IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 2470

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the death of Baby ABA[1]

Delivered on:	21 October 2020
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	21 October 2020
Findings of:	Judge John Cain, State Coroner
Counsel assisting the Coroner:	Sonja Mileska, Senior Solicitor to the State Coroner

[1] The names of the deceased person and their family members have been redacted and replaced with pseudonyms of randomly generated letters to protect their identity.

HIS HONOUR:

BACKGROUND

1. ABA **(Baby ABA)** was born on 11 November 2007 in Lebanon. She was the first-born child of Mr CB and Ms ST.

2. On 31 January 2008, Baby ABA and Ms ST arrived in Australia, and the family resided in Hadfield. Baby ABA had been in good health and had attended the doctor only for required immunisations. She had otherwise not required medical support[2] or engaged with child maternal health services in Australia.[3]

3. Ms ST reported to police that some weeks prior to Baby ABA's death, she had been playing with her, when without warning, Baby ABA became pale, cold and stiff. She remained this way for approximately five minutes before recovering and returning to normal.[4]

4. Ms ST discussed the incident with Mr CB. He stated to her that if something similar occurred to Baby ABA again, they would then take her to see a doctor.[5]

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Baby ABA's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as she ordinarily resided in Victoria[6] and the death appears to have been unexpected and violent.[7]

6. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[8] 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 death occurred.[9]

7. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[10] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[11] or to determine disciplinary matters.

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

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[2] Coronial brief, Interview Transcript of ST dated 12 June 2008, pg 425 Q29, Q35.
[3] Coronial brief, Interview Transcript of CB dated 12 June 2008, pg 346, Q64.
[4] Coronial brief, Interview Transcript of ST dated 12 June 2008, pg 426 Q39.
[5] Ibid pg 427 Q49.
[6] Section 4 *Coroners Act 2008.*
[7] Section 4(2)(a) *Coroners Act 2008.*
[8] *Coroners Act 2008* (Vic) s 89(4).
[9] *Coroners Act 2008* (Vic) preamble and s 67.
[10] *Keown v Khan* (1999) 1 VR 69.
[11] *Coroners Act 2008* (Vic) s 69 (1).

9. For coronial purposes, the phrase "*circumstances in which death occurred,*"[12] 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.

10. 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.

11. Coroners are also empowered to;

    a. report to the Attorney-General on a death;[13]

    b. comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[14] and

    c. 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.[15] These powers are the vehicles by which the prevention role may be advanced.

12. All coronial findings must be based on the proof of relevant facts on the balance of probabilities.[16] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[17] 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.

13. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the death occurred in Victoria and a coroner suspects the death was as a result of homicide and no person or persons have been charged with an indictable offence in respect of the death.

14. I note the observations of the Victorian Court of Appeal in *Priest v West*, where it was stated:

> *'If, in the course of the investigation of a death, it appears that a person may have caused the death, then the Coroner must undertake such investigations as may lead to the identification of that person. Otherwise, the required investigation into the cause of the death and the*

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[12] *Coroners Act 2008* (Vic) s 67(1)(c).
[13] *Coroners Act 2008* (Vic) s 72(1).
[14] *Coroners Act 2008* (Vic) s 67(3).
[15] *Coroners Act 2008* (Vic) s 72(2).
[16] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[17] (1938) 60 CLR 336.

circumstances in which it occurred will be incomplete; and the obligation to find, if possible, that cause, and those circumstances will not have been discharged.'

15. Consistent with this judgment, and mindful that the Act mandates that I must conduct an inquest, one of the purposes of the inquest is to investigate any evidence that may lead to the identification of the person (or persons) who may have caused the death, bearing in mind that I am required to make findings of fact and not express any judgment or evaluation of the legal effect of those findings.[18]

16. 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.

17. In this instance, I consider that Baby ABA's death may be due to homicide as investigators have been unable to determine the cause of her injuries. No persons have been charged with respect to the death.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO SECTION 67(1)(C) OF THE ACT

18. On Saturday 7 June 2008, Mr CB, Ms ST and Baby ABA had spent the morning around their home. During the afternoon, they went shopping and returned home.[19]

19. At approximately 7.30pm that evening, Mr CB was in the lounge room with Baby ABA. She was lying on her back on the couch, drinking from her bottle. Ms ST was in the kitchen, preparing dinner. Mr CB stated that his wife called him, and he went into the kitchen, leaving Baby ABA unsupervised on the couch in the lounge room.[20]

