STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of TM
Hearing dates:	28 September - 30 September 2015 (Dubbo Local Court), 13 February - 15 February 2017 (Glebe Coroner's Court)
Date of findings:	22 May 2018
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – manner of death
File numbers:	2010/435326
Representation:	Mr Paul Bush, (Sergeant) Advocate assisting the Coroner
	Mr Chris Day, solicitor, Aboriginal Legal Service, for DM
	Ms Michelle Rabsch of counsel, instructed by Ms Cooper, solicitor, NSW Legal Aid Commission of NSW for AM (13/2/17 onwards)

Findings:

Identity
The person who died was TM.

Date of death
He died on 24 March 2010.

Place of death
He died at Sydney Children's Hospital, Randwick, NSW.

Cause of death
He died from complications of blunt force injury to the head.

Manner of death
The exact circumstances of TM's death cannot yet be established.

Non Publication order

Pursuant to section 74 (1) (b) of the *Coroners Act* 2009 (NSW) I direct that there be no publication of the name of the deceased child TM or his parents, siblings, cousins grandparents, aunts or uncles, friends or neighbours. Those persons will be referred to by pseudonym in the published findings. I make the order to protect the identity of TM.

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Introduction

1. On 24 March 2010 a critically ill boy named TM died at Sydney Children's Hospital, Randwick, New South Wales. He was surrounded by a number of loving family members who had travelled from Lightning Ridge and Dubbo in western New South Wales, to be with him.

2. TM was only 5 years of age.

3. The injuries which led to TM's death had occurred during the night of 19 March 2010 or some time in the early hours of 20 March 2010.

4. Since his death some members of TM's family have been determined to find out what happened and what or who caused TM's tragic death. Their commitment to this task has been extraordinary. It is clear that until there are answers they will continue to seek the truth. I offer TM's family my sincere condolences. I commend their tireless search for the truth in difficult circumstances.

The role of the coroner

5. An inquest is intended to be an independent examination of all the available evidence in relation to the circumstances of a person's death. The *Coroners Act* 2009 (NSW) requires a coroner to make findings as to the identity of the nominated person and in relation to the date and place of death. The coroner is also to examine the manner and cause of the person's death.[1] A coroner has additional powers pursuant to the Act. A coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future.[2] In certain limited circumstances, a coroner may also suspend an inquest and refer a known person to the Director of Public Prosecution if he or she is satisfied, to the requisite standard, that legally admissible evidence is sufficient to raise a resonable prospect of conviction for an indictible offence with respect to the death.[3]

6. In this case, the identity of the boy and the date and place of death are established on the available evidence. The medical experts are able to adequately explain the mechanism or medical cause of death. The real issues for investigation in this matter are found in the circumstances leading up to and surrounding TM's death. There have been unreliable and conflicting accounts given of the evening he was injured, as well as reports of conduct after his death which arouse suspicion. One purpose of this inquest has been to provide the family with some real clarity in relation to what actually occurred in the home that evening. In this respect, the process has been frustrating and ultimately unsuccessful.

The evidence

7. An initial report of the death was received by the coroner on 24 March 2010. The matter was quickly and appropriately referred to the Homicide Squad, which is part of the State Crime

[1] Section 81 *Coroners Act* 2009 (NSW)
[2] Section 82 *Coroners Act* 2009 (NSW)
[3] Section 78 *Coroners Act* 2009 (NSW)

Command. Detective Sergeant Glenn Smith took control of the investigation from an early stage and remains committed to finding out what occurred.

8. The police investigation was extensive and a coronial brief was received at the court in July 2013. The brief contained voluminous witness statements and recorded interviews, photographs and plans, medical records and reports. Even after the initial brief was served, investigations continued, with police following up a number of issues and utilizing a number of investigative strategies. At various times the court was hopeful that these investigative strategies might produce new evidence. There was also a chance that, with the passage of time someone close to the investigation would come forward ready to assist with information previously unknown. Unfortunately this has not occurred.

9. The inquest commenced in Dubbo Local Court in September 2015 and ran for three days. Oral evidence was taken from a number of TM's relatives and members of the local community. The court also heard from some of the professionals who had been involved in his medical care. The inquest was adjourned until 15 February 2016 for the provison of further expert evidence. However at that time there were problems with the availability of witnesses. Police also required further time for additonal investigations and with consent of the parties, the matter did not recommence until 13 February 2017. At that time the court sat for a further three days and the matter was then adjourned for further written material and the provison of written submissions.

