IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2005 3607

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of CHILD A

Delivered On:	
Delivered At:	THE CORONERS COURT OF VICTORIA 65 KAVANAGH STREET, SOUTHBANK
Hearing Dates:	6 JULY 2021
Findings of:	CORONER PHILLIP BYRNE
Counsel Assisting the Coroner:	MS PREMALA THEVAR

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2005 3607**

FINDING INTO DEATH WITH INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

I, PHILLIP BYRNE, Coroner having investigated the death of CHILD A
AND having held an inquest in relation to this death on 6 July 2021
find that the identity of the deceased was CHILD A
born on 14 May 1990
and the death occurred on 8 September 2005
at Royal Children's Hospital, 50 Flemington Road, Parkville VIC 3052

from:

I (a) ACUTE RESPIRATORY DISTRESS SYNDROME RESULTING FROM MULTI-ORGAN FAILURE AS A CONSEQUENCE OF DISSEMINATED TUBERCULOSIS

Pursuant to section 67(1) of the **Coroners Act 2008** I make findings with respect to **the following circumstances**:

BACKGROUND

1. Child A, together with his younger brother Child B and their father Mahamoud Awali arrived in Australia in 1998 after Mr Awali, who worked as an interpreter with the Australian Army in Somalia, was sponsored by the Australian Defence Force and given refugee asylum.

2. At the time of his death Child A was on an Interim Accommodation Order under the *Children and Young Persons Act* (1989) taken out by the Department of Human Services (**DHS**), now Department of Families, Fairness and Housing, on 26 August 2005 whilst Child A was an inpatient at the Royal Children's Hospital **(RCH)**. Consequently, being "in care" within the definition of the *Coroners Act* (2008), the matter proceeded to finalisation following an inquest.

THE REASONS FOR THE INORDINATE DELAY IN THE CORONIAL INVESTIGATION

3. In this finding, I propose to primarily focus upon issues reasonably proximate to Child A's death rather than what I will call "historical" matters, although all issues canvassed could in one sense be considered "historical," bearing in mind Child A's death occurred in 2005 at which time it was reported to the coroner.
4. I feel obliged to seek to explain why the matter lay in abeyance for many years before being enlivened as a coronial investigation.
5. The circumstances leading to Child A's death attracted the attention of Victoria Police including at a relatively early stage the Homicide Squad. The police investigation focussed upon the performance, or lack thereof, of Mr Awali in respect of his alleged neglect of Child A, and his failure to seek appropriate medical attention for his son, which investigating police considered constituted manslaughter by criminal negligence.
6. Following established protocols, while the police investigation ran its course, the coronial investigation lay in abeyance.
7. In February 2008 a copy of the police brief of evidence was forwarded to the Office of Public Prosecutions seeking advice as to the likelihood of a successful criminal prosecution against Mr Awali. The brief was examined by the then Director of Public Prosecutions, Mr Jeremy Rapke QC, who suggested police seek a further statement from Child B and conduct a formal interview with Mr Awali, and only then would advice be provided.
8. Homicide Squad detectives obtained a further statement from Child B and formally interviewed Mr Awali. Statements were also taken from several women in whose care Mr Awali had left his sons.
9. In 2019 the file, which had remained in the then State Coroners list, was allocated to me. Being concerned with the inordinate delay in the coronial process I asked the new police investigator Detective Senior Constable Luke Collyer, who had only taken over the file in late June 2019, attend the Court to advise as to the status if their investigation. Having been advised the investigation was ongoing I suggested the matter be re-referred to the Office of Public Prosecutions for the purpose of seeking advice as to the prospect of a prosecution against Ms Awali succeeding.

10. Subsequently, Detective Senior Constable Collyer submitted a letter from the Office of Public Prosecutions advising the re-submitted brief had been considered by the Director of Public Prosecutions herself and a Crown Prosecutor. The advice provided by the Office of Public Prosecutions was that there was not a reasonable prospect of conviction for the offence of manslaughter by criminal negligence, nor other offences related to causing Child A's death. The Office of Public Prosecutions further advised it would not be in the public interest to prosecute Mr Awali in light of the effluxion of time since Child A's death.

11. Subsequently, the police brief of evidence was lodged with the Court. As no prosecution was to be brought, I determined to proceed with the coronial investigation, which had lain in abeyance all that time.