20. Shortly thereafter, Ms ST and Mr CB heard a thud from the lounge room. A second thud was also heard. They both ran into the lounge and located Baby ABA face-down on the wooden floor.[21] She had fallen between the couch and coffee table and was crying.[22]

21. Ms ST picked up Baby ABA and placed her in the cot. There was no bruising on her face following the fall.[23] Baby ABA also did not appear to exhibit any other issues from the fall. Subsequently, Baby ABA fell asleep until 10pm before commencing crying again. Mr CB attended to her and placed her dummy in her mouth.[24]

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[18] *Perre v Chivell* (2000) 77SASR 282.
[19] Coronial brief, Interview Transcript of CB dated 12 June 2008, pg. 360-362.
[20] Ibid, pg 363 Q220.
[21] Ibid, pg 371-372 Q294, Q299-301.
[22] Ibid pg 374 Q314.
[23] Ibid pg 374 Q316.
[24] Ibid pg 375 Q329.

22. At approximately 9am on 8 June 2008, Mr CB and Ms ST were woken by Baby ABA. This was later than the usual time she would wake in the morning.[25] Mr ST got out of bed and made her a bottle. She commented to Mr CB that Baby ABA was not responding to her touch as she normally would.[26] She also noticed that she had some bruises on her face.[27] Her mouth was dry, and lips were orange.[28] Mr CB observed bruising to her cheek and forehead.[29]

23. Mr CB stated that they took Baby ABA outside in the backyard for some sun where Mrs ST became concerned that something was not right.[30] Mr CB stated to his wife, '*just make her another bottle and if she eats it, just put her back to bed.*'[31]

24. At approximately 11am, Baby ABA was given another bottle and put in her cot. Mr CB went back to bed and Ms ST cleaned the house.[32]

25. Shortly thereafter, Mr CB was again woken by Baby ABA's crying.[33] He attempted to give her a dummy, but she did not take it. He noticed that she looked pale.[34] When he picked her up, he stated that she '*just froze for about a minute*' and became stiff and floppy.[35] It appeared to him that she ceased breathing.[36]

26. Mr CB then shook Baby ABA and after about a minute, she went floppy.[37] He then shook her again[38] but she remained floppy.[39] He alerted his wife and took Baby ABA to the laundry and splashed some water on her face with limited response.[40] He could then hear her breathing softly.[41]

27. Mr CB then attended his neighbour's home to get the number for a doctor.[42] He was provided with a number for a 24-hour locum service and contacted the service. He was advised that a doctor would be unable to attend for another two hours and to call for an ambulance instead.[43]

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[25] Ibid pg 377 Q345.
[26] Coronial brief, Interview Transcript of ST dated 12 June 2008, pg 434 Q88.
[27] Ibid, pg 437 Q113-114.
[28] Coronial brief, Interview Transcript of CB dated 12 June 2008 pg 387 Q436.
[29] Ibid pg 378 Q356, Q359.
[30] Ibid pg 379-380 Q365-366, Q368. However, this is not supported by the statement of ST who indicated that they did not go outside until later-see Interview Transcript of ST dated 12 June 2008, pg 438 Q122.
[31] Coronial brief, Interview Transcript of CB dated 12 June 2008, pg 380 Q369.
[32] Ibid pg 381 Q381.
[33] Ibid pg 382 Q391-2.
[34] Ibid pg 388 Q450.
[35] Ibid pg 388-389 Q450, Q458.
[36] Ibid, pg 390 Q461.
[37] Ibid pg 390 Q466, pg 391 Q468, pg 407 Q634.
[38] Ibid pg 391 Q469.
[39] Ibid pg 393 Q490.
[40] Ibid pg 391 Q470-471.
[41] Coronial brief, Interview Transcript of CB dated 4 December 2008, pg 496 Q252.
[42] Coronial brief, Statement of Assia Assad, dated 16 June 2008, pg 55.
Coronial brief, Transcript of CB dated 12 June 2008, pg 391 Q477-478.
[43] Coronial brief, Transcript of CB dated 12 June 2008 pg 392 Q482-Q484 and pg 397 Q535-Q537.

28. At 3.20pm, Mr CB contacted emergency services and an ambulance was dispatched to their home address.[44] The ambulance arrived at 3.27pm and paramedics observed that Baby ABA had her eyes partially open but appeared pale and unconscious with bruising on her face.[45] An oxygen bag was applied via a bag valve mask and Baby ABA was breathing spontaneously.[46] She was also noted to have bruising to both cheeks below the eyes and discolouration on the left cheek and right forehead.