10. Most of the outstanding material was received promptly and written submissions were received from the parties by July 2017. Unfortunately the matter was further delayed by the provision of a final medical report which had earlier been requested. That report was finally made available on 27 February 2018. It was circulated to parties who then indicated that further written submissions would not be provided.

11. There have been numerous frustrating delays in this process, including the late provision of medical evidence. However, some of the delay occurred in the hope that new information might become available, either through the ongoing investigations being carried out by police or from known witnesses who might decide to give additional statements about their knowledge of events. Unfortunately, very little reliable evidence about what happened to TM has been obtained since these proceedings commenced.

12. I acknowledge the family's frustration with the process. As a coroner, this has undoubtedly been the one of the most frustrating and tragic inquests that I have been involved with. After eight years and significant investigations the exact circumstances of TM's death still cannot be identified to the relevant legal standard.

Issues to be examined

13. Prior to commencing the inquest a list of issues was circulated to the parties clearly identifying the direction of the inquest. The focus was always to establish exactly what had occurred at TM's family home at Lightning Ridge, NSW between the late afternoon of 19 March 2010 and the following morning. The focus was squarely on how TM received the injuries that led to his tragic death and whether any known person was involved in causing them. There was to be some consideration of the medical care TM received once he arrived at the local hospital, but given the very significant nature of his injuries, it appears likely that his injuries were always inconsistent with life, even if he had been attended to more quickly.

Background

14. TM was born on 2 June 2004 at Dubbo Base Hospital, to AM. AM later had another son and then became involved with DM. AM and DM had further children and reared them together with AM's two older boys. In 2010 the family was living in Lightning Ridge, with various other relatives living nearby.

15. AM gave evidence that TM was generally healthy although he had a "heart murmur" and wore glasses. There was also evidence recorded in the autopsy report indicating certain minor congenital defects.

16. TM was reportedly a happy and engaging child. He was apparently cooperative at school and happy to "sit and have a chat". He was full of life, loved motorbikes, football and playing with his siblings and cousins. He was described as "well behaved".

17. The grief and deep loss felt by many of his relatives after his tragic death was still clearly evident at court proceedings years later. There is no doubt TM is fondly remembered and thought about often.

The night of 19 March 2010

18. On 19 March 2010, TM walked home from Lightning Ridge Central School, where he was in year one. TM and his cousin played in the backyard on the trampoline and on a four wheeled motorcycle. AM and DM went shopping and AM's mother, BM minded TM and the younger children. There were no known injuries or accidents. TM appeared active and in good health. Having reviewed all the evidence, I find that it is most unlikely that he had been seriously injured during the day.

19. That evening TM ate some chicken for dinner and watched TV or played video games. He did not complain of ill health or headache. He did not report any serious accident or injury. The evening progressed without incident and it has generally been described as an unremarkable family night. It is likely that TM went to bed at some time between 12.30 and 1 am. He slept on the top bunk and his younger brother LM and cousin NC slept together on the bottom bunk. The top bunk had no railing. AM and DM estimated that they went to bed around 2.30am or 3 am.

20. There are a number of different accounts about exactly what happened from that point onwards. When one closely examines the various versions given to different doctors, the various statements and ERISPs given to police and AM's in court evidence there are a number of inconsistencies and variations in detail. However, it is clear that during the night or in the early hours of 20 March 2010, TM suffered some sort of blunt force injury to his head. Whether it was caused by a deliberate assault, an accident or a combination of both remains uncertain.

21. DM's initial account to the police suggested that he and AM first woke to the sound of TM vomiting. DM stated that he got up to clean the vomit, gave TM a drink and went back to bed. About half an hour later TM got up and "had an accident" or "pooed himself" on the way to

the toilet, so DM got up again and changed the boy's trousers. According to DM, both he and TM then went back to their respective beds. DM stated that it was "probably early hours of that mornin' [TM] just woke up screamin' and he was havin' a seizure in his bed". At this point DM said that he went to TM, who was lying on his bunk. AM stayed in their bedroom as she was feeding the baby. DM was concerned because TM was "all paralysed" and he called out to AM to get her to come. He was concerned that TM would not wake up and he thought he may have fallen off the bunk.[4]

22. AM's initial account differed in some respects, she remembered hearing TM cry while she was feeding the baby and she called out to DM who she thought was on the toilet at that point. After checking TM, DM told her to come.[5] She also remembered DM telling her that TM had "spewed" and had an accident earlier in the night.

23. When AM gave evidence at the inquest, some of the details given in relation to exactly what occurred on the night were different, but this may be explained by the passage of time. AM was an extremely vulnerable witness. There was evidence that she had experienced drug and mental health issues following TM's death and the subsequent removal of her other children. She presented as a sad and forlorn woman. She found it hard to sit in court and listen to the evidence.