BROAD CIRCUMSTANCES SURROUNDING DEATH

12. As stated earlier in this finding, my focus is, of necessity, upon matters that occurred in the months prior to Child A's hospitalisation and tragic death. However, I make several comments about events that occurred in 2000 – 2001 due to their relevance to the major issues.

13. Without going in to detail Child A and Child B were the subject of six notifications resulting in DHS involvement between 2000 – 2001 primarily in relation to allegations of abandonment and neglect. Several of the notifications emanated from female friends of Mr Awali with whom he left the children for periods of time. These matters are included in this finding in broad terms as they tend to demonstrate a pattern.

14. Again, in broad terms, and I will expand on the issue of the dramatic decline in Child A's physical health later in this finding, Child B, then 13 years of age, alarmed in relation to the very obvious decline in his brother's physical condition, particularly over the previous weeks, together with Mr Awali's lack of attention to the issue, on 31 July 2005 summoned an ambulance. Child A was conveyed to Northern Hospital and subsequently that day transferred to the RCH where upon assessment it was established that Child A was suffering from very advanced post-primary pulmonary tuberculosis. At the RCH Child A received maximal anti-tuberculosis therapy and spent most of the admission on ventilation.

15. By 8 September 2005 it became apparent that Child A's condition was unsalvageable; in consultation life support was withdrawn and Child A passed away. A Death Certificate was signed by one of the treating doctors in which the cause of Child A's death was cited as:

I(a) ACUTE RESPIRATORY DISTRESS SYNDROME RESULTING FROM MULTI-ORGAN FAILURE AS A CONSEQUENCE OF DISSEMINATED TUBERCULOSIS

REPORT TO THE CORONER

16. Due to its antiquity, it is unclear to me how precisely Child A's death was reported to the coroner but examining the old file it is clear Child A's body was never received into the Victorian Institute of Forensic Medicine and therefore no autopsy was performed. As stated earlier a Death Certificate was issued by a treating doctor at the RCH. In the final analysis nothing of significance turns on this because ultimately Child A's death the matter <u>was reported to the coroner</u>. The likelihood is the report was made by investigating police, DHS or perhaps the RCH.

17. Again, as stated earlier in this finding the matter lay in abeyance in the then State Coroner's list until it was allocated to me in early 2019. Prior to the matter being re-allocated to me in January 2019 enquiries made by the Court indicated the matter was still under active consideration with remaining avenues of enquiry being pursued.

18. It is noteworthy that although the coronial investigation lay in abeyance for the reasons stated, the issues did not rest there as the circumstances surrounding Child A's death were investigated by the Commissioner for Children and Young People in late 2005 to mid-2006. It is of interest to me that although invited Mr Awali did not participate in this process.

19. In late August 2019 the police brief of evidence was lodged with the Court.

FURTHER INVESTIGATION

20. Wishing to progress the matter I listed it for a Mention/Directions hearing on 3 February 2020. Due to the impact of the COVID-19 pandemic Mr Awali, who then resided interstate, "attended" by way of WebEx, in my view not the preferred option. In any event, I conferred with Mr Awali particularly advising him quite bluntly what the focus of my investigation was. In light of that focus, I enquired whether he understood my position and whether he had taken legal advice. Mr Awali indicated he had not, but indicated he would try to do so. I commented that in my view is was imperative that he do.

21. Again, seeking to progress the matter after further significant delay, I listed the matter for a second Mention/Directions hearing for 6 July 2021. In the intervening period counsel assisting, Ms Premala Thevar **(Ms Thevar)**, had several discussions with Mr Awali. It was clear he had still not sought legal advice in spite of being told the prospect was strong

adverse findings would likely be made in relation to his apparent failure to provide adequate care to Child A proximate to his death. One of my major concerns was the prospect of calling Mr Awali as a witness at formal inquest and whether he would seek to be excused from giving evidence on the basis of the protection from self-incrimination. If Mr Awali sought to rely on that protection it would be necessary to go through the process of section 57 of the *Coroners Act* (2008), a process that would be virtually impossible to navigate with an unrepresented lay-person.

