



MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends and others by direction of the Coroner pursuant to S.57(1)(c) of the Coroners Act 1995)

I, Duncan Robert Fairley, Coroner, having investigated the death of ADT

Find that:

- a) The identity of the deceased is ADT;
- b) ADT died in the circumstances set out below;
- c) ADT died as a result of subdural haemorrhage, intracranial haemorrhage and oedema;
- d) ADT died in February 2014 at the Royal Hobart Hospital, Liverpool Street, Hobart; and
- e) ADT was born in Tasmania in November 2013 and was aged 10 weeks at the date of death.

Background:

ADT was the first child of CT and BK. ADT was born in November 2013 via lower uterine caesarean section and remained in hospital for five weeks due to difficulty with breathing and feeding from the time of her birth. In December 2013 ADT underwent a brain scan which found no abnormality. She returned home with her parents during early January 2014.

Circumstances Surrounding the Death:

In early February 2014 ADT's parents presented her at the Launceston General Hospital (LGH) Emergency Department stating that she had been running a fever, was not feeding and was suffering from loose stools. Staff noticed she was semi-conscious, irritable and non-responsive. She was admitted and an emergency CT scan performed. Radiological investigations revealed extensive bleeding to the brain together with multiple rib fractures. A number of the rib fractures showed callus formation suggesting they were not of recent origin. ADT's parents were spoken to by hospital staff and neither could provide an explanation for her injuries.

Due to the nature of the injuries sustained, ADT was immediately flown to the Royal Hobart Hospital and admitted to intensive care. Upon arrival ADT was placed on a ventilator where she remained until consent for the withdrawal of intensive care support was given by both parents subsequent to receipt of advice from medical staff. The ventilator was switched off and ADT was subsequently declared deceased. Dr Chris Williams, Neonatal Paediatric Intensive Care physician, opined that the cause of death was bleeding to the brain caused by severe shaking. Dr Williams further observed that injuries of such severity were rare in his experience and there was no possibility such injuries might have been caused accidentally.

A post mortem examination performed by Dr Christopher Lawrence, State Forensic Pathologist, revealed that ADT had suffered the following head injuries:

- Subdural haematoma;
- Subcortical tears in the right temporal lobe;
- Intracranial haemorrhages;
- Cerebral oedema;
- Subfalcine and uncal herniation;
- Secondary infarction;
- Hypoxic/ischaemic brain damage;
- Retinal haemorrhages; and
- Bruising around the head and neck.

In addition to the head injuries detailed above ADT suffered multiple left posterior rib fractures with marked callus formation and bilateral anterior rib fractures with less identifiable callus formation. Dr Lawrence also observed numerous, widespread, soft tissue injuries consistent with trauma.

In summary Dr Lawrence advised;

“The cause of death in this 10 week old ... infant...is head injuries...with rib fractures and retinal haemorrhages.”

Police were contacted by Kerrie Butler, on-call Child and Family Services worker, subsequent to ADT's initial presentation to the LGH. Detectives Dunstone and Knight took initial carriage of the investigation and, after being briefed by staff at the LGH, spoke with both of ADT's parents. A search of the family residence was conducted on the same evening with no items of interest being located.

Due to the urgent need to transfer ADT to the Royal Hobart Hospital no further action was taken by police until after the death of ADT when Senior Sergeant Orr took carriage of the investigation. CT and BK had returned to the north of the state but were living separately. Each participated in an electronically recorded interview with police.

During her formal interview CT advised police that, although she had never seen her partner harm ADT she was certain that he had caused the injuries which led to her death. CT stated that BK had a history of anger management issues and that he would often become angry and frustrated with ADT when she would cry or refuse to feed. She suspected BK of causing bruises to their child's legs by pinching her and had accused him of such in front of friends a short time before ADT's death. CT told police that she did not formally report the full extent of BK's behaviour as she was afraid of him.

BK ceased work at his place of employment approximately 2 weeks prior to ADT's death, ostensibly to assist CT with her care. After that time BK undertook most of the tasks associated with ADT's care and would often take her to another part of the house, away from CT, for this purpose.

CT told police that on the morning of ADT's initial presentation to the LGH BK arose between 7am and 8am to feed ADT. When he returned ADT was screaming loudly and he placed her into bed between himself and CT. At approximately 11am CT said she tried to feed ADT again but she would not settle. ADT's demeanour was such that CT suggested they take her to hospital. BK objected initially but later acquiesced and they attended the Launceston General Hospital Emergency Department.

During his initial interview with police BK denied that he had caused any of the relevant injuries to his daughter. He accepted that ADT's injuries could not have occurred accidentally and stated that only he and CT had been caring for their daughter. He confirmed that he had taken unpaid leave from his position at his place of employment to assist his partner with ADT's care. He denied that he had taken leave so that he could care for ADT while her rib injuries healed subsequent to his having squeezed her violently. BK admitted to having assaulted CT some years before while they were residing in Victoria but suggested that he had resolved his anger management issues with the assistance of professional counselling.

Subsequent to the initial interview process police continued their enquiries. In my consideration of this matter I have had regard to all of the relevant medical records and opinions. Further, I have considered the statements obtained from the parents and family members of both CT and BK. It is apparent that while family members knew of the somewhat tumultuous history between BK and CT none were aware that they were having particular difficulty caring for their infant daughter.

In August 2014 BK presented to Launceston Police Station and voluntarily participated in a second electronically recorded interview. During his discussions with police BK admitted that he had violently shaken and squeezed his 10 week old daughter on the day of her presentation to the LGH, sufficient to cause multiple rib fractures and head injuries. BK explained he had done so out of frustration when ADT refused to feed adequately. When asked why his frustration levels were heightened that morning BK suggested that it was probably because he had not smoked cannabis yet that day, a substance which he found calmed him. During further questioning by police BK admitted to causing the bruising to ADT's legs, previously observed by CT, by pinching his daughter to keep her awake so she would feed properly. Finally, BK admitted that during the week preceding ADT's death he had squeezed her with sufficient force so as to cause the partially healed rib fractures

revealed by subsequent radiological investigations. He confirmed that at no time was CT aware of the extent of his assaults upon their daughter.

BK was subsequently charged with and convicted on his plea of guilty of *Ill-treatment of a Child* and *Murder*. In relation to the latter charge Justice Wood sentenced BK to a term of imprisonment of 21 years with a consequential order that he not be eligible for parole until he has served 11 years of that sentence. On the indictment for *Ill Treating a Child* Justice Wood sentenced BK to 3 ½ years' imprisonment, 1 year of which to be served concurrently with the sentence imposed for ADT's murder.

Comments and Recommendations:

Despite the circumstances surrounding ADT's death falling within the provisions of s. 24(1)(a) of the *Coroners Act* 1995 I have determined that, in light of the thorough nature of the police investigation and BK's full, albeit belated, confession, a public inquest is not required. I make such determination pursuant to s. 26 of the Act.

A thorough review of the file indicates that there was no juncture at which child protection authorities or police might reasonably have become aware of the danger to ADT. In the circumstances there is no need for me to make any further comment or recommendations.

In concluding, I convey my sincere condolences to the family of ADT.

Dated: 22 July 2016 in the State of Tasmania.

Duncan Robert Fairley
Coroner