24. At times AM found it difficult to give her evidence in a logical fashion, at other times she spoke as though she was trying to remember a script. AM appeared both distraught at remembering events, but also frightened and nervous as though she felt she might make a mistake. I have no doubt that she loved TM deeply and that her ongoing separation from her other children is a constant source of pain. I had hoped that she might have been able to provide further information than she did.

25. At the time of giving evidence AM was still in a relationship with DM, but she denied that she was covering up for him or that he was "standing over" her in any way. AM maintained that she did not know how TM had been injured. She told the court that she herself had asked DM if he had hurt TM and that he had always denied it. Equally she told the court that DM had asked her the same thing.[6]

26. The court also heard from NC, TM's cousin, who was asleep in the room during the evening that TM sustained his injury. He too was a vulnerable witness, who had been only ten years of age when he was first interviewed by police. His evidence was at times confused and difficult to rely upon. However, he maintained that he went to DM and AM's bedroom to tell them that TM would not wake up. He described TM moving on the bed like he might be having a fit. After that DM came and shook TM to try and wake him.[7] He saw spew on the floor. NC gave evidence that he had not heard of TM falling out of bed before and that if TM had got down from the top bunk, it would have woken him up.[8]

27. The only evidence that TM fell out of bed is wholly unreliable. TM's three year old brother, LM told investigating police that TM had "bumped himself" on the ground.[9] At one point he

[4] DM ERISP 22 March 2010, Q125 onwards
[5] AM ERISP 23 March 2010, Q 346 onwards
[6] AM Transcript 14/2/17, page 73, line 47
[7] NC Transcript 29/9/15, page 21, line 25 onwards
[8] NC Transcript 29/9/15, page 20, line 15 onwards
[9] LM ERISP, 20/5/10 Q 21 onwards

says TM tripped and at another that he fell out of bed. Both NC and DM refer to LM telling them this. LM's age and the passage of time meant that he was not cross-examined before me and it is clear, on any close reading of the interview that took place when he was three, that one cannot rely on his account.

28. DM's father gave evidence that he was aware of three previous occasions when TM had fallen out of the bunk.[10] This evidence was in contradiction to all other witnesses. Nevertheless, it is interesting to note that RM said when this had occurred in the past he had been able to hear the thump from another room.

29. AM was asked if she remembered TM ever falling out of bed. She was not sure, but she thought not. She did however notice that on the morning of 20 March 2010 TM was lying in the opposite direction to how he had been earlier in the night. When asked directly, what she thought had happened to her son, she told the court that she did not believe he had fallen out of bed and that perhaps something had happened during the day.[11]

30. I have had the opportunity to review the discrepancies and contradictions in the various accounts of the evening. I do not intend to refer to each and every one. On careful review of all the evidence there is currently no reliable way to establish how TM was injured. There is no evidence that he fell from the top bunk, it is merely one of a number of possibilities. At the end of the day, there is also no eyewitness evidence to support the suspicion that a known person assaulted TM or was somehow directly or indirectly responsible for his injuries.

A brief medical chronology

TM's arrival at hospital

31. AM put TM in the car and collected her mother BM from a nearby house. She realized that TM needed an urgent medical assessment. After she collected BM, they returned briefly to get TM clean shorts as he had wet himself and then they made their way directly to Lightning Ridge Hospital. TM was unresponsive. They arrived at the Emergency Department at about 7am. Unfortunately medical staff were not told at that time that TM had likely suffered a head injury. While Dr Ekeocha, Nurse Cager, and a number of family members including DA observed bruising to TM's left temple, it appears that it was some time before the possibility of a brain haemorrhage was properly considered.

32. It appears that Dr Ekeocha provisionally diagnosed TM with having had a seizure of some kind. TM's initial Glasgow Coma Scale (GCS) score was assessed as being 12, before briefly increasing to 14. TM was later observed to have a tonic clonic seizure and a reduced GCS score of 6. Around this time Patient Flow was called and a request was made to speak with a paediatric consultant via NETS (Newborn & paediatric Emergency Transfer Service), which is a statewide service offered by NSW Health.

33. After receiving specialist advice through a number of NETS calls, TM's diagnosis was adjusted. Dr Ekeocha realised that there was a real chance that TM was suffering from raised intra-cranial pressure, possibly from a cerebral oedema, something that he had not before considered.[12]

[10] RM Transcript 1/10/15, page 5, line 12 onwards
[11] AM Transcript 14/2/17, page 57,line 45
[12] Dr Ekeocha, Transcript 14/2/17, page 12, line 27 onwards

34. Care and treatment of TM continued as arrangements were made to evacuate him by using the Flying Doctor Service. Unfortunately he was not given Acyclovir or Mannitol, with Dr Ekeocha saying that the medication was unavailable. TM was intubated and arrangements were eventually made to have him airlifted to Sydney for treatment. Further seizures resulted in the administration of additional intravenous midazolam. There were problems keeping him properly ventilated.