22. In a conversation with Mr Awali several days prior to the scheduled second Mention/Directions hearing Mr Awali advised Ms Thevar he still had not taken legal advice and did not propose to do so. In relation to the proposed hearing, he stated:

    > *"I'm really exhausted of this dragging on year after year, and this should have been finalised in 2020. I am coming to the hearing on my own and what happens happens."*

    That comment, which Mr Awali subsequently confirmed he made, was related to me, I pondered precisely what Mr Awali meant to convey. I might add I concluded Mr Awali is a relatively intelligent man with quite a good grasp of the English language.

23. In any event, the proposed hearing proceeded on 6 July 2021 with Mr Awali again in "attendance" by way of WebEx. I again advised Mr Awali that my focus was upon his apparent failure to provide adequate care to Child A and his apparent failure to seek medical attention for Child A when it was patently obvious, even to his 13-year-old son Child B, that urgent medical attention for Child A was required. I discussed with Mr Awali a proposed list of witnesses including Child B, the RCH Respiratory Physician Dr Sarath Ranganathan, Consultant Physician Dr Graham Simpson, and, depending on his position on the issue, Mr Awali himself.

24. I again went to considerable lengths to explain to Mr Awali the prospect of an adverse finding, referring to his failure to provide care which could be seen as an omission of a recognised duty of care. I further stated that a finding that his failure to recognise Child A's dramatic decline and his not taking action to address it would likely be seen as a <u>causal or contributing factor in Child A's death</u>. Mr Awali said he understood.

25. Having advised Mr Awali that due to Child A being on a DHS protection order and therefore "in care" inquest was mandated. I advised him there were in effect two options:

- formal inquest at a later date where I would hear oral evidence from Drs Ranganathan and Simpson and Child B, with a prospect I would call Mr Awali; or
- if he was in agreement, I could convert the Mention/Directions hearing into a summary inquest where I would finalise the matter on the material to hand, copies of which had been provided to him.

26. Mr Awali confirmed he wanted the matter finalised. If that course was to follow it would require some form of formal concession by Mr Awali. Wanting to ensure Mr Awali was provided procedural fairness I put the following question to him:

> *"The point is, before [Child A] went to hospital he was very ill, because when he got to hospital he was on life support for the whole period he was there, he was very ill when he got to hospital. I'm talking about the period prior to going to hospital, that period is the period when you should have, I believe, you acknowledged you should have sought some medical assistance for him prior to that. That's what I'm trying to determine, whether you agree that you should have sought some medical assessment and treatment for Child A prior to going to hospital, do you agree with that or do you not?"*

Mr Awali responded:

> *"I do agree with that, Your Honour."*

I then again asked Mr Awali whether he preferred to proceed to finalisation that day. Mr Awali re-iterated he wanted the matter finalised.

27. Ms Thevar then formally submitted the brief of evidence.

28. I invited Mr Awali to make a submission or provide an explanation for his inaction. Mr Awali described the difficulties he encountered when he and the boys came to Australia. Much of what Mr Awali said by way of explanation for his neglect of his sons, particularly Child A proximate to his admission to hospital was self-serving and a less than persuasive endeavour to exculpate himself for his inaction. However, he did concede he "could have done a bit better." I suggested to Mr Awali that objectively he could have done a "lot better" to which he agreed. Mr Awali stated that he would have to live with the memory of what occurred in relation to Child A's death for the rest of his life, and would take it to his grave.

29. At the conclusion of Mr Awali's submission I adjourned the further hearing to a date to be fixed to pen a formal finding.

30. Among the reasons I proceeded to finalisation by way of summary inquest was to avoid Child B having to give evidence against his father. Shortly prior to the hearing Child B had advised Ms Thevar he was prepared to give viva voce evidence confirming the criticisms he made in his earlier statement of his father's inaction leading to Child A's hospitalisation.

31. Another basis of proceeding to finalisation by way of summary inquest was that the body of material accumulated by investigating police over a number of years, which subsequently constituted the coronial brief, was irresistible/virtually indefensible.

32. I now turn to the evidence upon which I will reach conclusions on the critical issues. I propose to include in this finding significant excerpts from the statements of Child B particularly and Drs Ranganathan and Simpson.

33. A video-taped statement from Child B was taken by police investigators on 22 May 2007 in the presence of Child B's guardian. It is to be recalled Child B was by then only 15 years of age. The lengthy 59-page statement makes chilling reading. Subsequently a further statement was taken from Child B in 2013. While I will refer to several particular comments from it, I propose to let the statement "speak for itself."

