STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of AF
Hearing dates:	20 November 2017
Date of findings:	1 December 2017
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, peritonitis, bowel perforation, traumatic injury, Children's Hospital at Westmead, section 29 *Coroners Act 2009*
File numbers:	2005/370258
Representation:	Ms D Ward, Counsel Assisting, instructed by Ms C Berry, Crown Solicitor's Office Mr E Anderson (for AC) Mr M Hutchings (for the Department of Family and Community Services)

Non-publication orders: Pursuant to section 74(1)(b) of the Coroners Act 2009, the following material is not to be published:

1. The names and/or identifying information (including images) of any of the following persons:

   (a) AF;
   (b) TF;
   (c) MaC;
   (d) MiC;
   (e) SC;
   (f) EC;
   (g) AKF;
   (h) AC;
   (i) SG; and
   (j) BD.

Findings: Pursuant to section 81(1) of the *Coroners Act 2009*, I find that AF died on 9 February 2005 at Marayong NSW 2148. The cause of AF's death was peritonitis. The peritonitis was caused by the perforation of AF's small bowel. The perforation was a traumatic injury and not due to a natural disease process or misadventure. However, the available evidence does not allow for a finding to be made as to the mechanism of injury.

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Introduction

1. AF died on 9 February 2005. She was 3 years and 8 months old at the time. The death of any child is, without question, a tragic event. Where that child has a twin sibling the grief and anguish associated with the death becomes even more pronounced and distressing. AF's death at such a young age from a serious injury raises questions about the circumstances in which she died, and whether any system was in place to protect her and keep her safe. In the more than 12 years that has passed since AF's death, investigation has been conducted and evidence gathered in an attempt to answer these, and other, questions.

Why was an inquest held?

2. All violent and unnatural deaths must be reported to a Coroner. A Coroner has an obligation to make findings about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances in which that person died. If it appears to a Coroner that a person died, or might have died, as a result of homicide, then section 27(1)(a) of the *Coroners Act 2009* (the Act) requires that an inquest must be held.

3. In AF's case, because the evidence that has been gathered about her death indicates that she might have died as a result of homicide, the law requires that an inquest must be held into her death.[1] Regrettably, the mandatory requirements of the Act bring with them the upsetting memories associated with AF's death.

A brief family history

4. AF and her identical twin sister, TF, were born on 1 July 2001 to Ms AKF. The twins were born prematurely at 29 weeks at Mercy Hospital in Melbourne. After spending some time in the hospital neonatal intensive care unit, the twins were transferred to Bendigo Hospital for further care before eventually being discharged home at 9 weeks of age.

5. At the time of the twins' births their biological father was not engaged in their life. Ms AKF ended her relationship with the twins' father before the twins were born and subsequently had no further contact with him.

6. After being discharged from hospital Ms AKF and the twins lived with Ms AKF's mother, Ms SG, and Ms AKF's sister in the Bendigo area. When the twins were about 18 months old Ms AKF and the twins moved into their own home in a different part of Bendigo.

7. In March 2003 Ms AKF met Mr AC on an online single parents support group. At the time Mr AC was living in Stanhope Gardens in Sydney. Ms AKF and Mr AC formed a relationship shortly afterwards. For the remainder of 2003 Ms AKF and the twins travelled to Sydney in order to visit Mr AC, and Mr AC also travelled to Melbourne to visit them.

8. In June 2004 Ms AKF and the twins moved from Bendigo to Quakers Hill in Sydney. By this time Mr AC was living in Marayong. After moving to Sydney Ms AKF and the twins spent the majority of their time at Mr AC's home.

[1] Section 27(1)(a), *Coroners Act 2009*.

What happened in the period leading up to 9 February 2005?

9. Ms AKF and the twins travelled to Melbourne on 16 January 2005 to visit Ms AKF's grandmother, Ms BD. They also visited Ms SG on 20 January 2005 before returning to Sydney on Sunday, 30 January 2005.[2]

10. On Monday, 7 February 2005 Ms SG called Ms AKF to ask about the twins. Ms AKF told her mother that AF had been sick and vomiting, and believed that this was due to some stomach complaint. Ms SG told Ms AKF that AF might be suffering from some food poisoning and suggested that Ms AKF take AF to see a doctor.

11. The following day, Tuesday 8 February 2005, Ms AKF took AF to see a general practitioner at Quakers Hill Medical Centre. Ms AKF told the GP that AF had vomited on the Sunday that she returned from Melbourne and had vomited again on Saturday 5 February 2005. Ms AKF also described AF as being lethargic and having a moist cough.[3] Upon examination the GP found that AF appeared lethargic but cooperative, that her chest was clear, and that she was not feverish. The GP also examined AF's torso and found that she had no signs of physical injury to her body.[4] The GP formed the view that AF was suffering from a viral infection and prescribed a course of Panadol for pain relief.