TM's evacuation to Sydney

35. TM did not arrive at Sydney Children's Hospital at Randwick until approximately 5.35 pm.[13] Dr Pigott, at the time a staff specialist in paediatric intensive care at Sydney Children's Hospital in Randwick assumed the clinical care of TM after he was admitted on 20 March 2010. He had also been involved in an earlier conference call with other doctors and NETS in relation to TM. Dr Piggott was involved in TM's resuscitation on arrival and the subsequent decision to operate urgently. Dr Pigott remained responsible for TM until his death.

36. On arrival in Sydney, TM was in a critical condition. His GCS was assessed as 3. He was administered further medication and taken for an urgent CT scan which revealed a left epidural/extradural haematoma and fracture to the left temporal bone.

37. TM was taken to surgery in an attempt to evacuate the left front/temporal haematoma and relieve the swelling on his brain. Despite best efforts, TM's intracranial pressure remained consistently and dangerously high.[14]

38. TM was admitted to the intensive care unit at Sydney Children's Hospital at approximately 9pm on 20 March 2010. The pressure in his skull had been so high that the surgical team had elected not to replace a section of his skull.

39. TM was maintained on a mechanical ventilator and a right femoral venous line was inserted to facilitate drug and fluid administration. Another line was inserted to allow for blood testing and blood pressure measurement. He was cooled and placed in a still position with support.[15]

40. Over the next days his condition remained critical. He developed symptoms consistent with evolving brain death. An electroencephalogram (EEG) was performed on 21 March 2010, and no brain activity was detected. Over the next 24 hours sedative medications were discontinued. A second EEG was performed. It too showed no evidence of brain activity. Other responses were also non-existent and his pupils remained dilated and unresponsive to light.

41. While TM remained relatively stable, his family were informed that if there was no further improvement, doctors would perform brain stem function tests with the possible consequence that TM would be confirmed "brain dead".[16]

[13] Statement of Dr Pigott, dated 7/9/10, paragraph 6
[14] Statement of Dr Pigott dated 7/9/10, paragraph 6
[15] Statement of Dr Pigott, dated 7/9/10, paragraph 8
[16] See Statement of Dr Pigott for further detail in relation to TM's treatment

42. Further treatment ensued and on 24 March 2010, brain stem testing was repeated. TM was pronounced life extinct at 12.24pm on 24 March 2010.

Was the medical treatment TM received adequate?

43. There were no concerns raised about the quality of care received by TM once the retrieval team arrived at Lightning Ridge. However, concerns were raised about the quality of care received at Lightning Ridge Hospital and in relation to the speed of the medical transfer to a facility with paediatric and neurosurgical capacity.

The care provided by Dr Ekeocha

44. Dr Ekeocha was the visiting medical officer at Lightning Ridge Hospital at the time of TM's admission. He told the court that he was called to the hospital about 7.15 on 20 March 2010. Part of the history he took included that TM's sibling had recently had a seizure and that TM had been found having wet himself in bed. In other words he was not immediately told of the possibility of a recent blunt force trauma, nor was his initial attention drawn to the bruise on the side of TM's head. Dr Ekeocha "formed the opinion that [TM] had a seizure due to the [report of] bedwetting and the reduced level of consciousness."[17]

45. In his oral evidence Dr Ekeocha told the court that he had never, at the time of TM's admission had cause to treat a patient with cerebral oedema and had no experience with working with patients with intracranial pressure. His usual experience was with minor head injuries and he described his usual course of action which involved observing the patient for four hours and then sending them home[18]. In my view Dr Ekeocha's inexperience meant that he failed to see the emergency of the situation he was dealing with on 20 March 2010. It is clear he left the patient for a period of time to attend to other duties. It is in my view unfortunate that he did not immediately seek help through NETS as he needed expert advice in relation to how to manage the patient. It appears that the first of the conference calls occurred between 9.30am and 10am. Given the long distance to a tertiary paediatric centre, arrangements for transfer should have been commenced immediately. Even with the incomplete history given to Dr Ekeocha, he should have had more suspicion than he did. Nurse Cager was certainly concerned from an early stage that the initial history given did not appear to match the bruising found.[19] In my view Dr Ekeocha was out of his depth and should have realised he needed specialist advice immediately. I hope that Dr Ekeocha has learnt from the experience that seeking help, rather than thinking you can manage every situation, is the appropriate course.