34. Child B stated that noticeable changes in Child A's physical condition, including dramatic weight loss, existed for some <u>months</u> prior to him summoning an ambulance. During this time Child A and Child B were residing with their father in a flat in Reservoir. When asked why he called an ambulance Child B stated, "because my dad wasn't there." It is clear Mr Awali virtually left his sons to fend for themselves.

35. In his second statement taken in 2013 Child B made several pertinent comments which I include verbatim in this finding. He stated:

    > *"At the time, I was about 12 years old and Child A was about 14 years old. Dad would only come home every 2-3 days, and when he did come home, it was generally after he had worked night shift as a taxi driver, so he would sleep all day. We wouldn't see him much at all really. It was like that for about seven or eight months before Child A died."*

36. In late 2007 Dr Ranganathan made a formal statement to investigating police. Dr Ranganathan stated that on 9 August 2005, some nine days after Child A's admission to the RCH, he met with Mr Awali for the first time and advised him that Child A was extremely sick with evidence of multi-organ failure and may well die. Dr Ranganathan stated Child A's condition upon admission, a "very advanced stage of disease at presentation," was not

compatible with Mr Awali's claim that Child A only had a three-week history of cough; he said:

> *"It is highly unlikely that Child A developed symptoms of cough only 3 weeks prior to his admission and that Child A must have been unwell for a significant period of time prior to his presentation and it would have been reasonable to expect that a parent would have sought medical advice during that period of illness."*

37. Dr Graham Simpson, Consultant Physician, engaged by investigating police provided a statement dated 13 April 2009. He stated that chest x-rays taken upon admission to Northern Hospital demonstrated "very advanced post-primary pulmonary tuberculosis." The critical evidence of Dr Simpson is contained in the final paragraph of his statement where he opined:

> *"The typical clinical features of post-primary tuberculosis revolve around the respiratory system with chronic cough and sputum production. In addition there may be fevers, night sweats and weight loss, all of which Child A suffered. As the tubercle bacillus is a slow growing organism these features develop over a period usually of many months and certainly would not appear in a matter of weeks. Patients with progressive tuberculosis usually appear emaciated and obviously ill to the point that they are often suspected of having advanced cancer. In my opinion it is completely impossible that any concerned parent could fail to observe the development of chronic disease of this severity in a child and that this infection would have been obvious for a period of at least six months before Child A's final admission to hospital."*

38. A reader of this finding should understand that there are limitations/restrictions to the findings/conclusions I am entitled to make. Section 69 of the *Coroners Act* (2008) in part provides:

> *A coroner must not include in a finding or comment any statement that a person is, or may be, guilty of an offence.*

Consequently, I am specifically prohibited from finding criminality. Furthermore, there is powerful case law which prohibits a finding of civil liability or negligence. When one

examines the conclusions, I have reached it could be argued I have gone to the limit of my powers.

CONCLUSIONS

39. As I indicated earlier the available evidence leads to the irresistible conclusion that tragically Mr Awali abdicated fundamental parental responsibility. I am entirely satisfied that in the several months prior to his admission to hospital Child A's physical condition deteriorated markedly. I am further satisfied that had Mr Awali been exercising even reasonable parental attention to Child A's condition, at least in the two to three weeks prior to admission to hospital, it would have been patently obvious that Child A was desperately ill and that his condition demanded urgent medical intervention.

DHS INVOLVEMENT

40. As stated earlier in this finding Child A was under a protection order at the time of his death. When I took carriage of the matter in early 2019, I noted material on the file in relation to DHS (as it was then known) involvement with the family. In 2000 – 2001 there were a number of notifications made to the Department in relation to allegations of abuse, neglect and abandonment. The allegations were investigated by the Department. It would appear no formal protection orders were made and the cases closed on the basis Mr Awali gave assurances to address the concerns raised, or alternatively Child A and Child B were *not* at risk when in the care of several women whom Mr Awali was in some kind of relationship. Subsequently, in spite of an assurance that the boys would attend school they did not do so for some two years from 2003 – 2005. During that time no further notifications were received until 2005 after Child A was hospitalised at the RCH.