12. After leaving the medical centre Ms AKF and AF returned to Mr AC's house. AF had something to eat and drink and fell asleep from about 1:00pm to 2:30pm. During the afternoon AF vomited again, with Ms AKF describing the vomit as being green in colour.[5] Ms AKF felt that AF had a temperature and so that night she made a bed for AF in an empty bathtub, by lining the bathtub with some towels, in the hope that having AF sleep in a cooler environment would bring her temperature down.

13. During the night AF vomited another 3 times and appeared to be unable to keep down any fluids.[6] At about 10:30pm Ms AKF went to check on AF before going to bed. Ms AKF told AF to get some rest and told her that she would see her in the morning. AF said goodnight to her mother and told her that she loved her.

What happened on Wednesday, 9 February 2005?

14. On the morning of Wednesday 9 February 2005, Mr AC felt unwell. He woke up at about 6:20am and got out of bed to go to the toilet. On his way Mr AC saw that TF was in the bathtub with AF, instead of in the spare bedroom where she normally slept when she stayed over at Mr AC's house. Mr AC could not see AF in the bathtub and assumed that TF was either sitting on her, or next to her.[7] Mr AC called out to Ms AKF and told her that TF was in the bathtub.[8] Ms AKF took TF from the bathroom, told her not to sit on AF, and put her back to bed.[9] Ms AKF went back to the bathroom and asked AF if she was OK. AF said that she was and Ms AKF told her to rest before Ms AKF returned to her own bedroom.[10]

[2] Exhibit 1, tab 29, para 8-10.
[3] Exhibit 1, tab 30, para 5.
[4] Exhibit 1, tab 30, para 10.
[5] Exhibit 1, tab 26, Q/A 764.
[6] Exhibit 1, tab 26, Q/A 779.
[7] Exhibit 1, tab 27, Q/A 537.
[8] Exhibit 1, tab 26, Q/A 879.
[9] Exhibit 1, tab 26, Q/A 895.
[10] Exhibit 1, tab 26, Q/A 896.

15. About 5 minutes later Mr AC made his way from the toilet to the bathroom in order to wash his hands. He saw AF lying in the bath tub on her back. When Mr AC turned the light on he saw that AF appeared pale and that her eyes had rolled to the back of her head.[11] Mr AC called out to Ms AKF for help and picked up AF. Mr AC felt that AF's body was hot and limp. He tried to rouse AF by calling her name and patting her on the face. Mr AC turned on the shower and placed AF under the water in an attempt to cool down her body temperature, whilst still attempting to rouse her.

16. By this time, Ms AKF had come to the bathroom and Mr AC passed AF to her. He noticed that AF's body was still limp and he could hear that her breathing was laboured.[12] Whilst she was in Ms AKF's arms AF vomited. Ms AKF took AF to her bedroom and lay her down on the bed whilst she and Mr AC continued trying to rouse her. At this time Ms AKF described AF's breathing as irregular.[13] Mr AC went to call for an ambulance, telling the operator that AF had had a fit or seizure, that her eyes had rolled to the back of head, and that her breathing was laboured.[14] The operator told Mr AC that an ambulance was on the way and instructed Mr AC to lie AF down on the floor.

17. A short time later Mr AC heard AF struggling to breathe and then noticed that AF had stopped breathing.[15] Mr AC called for an ambulance again and told the operator AF had stopped breathing. The operator confirmed that an ambulance had already been despatched and told Mr AC to make sure that AF's airway was not obstructed. Mr AC did so and also felt for a pulse but could not find one.[16] The operator told Mr AC to immediately begin cardiopulmonary resuscitation (**CPR**) and provided instructions on how to do so.

18. Paramedics received the call to attend AF's home at 6:39am and arrived at 6:56am. They entered the house and saw AF lying on her back in the lounge room. Paramedic Keith Craig saw that Mr AC was performing mouth-to-mouth resuscitation. Paramedic Craig felt for a pulse but also could not find one. He opened AF's eyes and saw that her pupils were not reactive. The paramedics began chest compressions and prepared to use a defibrillator. Whilst doing so they attempted to obtain a history from Mr AC and Ms AKF.

19. Mr AC told the paramedics that he got up at about 6:30am that morning and found that AF was vomiting. Mr AC placed AF in the bathtub, went to wash his hands, and returned to find that AF's eyes had rolled back into her head and "*she was having a fit*".[17] Mr AC said that he cooled AF off in the shower, brought her to the lounge room and called an ambulance. At some point Ms AKF told the paramedics that TF had been sitting on AF's stomach.[18]

20. The paramedics turned AF on to her side in order to place the defibrillation pad on her back and saw some green coloured fluid, which appeared to be bile, drain from her mouth. When the defibrillator was turned on it showed that AF was in asystole with no electrical activity of the heart. Paramedic Craig attempted to open AF's mouth in order to insert a Guedel's airway[19] and

[11] Exhibit 1, tab 27, Q/A 543.
[12] Exhibit 1, tab 27, Q/A 564.
[13] Exhibit 1, tab 26, Q/A 932.
[14] Exhibit 1, tab 27, Q/A 578.
[15] Exhibit 1, tab 27, Q/A 581.
[16] Exhibit 1, tab 27, Q/A 597.
[17] Exhibit 1, tab 19, para [5]; tab 20, para [7].
[18] Exhibit 1, tab 19, para [5].
[19] A medical device used to open and maintain a patient's airway.

found that AF's jaw was stiff and that he could not insert the airway. As a result he commenced bag mask ventilation whilst the other paramedic continued with the chest compressions that she had been performing upon arrival at the scene.