46. There was also evidence that the work atmosphere was at times unprofessional[20]. Dr Ekeocha described the atmosphere as tense and agreed that a nurse could have thrown something at a wall[21], although he said he could not remember having an argument with her. There was evidence that he had a heated phone call during the consultation, a suggestion he

[17] Statement of Dr Ekeocha, dated 23/3/2010, Exhibit 1, page 396
[18] Dr Ekeocha, Transcript 14
[19] Nurse Cager, Transcript 29/9/15, page 81, line 44
[20] See for example DA's description of an argument at Transcript 29/9/15, page 94, line 50 onwards. DA, whose evidence I accept also described Dr Ekeocha appearing "out of his depth". Page 96, line 15 onwards
[21] Dr E

denied. It is difficult to make firm findings at this distance about exactly what went on and how it affected the care given, however it is clear that family members had little confidence in the professionalism of the attending doctor.

The failure to provide Mannitol

47. After speaking to the NETS coordinator and getting advice from the paediatric ICU consultant Dr Ekeocha was advised that TM may have a cerebral oedema. However, Dr Ekeocha told the court that TM was not given Mannitol or acyclovir, as none was available.[22]

48. The lack of Mannitol at Lightning Ridge was disturbing and the Court sought further information from the Western NSW Local Health District. The LHD response indicated that Mannitol was in fact stocked at Lightning Ridge Hospital at the time of TM's admission, however staff were unable to locate the medication at that time. The response indicated that "staff inability to locate Mannitol was reported at the time and a sign was placed on the cupboard alerting staff."[23] The response confirmed that both Mannitol and Acyclovir are currently available at Lightning Ridge Hospital. In all the circumstances, it appears to have been a serious but isolated staff error that has now been rectified.

49. Dr Pigott gave evidence that while TM should have been given Mannitol in a timely manner, he could not say whether that would have changed the eventual outcome.[24]

Delay

50. Small hospitals in regional areas face particular issues with patient transfer to specialist centres. The distances can be enormous and there is reliance on aeroplanes or helicopters being available at short notice. Initially plans were made to transfer TM to Dubbo Hospital, but as his condition deteriorated, there was a need to get him paediatric neurosurgical support.

51. Unfortunately there were delays in transferring TM via air ambulance due to aircraft issues and availability. By the time the aeroplane reached the Sydney area TM's condition was deteriorating. A decision was made to fly to Randwick rather than Westmead in an attempt to get help more quickly.

52. It was Dr Pigott's view that the "unavoidable delay" in transferring TM from Lightning Ridge to a neurosurgical centre "almost certainly exacerbated" his poor outcome.[25] In oral evidence he noted that while there is an ongoing problem with respect to the long distances which exist in NSW, the delay for TM was "very significant" and would not be regarded as ideal.[26] In my view it was unacceptable.

53. I note also the opinion of Dr Chitsunge that TM "was likely brain dead before transfer". Nevertheless, it was clear that TM's distance from paediatric assistance was a factor in both his diagnosis and treatment. Dr Catherine Johnson, the neurosurgical registrar who was on call at Sydney Children's Hospital at the time of TM's admission, gave evidence before me.

[22] Statement of Dr Ekeocha, dated 23/3/2010, Exhibit 1, page 398
[23] Letter to Registrar, Coroners Court, from Cathy Marshall, Patient Safety and Clinical Quality Manager, Western NSW Local Health District, dated 27 April 2017.
[24] Dr Pigott, 13/2/17, page 17, line 23.
[25] Statement of Dr Pigott, dated 7 September 2010, Exhibit 1, page 374
[26] Dr Pigott, Transcript 13/2/17, page 17, line 4 onwards

She assisted with the craniectomy that was performed on arrival. It was her evidence that it was a procedure that needed to be performed "the sooner the better".[27]

54. In summary, the delay in getting TM to paediatric care was multi-factored. The diagnosis was delayed, there were aeroplane and transport issues and the distance itself was significant. I accept that even if transport had occurred earlier, given the extent of the injury there is no guarantee the outcome would have been different.