29. Baby ABA was subsequently transported to the Royal Children's Hospital, arriving at 4.05pm.[47] She was placed in the Paediatric Intensive Care Unit. A CT scan was performed of her brain, facial bones and cervical spine at 6.25pm. The scan revealed; '*Right sided inferior frontal mixed density subdural collection of 3mm thickness. Left sided high-density collection, over the frontal region of smaller size than the right-sided collection. Appearance of both of these would be in keeping with acute haemorrhage. No calvarial or skull base fractures. No cerebral oedema. Normal appearance of cervical spine and facial bones.* '[48]

30. Dr Margeurite Fulton performed an examination of Baby ABA in the Intensive Care Unit. She noted her to be completely immobile with no response to tactile stimulation.[49] She was also noted to have multiple facial bruises and bruises on her legs.

31. At 4am on 9 June 2008, Baby ABA's condition deteriorated, and another CT brain scan was performed. The report from that scan concluded, '*on comparison with the previous scan performed on 8 June, the present scan shows diffuse cerebral swelling and diffuse loss of grey-white differentiation.*'[50] The neurosurgical opinion of Dr Gerard Ross was that the scan demonstrated an unsurvivable head injury.[51] Ophthalmological evaluation was conducted by Dr Wendy Marshman on 9 June 2008. Examination of Baby ABA's eyes revealed evidence of bilateral retinal haemorrhages that Dr Marshman described as being widespread and consistent with trauma.[52]

32. Following receipt of these reports, discussions were held with Baby ABA's family by the treating teams to advise them of her deteriorating condition and poor prognosis. It was

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[44]Coronial brief, Statement of Samantha Paton dated 7 July 2008, pg 58.
[45] Coronial brief, Statement of Jamie Flett dated 1 July 2008 pg 61.
[46] Ibid pg 62.
[47] Coronial brief, Statement of Christine Frampton dated 10 July 2008, pg 66.
[48] Coronial brief, Statement of Dr Marguerite Fulton dated 31 July 2008, pg 80.
[49] Ibid, pg 81
[50] Ibid, pg 84.
[51] Ibid.
[52] Ibid, pg 85.

determined that the treatment should be withdrawn.[53] Baby ABA was declared deceased on 10 June 2008 at 8.30pm.

IDENTITY OF THE DECEASED PURSUANT TO S.67(1)(a) OF THE ACT

33. On 11 June 2008, Mr CB visually identified his daughter, ABA born 11 November 2007.

34. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH PURSUANT TO S.67(1)(b) OF THE ACT

35. On 12 June 2008, Forensic Pathologist Professor Noel Woodford from the Victorian Institute of Forensic Medicine performed an autopsy on Baby ABA and provided a written report of his findings.

36. Professor Woodford identified that Baby ABA had a number of bruises, predominantly to the anterior half of the face/head but also to the left lower leg and right thigh. [54]

37. He further stated;

> *'The development of inflammation and Perls positivity (haemosiderin deposition) within a bruise indicate the onset of healing changes but there may be significant variability in the development or observability of these findings. Bruising comprising haemorrhage with neither of the accompanying phenomena of inflammation or haemosiderin deposition suggests recency (very approximately within two days of death). With these comments and caveats in mind, many of the bruises appear recent although some (head and neck 6, head and neck 7, head and neck 12, head and neck 13, anterior vertex, and right lower limb 1) appear comparatively older.'* [55]

38. Neuropathological examination of the brain showed evidence of acute subarachnoid and subdural haemorrhage with widespread hypoxic/ischaemic injury of neurons and evidence of brain swelling. Examination of the eyes showed multiple intra-retinal haemorrhages in all layers in both eyes associated with intra and extradural haemorrhages around the optic nerves.

