non-traumatic causes for intracranial haemorrhage; and

(e) The right femoral fracture is a highly unusual fracture and should be considered to be the result of inflicted injury. The features of this fracture would be consistent with Baby A's presentation at Colac Hospital on 13 October 2011.

26. On 17 November 2011, Dr Linda Iles, Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination of the deceased's brain. Dr Iles found evidence of extensive global cerebral ischaemic injury and subdural haematoma (without mass effect) on a background of chronic subdural membrane formation.

27. A toxicological analysis of post-mortem samples from the Baby A's body detected the presence of therapeutic medication that would have been administered during an inpatient stay.

28. I accept the cause of death proposed by Dr Baber.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

29. On the morning of 15 October 2011, at around 11.00am, Mr X left the Hearn Street residence with one of his daughters to attend a birthday party.[28] Baby A and his brother were left in the care of Ms Y who also had a friend visiting who often babysat for the couple.[29]

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[28] *Coronial Brief*, Statement of Scott Hammond dated 9 February 2012, 735
[29] Ibid

30. Upon returning to the residence at around 5.00pm, Mr X noted that Ms Y was alone with the twins and started to cook dinner.[30] Ms Y decided to go out with Mr X's daughter to deliver thank you cards and left both twins in the care of Mr X.[31]

31. Mr X stated that whilst caring for Baby A during this period, he had observed Baby A to be pale and floppy and that Baby A had not wanted to take his bottle.[32] Mr X stated that he then settled Baby A and placed him in his bassinet. After a period of time had passed, Mr X checked on the twins in their bedroom but noticed that Baby A had vomited and was not breathing. Mr X then attempted to resuscitate Baby A before calling Ms Y to come back to the house.[33]

32. Ms Y returned home and took Baby A to Colac Hospital.[34] Baby A was admitted at 7:55pm and upon arrival was found to be asystole and not breathing.[35] An x-ray of Baby A's chest and legs was performed and this identified that Baby A had a recent spiral fracture of the right mid femur, and healing right anterior rib fractures.[36] This led medical staff to suspect a non-accidental injury and a report was made to the police. Baby A was then transferred from Colac Hospital to the Royal Children's Hospital via the Paediatric Emergency Transfer Service.

33. Evidence from the Victorian Forensic Paediatric Medical Service indicated that the injuries suffered by Baby A were most likely a result of abusive head trauma, usually seen in infants who have been violently shaken with or without impact.[37]

34. After further investigation and examination of Baby A's neurological function, he was found to have a very poor prognosis with no prospect of amelioration.[38] This was discussed with Baby A's parents and a decision was made to withdraw life support. Baby A died on 23 October 2011 at 11.50pm.[39]

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[30] Ibid, 735-736
[31] *Coronial Brief,* Statement of Nikita Cook dated 28 October 2011, 87
[32] *Coronial Brief*, Statement of Scott Hammond dated 9 February 2012, 736
[33] *Coronial Brief*, Statement of Scott Hammond dated 9 February 2012, 737; Statement of Nikita Cook dated 28 October 2011, 87
[34] *Coronial Brief,* Statement of Nikita Cook dated 28 October 2011, 87
[35] *Coronial Brief*, Victorian Forensic Paediatric Medical Service Report, 241-242
[36] Ibid
[37] Ibid, 242-243
[38] Ibid, 248-249
[39] Ibid

35. On 20 February 2017, Mr X was charged with the murder of Baby A and child homicide.[40] On 25 March 2019, due to issues with evidence of intent required to prosecute Mr X, the charge of murder was withdrawn from consideration by the Jury by the trial Judge and a verdict of not guilty was entered.[41]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

36. The unexpected, unnatural and violent death of a young child is a devastating event. Violence perpetrated by a family member is particularly shocking, given the family unit is expected to be a place of trust, safety and protection.

37. Homicide is the killing of one person by another person. In forming the belief, on the balance of probabilities, that Baby A's death was the result of a homicide, I make no finding as to criminality on the part of Mr X or Ms Y. I note that the evidence indicates that Mr X and Ms Y were the only persons present in the house prior to Baby A being presented to CAH and that there was no evidence of any third-party involvement.

38. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Baby A and his parents was one that fell within the definition of family member[42] under that Act. Moreover, the non-accidental injuries that led to Baby A's death constitutes family violence.[43]

39. In light of Baby A's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[44] examine the circumstances of Baby A's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**). The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition, the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community.

40. I confirm that the CPU family violence team did not identify any missed opportunities for prevention or intervention in relation to services that had proximate contact with Baby A and his immediate family.

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[40] *R v Hammond* [2019] VSC 135, 1

[41] *R v Hammond (Ruling No 3)* [2019] VSC 195, 7

[42] *Family Violence Protection Act 2008,* section 8.

[43] *Family Violence Protection Act 2008*, section 5(1)(a)(i)

[44] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety

41. I also directed healthcare professionals from the CPU to evaluate the clinical management and care provided to the deceased by reviewing the medical records, the autopsy report and any particular concerns which have been raised by the deceased's family.

Review of the medical treatment proximate to the fatal incident

42. In the proximate period prior to the fatal incident, Baby A had contact with several services including Maternal Child Health (**MCH**) nurses, GPs at Birregurra Community Health Centre and medical practitioners at Colac Hospital.