TM's death and autopsy

55. A post mortem examination was conducted on 25 March 2010, by Dr Rebecca Irvine. The autopsy revealed a severe cerebral oedema, evidence of recent craniectomy and an acute fracture within the left middle cranial fossa. Significantly, Dr Irvine noted in her report that "no features of the injury were identified at autopsy which would clarify the way in which the injury occurred".[28]

56. Dr Irvine also gave oral evidence at the inquest at which time she suggested that the brain should be microscopically examined by a neuropathologist to determine whether there was evidence of "traumatic axonal injury or diffuse axonal injury". Dr Irvine posited that if "such injuries were present they might provide further information about the type of force that might have caused this situation."[29] She explained that although a neuropathologist, Dr Rodriguez had already examined TM's brain "with his eyes", it had not been examined under the microscope.

57. Dr Rodriguez subsequently undertook further examination and provided a microscopic report[30] to supplement his original macroscopic report. Disappointingly, it provided no reliable evidence that can be used to establish whether the injuries were accidental or deliberate.

Are the medical experts able to say if the injuries were caused by an accidental fall or by a deliberate assault?

58. While the evidence of the forensic pathologist and forensic neuropathologist was not able to establish exactly how TM sustained his injury, the question was also examined by Dr Dimitra Tzioumi, a consultant paediatrician of the Child Protection Unit at Sydney Children's Hospital. She described her specialty as involving "the assessment of injuries in children, where it's a concern that the injuries may have been inflicted by another person"[31] The task is particularly difficult in a case such as this where there is no direct or reliable evidence indicating the mechanism of the injury.

59. Dr Tzioumi reviewed all the available medical information and was briefed by police in relation to aspects of the investigation. She had photographs and measurements of the room

[27] Dr Johnson, Transcript 13/2/17, page 54, line 3
[28] Dr Rebecca Irvine, Autopsy Report
[29] Dr Rebecca Irvine, Transcript 13/2/17, page 6
[30] Dr M Rodriguez, Neuropathology Report, dated 26 February 2018
[31] Dr Tzioumi, Transcript, 13/2/17, page 34, line 20

where TM had been sleeping and was aware of the bunk bed height and the nature of the floor surface. She had access to the CT scans and the results of various other investigations.

60. In her view the injuries clearly indicated a blunt force trauma to the left side of the head. This could account for the bruising and soft tissue swelling on the left frontal temporal area, the temporal bone fracture and the large extradural haematoma. [32] In her view it was unlikely that this injury had been caused two days earlier during play on the trampoline, but she could not rule out that it could have been caused by falling from the bunk. She also thought it possible that he could have fallen and then made it back up into the top bunk bed where he was apparently found. However, she found it surprising that "adults in the house did not hear such a significant fall if it had occurred".

61. Dr Tzioumi gave oral evidence before me. She elaborated that the location of the injury made it especially difficult to assess. She stated "falling onto a hard floor and hitting that side part of the head can cause enough force to cause the fracture and bleeding under the fracture …It's well documented in accidents, witnessed accidents, where people fall and have that type of bleed."[33] She continued, saying "there's a lot of literature about extradurals and what they call short falls, and it can even be caused by falls shorter than that on a hard surface."[34] She later agreed that theoretically the injury could have been caused by impact with a bathroom vanity at some force, or in a number of other ways.

62. At the conclusion of her evidence, it was clear that while significant concerns remained, it could not be established on the medical evidence that the injury TM suffered was inflicted upon him by another person.

Were the circumstances as they emerged suspicious?

63. The court heard evidence which emerged in the investigation and which aroused suspicion in family members or raised questions about the reliability of some of the accounts given. Family were particularly concerned that some of DM's actions after TM's arrival at hospital appeared unusual. Some of those concerns included, but were not limited to,

- DM immediately cleaned the house and pulled the bunk beds apart. He did this even before visiting TM in hospital.[35]
- DM appeared to be more worried about his "pot" than TM when the police came to the house.[36]
- DM did not show emotion or appear upset at the hospital in Sydney.[37] He did not sit by TM's bed and chose to go shopping with AM on occasion.[38]

[32] Statement of Dr Tzioumi, dated 11 May 2010, Exhibit 1,page 685
[33] Dr Tzioumi, Transcript, 13/2/17, page 42, line 40 onwards
[34] Dr Tzioumi, Transcript, 13/2/17, page 43, line 2 onwards
[35] ERISP AM 23 March 2010 Q 56, and elsewhere
[36] See for example evidence of GM, Transcript 30/9/15, page 72, line 40 onwards
[37] See for example evidence of GM, Transcript 30/9/15, page 66, line 24 onwards
[38] See discussion of this point in BM, Transcript 29/9/15, page 64, line 25 onwards

- DM did not appear "happy" like other family members when there briefly appeared to be some hope for TM at the hospital in Sydney.[39]

- DM acted strangely and said words to the effect of "I'm sorry son" when TM was in a coma on 21 March 2010. When confronted about this by BM, DM "went mad" and started yelling.[40]

- After TM's death, DM tried to distance AM from her family.