39. Professor Woodford stated that a number of features need to be considered in this case including;

    a. multiple bruises in multiple planes over the face;

    b. the triad of acute subdural haemorrhages, cerebral swelling and bilateral, multilayered retinal haemorrhages;

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[53] Coronial brief, Statement of Dr Kathryn Irving, undated, pg 93.
[54] Coronial brief, Medical Examiner's Report dated 12 June 2008, pg 47.
[55] Ibid, pg 48.

c. the history of short distance fall onto a hard surface approximately one day prior to the episode of unconsciousness and respiratory arrest;

d. the presence of apparent lucid interval and;

e. the admitted episode of shaking, following the onset of unconsciousness and respiratory arrest. [56]

40. Professor Woodford opined that '*it is unlikely that the short distance fall suffered the day prior to the infant's collapse has been a significant factor in her rapid decline and respiratory arrest, although for reasons stated above, this cannot be absolutely excluded. The concentration of the injuries in the area of the face as well as their presence in multiple areas is very suggestive that they have not been sustained as a result of one or two simple falls. The subdural haemorrhage could be a consequence of one or more of the blunt impacts causing these bruises. The existence of retinal haemorrhage in association with thin bilateral acute subdural haemorrhages and hypoxic-ischaemic encephalopathy also raises the spectre of shaking as a separate episode, or in conjunction with blunt impact, causing one or more of the head bruises.*' [57]

41. Professor Woodford also reported that there was no natural disease identified at autopsy of a type likely to have caused or contributed significantly to death. Toxicological analysis on admission to hospital did not show any findings of significance.

42. Professor Woodford concluded that a reasonable cause of death was;

1(a) Head Injury.

43. I accept the cause of death as proposed by Professor Woodford.

VICTORIA POLICE INVESTIGATION:

44. Due to the unexplained nature of Baby ABA's injuries, the Homicide Squad commenced a criminal investigation. Despite this thorough and extensive investigation, no person or persons have been charged with indictable offences in connection with Baby ABA's death.

45. Section 7 of the Act specifically states that a coroner should avoid unnecessary duplication of inquiries and investigations, by liaising with other investigative authorities, official bodies or statutory officers. The rationale behind this provision is to allow for consideration of public interest principles that weigh against the potential benefits of any further investigation, such as further cost to the community. It also acknowledges that although a number of authorities or organisations may have the mandate to investigate, some are more appropriately placed than others to do so in any given circumstance.

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[56] Ibid, pg 49.
[57] Ibid.

46. In this case, I acknowledge that Victoria Police through the Homicide Squad, have conducted an extremely thorough investigation into this matter. Section 49 of the Act provides that the Principal Registrar must notify the Director of Public Prosecutions if the coroner investigating a death forms the belief that an indictable offence may have been committed in connection with the death. With respect to that requirement, I note that the Office of Public Prosecutions have already considered this matter and on their advice, no persons have been charged to date with an offence in relation to Baby ABA's death. On that basis, I am satisfied that no investigation which I am empowered to undertake would likely result in the identification of any person or persons who may have been involved in Baby ABA's death.

47. I note that if new facts and circumstances become available in the future, section 77 of the Act allows any person to apply to the Court for an order that some or all of these findings be set aside. Any such application would be assessed on its merits at that time.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT:

Family Violence

48. The unexpected, unnatural and violent death of a person is a devastating event. It is important to recognize that violence perpetrated by an intimate family member is particularly shocking, given the family unit is expected to be a place of trust, safety and protection.

49. For the purposes of the *Family Violence Protection Act 2008* **(FVPA)**, the relationship between Mr CB, Ms ST and Baby ABA fell within the definition of 'family member' under the FVPA.

50. Considering the circumstances of Baby ABA's death, I requested that the Coroner's Prevention Unit **(CPU)**[58] examine the circumstances of the death as part of the Victorian Systemic Review of Family Violence Deaths.

51. I confirm that a thorough review of the evidence did not reveal any missed opportunities for intervention or prevention in the circumstances of Baby ABA's death. I am satisfied, having considered all the available evidence, that no further investigation is required.

FINDINGS AND CONCLUSION:

52. Having investigated the death of Baby ABA, and having held an inquest into the death, I make the following findings with respect to section 67(1) of the Act:

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[58] The CPU was established in 2008 to strengthen the prevention role of the Coroner. The unit assists the Coroner research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

a. The identity of the deceased was ABA, born 11 November 2007;

b. That she died on 10 June 2008 at the Royal Children's Hospital, 50 Flemington Road Parkville, 3052 Victoria from a head injury and;

c. The death occurred in the circumstances set out above.

53. I convey my sincerest sympathy to the family of Baby ABA.

54. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

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

The family of Baby ABA,

Detective Sergeant David Barry, Coroner's Investigator, Victoria Police

Professor Jeremy Oats, Consultative Council on Obstetric and Paediatric Mortality

Signature:

JUDGE JOHN CAIN
STATE CORONER

Date: **21 October 2020**

Coroners Court of Victoria

NOTE: Under section 83 of the **Coroners Act 2008** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.