Maternal Child Health Services

43. Following his birth, Baby A was seen on 29 July 2011 by a MCH nurse who conducted a home visit and did not note any concerns.[45]

44. On 9 August 2011, a MCH nurse spoke with Mr X regarding the upcoming home visit.[46] During this conversation, Mr X was reportedly aggressive towards the nurse and accused MCH of inaccurately measuring Baby A and Baby B's weight.[47] Given concerns for the family, the MCH nurse made a referral to Child FIRST, informing them that the '*family had disengaged from [their] service and that it was a high risk family'*.[48] In a statement to police, the MCH nurse notes that the family were considered high risk as Ms Y was a young mother and both children were small.[49] The Child FIRST referral made by MCH was not actioned as Mr X and Ms Y did not engage.[50]

45. Baby A was seen by MCH again on 19 August 2011, 6 September 2011 and 23 September 2011.[51] At each visit, Baby A was examined with and without clothing and no concerns for his wellbeing or development were raised. Furthermore, during the four-week check-up, a wellbeing checklist was undertaken with Ms Y and she identified that she was well and had support.[52]

46. I find that the care provided by the MCH Nurses who reviewed Baby A was adequate and that nurses continued to engage with Baby A's family despite verbal aggression from Mr X on

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[45] *Coronial Brief*, Statement of Jane Louise Hammer dated 14 November 2011, 35
[46] Ibid, 36
[47] Ibid
[48] Ibid
[49] Ibid
[50] *Coronial Brief*, Victorian Forensic Paediatric Medical Service Report, 249
[51] *Coronial Brief*, Statement of Jane Louise Hammer dated 14 November 2011, 35-39; Statement of Christine Towers dated 14 November 2011, 40-42
[52] *Coronial Brief*, Statement of Jane Louise Hammer dated 14 November 2011, 35

several occasions. The nurses examined both Baby A and his brother appropriately and screened Ms Y for risk of family violence.

Colac Hospital and GP treatment on 13-14 October 2011

47. I note that Colac Hospital is a small hospital and they do not have an emergency department, instead they have an Urgent Care service staffed by Hospital Medical Officers (HMOs) and an emergency registrar, on rotation from University Hospital (Barwon Health) Geelong.[53] Local GPs are on call to assist as required and X-ray and pathology services are available through a private company at additional costs which may be incurred by the patient, in addition to a call-out fee if X-ray is required after hours.

48. I confirm that if an X-ray had been performed between 13-14 October 2011, it is likely that evidence of non-accidental trauma would have been apparent and a report to Child Protection Services would have been warranted.

49. In consultation with medical specialists from the CPU, I have conducted a thorough review of the statements provided by medical staff at Colac Hospital and medical records. Medical specialists from the CPU note that it is not uncommon to admit a baby or child for observation overnight if a clinician is unsure of a diagnosis. The treating medical practitioners noted this was a re-presentation so this was the reason for overnight admission. The medical notes indicate that the clinicians were considering a diagnosis of irritable hip (transient synovitis).[54] This is a self-limiting inflammation of the hip joint causing decreased movement and pain often following a respiratory tract infection. This was suggested by noting the low-grade temperature and suggesting an ultrasound if it did not settle.[55]

50. Further evidence from the medical records indicates that the treating medical practitioners completed a thorough examination of Baby A on 13 October 2011. The examination evidenced that both hips flexed (left more than right), that Baby A was able to straighten his knee and that he was no more irritable on moving right hip than his left.[56] Abdominal examination was also normal, with no hernia and normal testes. On review the following morning, the 14 October 2011 at 8.40am, treating medical practitioners documented that the

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[53] Colac Area Health response dated 11 November 2019
[54] *Coronial Brief,* Appendix F, 590-610
[55] Ibid
[56] Ibid

afebrile (normal temperature) had reasonably settled over night and that Baby A was moving his right leg and that with the range of movement of his right leg was normal.[57]

51. I find that there was nothing in his history or the repeated examinations to lead the treating clinicians at Colac Hospital to suspect Baby A had a fractured femur. As such, there was no clinical indication for an X-Ray to be performed on that day.

52. On 14 October 2011, the GP treating Baby A appropriately assessed and examined both Baby A and his brother and made an urgent referral to a paediatrician.[58] Whilst the GP noted decreased movement of Baby A's right leg, I accept that there was insufficient evidence at this presentation to warrant ordering an x-ray as well.

53. Since Baby A's death, Colac Hospital have conducted an in-depth case review[59] and have since implemented the following relevant recommendations:

    (a) Adopt a 'Vulnerable babies, children and young people at harm' best practice framework across the entire organisation. This is a tool to assess all paediatric presentations and admissions against indicators for abuse and neglect.

    (b) Adopt changes in procedures and education policies to include family violence education and screening urgent care centre presentations using the Paediatric Risk screen.

    (c) Update patient record systems to implement an alert flag notifying staff of previous Child First referrals, indicating a vulnerable child.

    (d) Implement a Child Safety and Wellbeing policy that includes identifying and responding to family violence.

54. I am satisfied, having considered all the available evidence, that no further investigation is required.

FINDINGS AND CONCLUSION

55. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    a) the identity of the deceased was Baby A, born 19 July 2011;

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[57] Ibid
[58] *Coronial Brief,* Statement of Raymond Rimantas Sarkis dated 14 November 2011, 44-45
[59] Colac Area Health response dated 11 November 2019

b) the death occurred on 23 October 2011 at the Royal Children's Hospital, Parkville, Victoria, from head injuries; and

c) the death occurred in the circumstances described above.

56. I convey my sincerest sympathy to Baby A's family.

57. Pursuant to section 73(1) of the *Coroners Act 2008*, I order that this finding be published on the internet.

58. I direct that a copy of this finding be provided to the following for their information:

a) Ms Y, Senior Next of Kin;

b) Dr Iman Didir, District Director of Medical Administration, Colac Area Health;

c) Dr Emma Magrath, Medicolegal Physician, Royal Children's Hospital; and

d) Detective Leading Senior Constable Leigh Smyth, Victoria Police, Coroner's Investigator.

Signature:

JOHN CAIN
STATE CORONER
Date: 20 August 2020