64. It is clear that over time, some family members began to believe that DM knew more about what had happened than he had shared with the police. They came to believe that his actions demonstrated a consciousness of guilt and relations between DM and other family members soured.

Was there a pattern of domestic violence in the home?

65. The court heard from a number of witnesses in relation to the relationship between AM and DM and in relation to the way they raised their children. AM came from a close family and a number of her relatives had long been concerned that she was subject to various forms of control and domestic abuse throughout her relationship with DM.

- AM's mother BM, who was often in the house, stated that she had never seen DM hit AM, but she knew he did and she had seen the bruises.[41]

- DA, AM's brother-in-law and a health worker himself was concerned when his daughter had reported seeing DM assault AM at home[42].

- RM, AM's sister, told the court that she had not seen violence but that AM and DM were "very jealous" of each other and swore at each other a lot.[43]

- AM's brother GM said that he had heard "on the grapevine" that there was violence between his sister and DM, but she did not admit it to him when he asked. He gave evidence that on one occasion he heard DM assault AM in the shower and subsequently his wife had seen fresh marks and significant bruises.[44] He described the relationship as "one of severe abuse of a female". He told the court that TM and his brother LM also told him that "DM would hit Mum" and sometimes he would smack them too.[45]

- BC, AM's sister gave compelling evidence of domestic abuse. She described her sister as living "like a prisoner" because of DM. BC had been present when AM had disclosed to her doctor the nature of some terrible beatings she had sustained from DM. These assaults included kicks to the head and other severe abuse[46]. BC gave evidence of finding a note at AM's address, some years ago where AM indicated that she must say goodbye because she was "sick of" being hit by DM. At the time BC gave her evidence to this court AM was living apart from DM and BC hoped that she

[39] See for example evidence of GM, Transcript 30/9/15, page 70, line 40 onwards
[40] Statement of BM, dated 25 March 2010, Exhibit 1, page 766, paragraph 6,
[41] BM Transcript 29/9/15, page 69, line 5 onwards.
[42] DA Transcript 30/9/15, page 24, line 1 onwards
[43] RM Transcript 30/9
[44] See for example evidence of GM, Transcript 30/9/15, page 73, line 50 onwards
[45] See for example evidence of GM, Transcript 30/9/15, page 75, line 1 onwards
[46] Evidence of BC, Transcript 30/9/15, page 87, line 35 onwards

was gaining the strength to talk about what had occurred. She felt her sister was still struggling with "ice" and the effects of living in an abusive relationship. BC told the court that her sister had spoken to her a little about what had occurred on the night. She thought her sister would "talk about things when she's ready".[47] Unfortunately, although the matter was adjourned and AM did finally give evidence in the proceedings, it appeared that her mental health was still extremely fragile and no disclosures of the kind foreshadowed were in fact made.

- AM's friend KS had heard rumours of domestic violence, but not seen it herself.

- AM's neighbour LB heard constant arguing, swearing and fighting. At one point she intervened when she saw DM "backhand" TM's younger brother LM.[48] She had also seen DM in a fight with another man. I accepted her independent evidence that physical violence occurred "almost every day".

66. Against this strong evidence establishing ongoing domestic violence in the house, was the evidence of DM's father and stepfather who denied being aware of any violence. DM's father described DM as a "gentle giant", which is in stark contrast to the way he was seen by most members of AM's family. I found his evidence largely unreliable. I note also that another neighbour, VW told the court that she had never heard "any dramas" from AM's house before TM died. However, I was concerned that she was a timid witness who appeared worried about the consequences of getting involved in the investigation. I place little weight on her evidence in relation to this matter.

67. I note that AM was asked directly about this issue during the inquest. She said that prior to TM's death, "we didn't really argue that much, but we did argue, like, just like a typical household". I found her evidence on this issue wholly unreliable. She appeared very concerned about offending DM. When asked directly if an argument ever involved "physical altercations", she answered "not really"[49]. I understand the pressure that she was under in the witness box and I do not accept that she felt able to give consistently truthful answers.

68. In my view it is sufficiently established that there was significant violence perpetrated on AM by DM in the course of their relationship. I accept evidence before me that DM had a temper he found difficult to control. I accept he beat and kicked AM on occasions and while there is less direct evidence of him assaulting the children, I accept this too occurred from time to time.

The "confession"

69. During the investigation police took a statement from a man named DG. DG had been staying with his father, PG, at a place on Three Mile Road, Lightning Ridge. PG appeared to know AM and DM and after TM's death, they would visit from time to time "for a chat and to smoke bongs". DG was aware of TM's death and that the other children were no longer in their parents' care.