41. Subsequent to the 2005 notification, which resulted in the protection order, the appropriate investigative authority undertook a comprehensive investigation into DHS involvement with the family. The scope of that investigation was wider than any investigation I could undertake as I am restricted to investigation issues that have the necessary nexus to the cause of Child A's death.

42. At the Mention/Directions hearing of February 2020 DHS was represented by Ms Michelle Wilson of counsel. I discussed with Ms Wilson issues raised in the Commission for Children and Young People investigation report, which had been provided by the Commission subject to the confidentiality provisions under s 55 of the *Commission for Children and Young People Act* (2012). I confirmed my primary focus was upon Mr Awali's apparent significant

deficiency in his obligation to provide appropriate care to Child A in the months and weeks prior to the child's admission to hospital, not the previous involvement of DHS.

43. The upshot of this discussion with Ms Wilson was that in addition to the material I had to hand, particularly a statement by Dr Eamonn McCarthy dated 11 October 2019, she would take further instructions from her client with a view to providing a further submission focusing on the fundamental nature of the DHS's role in relation to child protection prior to 2005, and the transition/evolution of the Department's role in intervening years.

44. Subsequently, a comprehensive statement, with appendices, under the hand of Mr Shane Wilson, Assistant Director Child Protection and Care, Children and Families Branch of DHS was submitted.

45. At the completion of that first Mention/Directions hearing, having earlier conferred with my registrar and Ms Thevar assisting, I had hoped to list the matter for formal inquest on 22 – 23 April 2020. However, the restrictions flowing from the impact of the COVID-19 pandemic precluded that proposal, and the matter again stalled with access to Victoria from New South Wales and the Australian Capital Territory being severely restricted for significant periods.

46. The statement provided by Mr Shane Wilson demonstrated that the regime in place under the *Children and Young Persons Act* (1989), the relevant legislation at the time was, in my view, what I will call a <u>reactive</u> process dependent upon <u>notification</u> to the Department. Significant legislative changes came with the *Children, Youth and Family Act* (2005). One of the significant advances in child protection has been the introduction of the concept of "cumulative harm." The introduction of the <u>Best Interest Case Practice Model – Summary Guide</u> in 2010 further enhanced the prospect of meaningful departmental involvement in cases where children could be at risk. In very broad terms, under these legislative interventions and practice alterations the involvement of the Department is more <u>proactive</u> than previously

47. In his statement Mr Wilson also referred to the <u>Education and Training Reform Regulations</u> (2017). He commented that non-attendance at school, as was the case here, can be an indication of risk. It is likely had these boys been attending school in the period leading to June – July 2005 Child A's deteriorating physical condition would surely have been recognised. That was a lost opportunity for meaningful intervention. <u>If the present regime was in place in 2005 prior to Child A's death I believe the tragic outcome would very likely have been averted.</u>

48. In the intervening period a number of matters have led me to the view that it is not now appropriate for me to re-investigate the DHS involvement prior to the final notification. Section 7 of the *Coroners Act* (2008) provides:

    Avoiding unnecessary duplication

    It is the intention of Parliament that a coroner should liaise with other investigative authorities, official bodies or statutory officers—

    (a) To avoid unnecessary duplication of inquiries and investigations; and

    (b) To expedite the investigation of deaths and fires.

    I concluded the contemporaneous investigation undertaken in 2005 – 2006 by the relevant investigative authority was comprehensive and thorough.

49. Given the effluxion of time since the event, some fifteen years, I concluded no meaningful further investigation could be undertaken.

FINDING

50. I formally find Child A, 15 years of age at the time of his death, died at the Royal Children's Hospital on 8 September 2005 after life support was withdrawn as futile. His death was due to multi-organ failure leading to respiratory distress and respiratory failure due to disseminated tuberculosis. I find his father Mr Mahamoud Awali's abject failure to seek medical intervention for his patently critically ill son was an omission in breach of a fundamental duty of care and consequently a causal/contributing factor in Child A's tragic death.

DISTRIBUTION OF FINDING

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

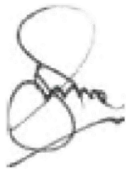
    Mr Mahamoud Awali, Senior Next of Kin

    Child B

    Sandy Pitcher, Secretary for Department of Families, Fairness and Housing

    Detective Senior Constable Luke Collyer, Victoria Police

Signature:



PHILLIP BYRNE
CORONER
Date: 26 August 2021