[47] Evidence of BC, Transcript 30/9/15, page 93, line 47 onwards
[48] Evidence of LB, Transcript 1/10/15, page 37, line 1 onwards
[49] Evidence of AM, Transcript 14/2/17, page 37, line 45

70. It was DG's evidence that on one occasion PG told him that "DM had broken down crying and said words to the effect that he smacked the boy and it was all his fault". PG told his son that DM said "the boy either pissed himself or had to go to the toilet so DM took him to the bathroom and smacked him in the head then his head hit the vanity or the cupboard beside him. DM said "I didn't mean to hit him so hard".[50]

71. PG declined to make a statement at the time. Both men were called to give oral evidence before me. PG confirmed that there had been an occasion when AM and DM attended his camp and the issue had been raised. In oral evidence, PG stated that he had asked DM when he was "getting his kids back". PG indicated that DM went silent for a minute and then he thought he may have been crying. PG asked him what the matter was and DM said "I didn't mean to do it, I didn't mean to do it"[51] When questioned further he "sort of had a bit of a sook and then sort of snapped out of it and started joking about things and that's all that was said"[52] PG said that was the only time they spoke about it and it lasted a couple of seconds. Later when he asked DM about it, DM said he didn't know what he was talking about and just made a joke of it.

72. PG told the court that he had heard rumours around town about the death of TM[53], but he felt that it was not his business to question DM and AM. It was just "hearsay" and "it's wrong to talk about rumours". He later told the court that he didn't think DM "did it", but he had a theory the young fellow might have fallen out of bed and DM did not know enough about head injuries to realize that the child should have been carefully watched. He agreed this was "just a theory".

73. In oral evidence PG's son DG remembered the words "I didn't mean to do it", but found it hard to recall the specific conversation that he had previously reported about "hitting" TM in the bathroom. He also recounted being abused near the supermarket at Lightning Ridge by DM after giving his statement to police. He told the court DM called him a "fucking dog" and that there had been a bit of a scuffle.

74. The conversation attributed to DM certainly raises suspicion, but it remains somewhat ambiguous. All parties were likely to have been affected by drugs and the only words now remembered with any clarity are somewhat ambiguous in the context of talking about the removal of the AM and DM's children. Suspicion remains, but it is significant that DG admitted that his actual recall of what he had been told was fairly shaky and could have been affected by the rumours he had heard.

75. It should also be noted that DM emphatically denied the conversation when it was put to him during a recorded interview on 8 November 2012. He told police that if he had hit TM, causing TM to hit the vanity, "I could guarantee you I would have walked through that door (to Lightning Ridge Police Station) and handed myself in the day it happened…I wouldn't have been able to live with it…"[54]

[50] Statement of Damien Gleeson, dated 7/11/2012, Exhibit 1, page 1020, paragraph 6
[51] PG transcript 1/10/15, page 52, line 28
[52] PG transcript 1/10/15, page 52, line 30 onwards
[53] See for example discussion of this issue at Transcript 1/10/15, page 56, line 27
[54] DM ERISP 8/11/12 Q 251-253

Can the Court establish a manner of death?

76. The court has given careful consideration as to whether a finding of accident or homicide can be made out on the evidence currently available. The court has also carefully considered whether it is appropriate in all the circumstances to suspend the inquest and refer any person to the Director of Public Prosecutions. The answer to both questions is no.

77. There is no reliable eye-witness account of what occurred. The medical evidence cannot rule out the possibility of an accident. While there is evidence that raises certain suspicions, it is not strong enough to ground the referral of any person.

Findings

78. The findings I make under section 81(1) of the Act are:

Identity
The person who died was TM.

Date of death
He died on 24 March 2010.

Place of death
He died at Sydney Children's Hospital, Randwick, NSW.

Cause of death
He died from complications of blunt force injury to the head.

Manner of death
The exact circumstances of TM's death cannot yet be established.

Conclusion

79. I have been unable to determine, to the requisite standard the manner of TM's death. In my view significant suspicions remain. Should any further evidence become available about what occurred on the night of TM's death, this matter should be re-opened.

80. I acknowledge the family's pain and suffering. Their attendance at the inquest and their ongoing attempts to find out what happened to this much loved child, TM are commendable. TM's death has devastated a family and their pain is ongoing. I will never forget the death of TM and I sincerely hope to be called upon one day to consider fresh evidence in this matter.

81. There is nothing further that can be achieved at this stage and reluctantly I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
22 May 2018
NSW State Coroner's Court, Glebe