21. By 7:03am another paramedic crew arrived. AF had been administered CPR by the paramedics for at least 9 minutes and had not been breathing since about 6:30am. AF was still in asystole with no pulse, had lividity in her upper back and shoulders, and her pupils were not reactive to light. At 7:05am the paramedics decided to stop the resuscitation attempts as AF was determined to be deceased.

The findings at autopsy

22. As AF had died in sudden circumstances where the cause of her death was not known at the time, her death was reported to the Coroner. As a result, AF was taken to the Department of Forensic Medicine located (at the time) at Westmead Hospital. Associate Professor Neil Langlois performed the autopsy on 11 February 2005. In a report dated 31 August 2005[20], Associate Professor Langlois noted the following relevant clinical findings:

    (a) There was a 1cm perforation of the small bowel around 140cm from its origin;

    (b) The serosa[21] around the bowel appeared necrotic and haemorrhagic, however the small bowel mucosa[22] at this site appeared normal with no evidence of haemorrhage or ulceration;

    (c) The bowel was markedly reddened with inflammation with red discolouration present through the full thickness of the bowel involving the serosal and mucosal surfaces, with no mucosal ulceration;

    (d) Opening the small bowel revealed two further areas of mucosal reddening;

    (e) On microscopic examination, the bowel perforation involved the full thickness of the bowel wall, through the muscular layer into the subserosa, with subserosal tissue markedly thickened by a granulating chronic inflammatory cell reaction.

    (f) There was a laceration of the anal margin extending into the skin, with mucosal haemorrhaging on the left internal wall.

23. In his report Associate Professor Langlois concluded[23] that the cause of AF's death was peritonitis.[24] Associate Professor Langlois noted that the peritonitis appeared old and that it was well established with a granulating response in the submucosa. Whilst noting that there was no data on ageing peritonitis in children, Associate Professor Langlois thought that the process must have been present for several days and possibly up to a week or more.

24. Associate Professor Langlois noted that the cause of the peritonitis was unclear but that it had most likely arisen from a perforation of the small bowel. Associate Professor Langlois noted 3 possibilities as the cause of the perforation:

[20] Exhibit 1, tab 4.
[21] A smooth tissue membrane consisting of a thin layer of cells, found on the outer walls of the organs of the abdominal cavity.
[22] Mucous membrane lining the inner surface of the stomach.
[23] Exhibit 1, tab 4, page 14.
[24] Inflammation of the lining of the intestines and organs within the abdominal region.

(a) The appearance of bowel disease involving the small bowel and anal margin was consistent with a clinical picture of Crohn's disease[25], however insufficient blood samples for testing could not confirm this diagnosis;

(b) Trauma in the form of a hard blow or pressure to the abdomen, although Associate Professor Langlois noted that it was unlikely that a mobile section of the small bowel would perforate and that there was no evidence there had been bleeding around the site of the perforation;

(c) The swallowing of a hard object or foreign body.

Initial involvement of the Coroner's Court

25. The autopsy report by Associate Professor Langlois, and other information that had been gathered about the circumstances of AF's death, was later reviewed by his Honour, former Deputy State Coroner Milovanovich. On 8 September 2005 his Honour dispensed with holding an inquest into AF's death. In his reasons for dispensing with the matter, his Honour recorded the following: "*On the balance of probabilities cause of death appears to have been from a natural cause…There is no evidence of assault or criminal offence. I am prepared to records [sic] this cause of death as a natural cause. [Cause of death] as per final [autopsy report]. Dispens*e.".

26. The effect of his Honour's conclusions is that the cause of AF's death was recorded to be peritonitis, and the manner of her death was recorded as due to a natural cause.

Relevant history regarding TF

27. At this point it is necessary to provide an account of some events between 2004 and 2006 that related to TF. This is because these events are relevant to determining the manner of AF's death, and are relevant to the question of whether there are any systemic issues connected with AF's death. Both matters will be discussed in more detail below.

28. In about August 2004 TF had an episode where her eyes rolled back and her right arm was stiff and straight whilst the rest of her body was limp.[26] After the episode, which lasted for a few minutes, TF appeared confused and drowsy and vomited a number of times over the subsequent 24 hours. Over the following 2 months TF had similar episodes 3 or 4 times, including one on or about 15 October 2004.

29. About a week after the first episode, Ms AKF noticed that TF's left eye suddenly turned in and, 3 days later, TF's right eye also turned in. TF was referred to an eye specialist (Dr Flaherty) for review. During this initial examination TF's eyes were found to be normal but a second appointment was made in 4 weeks time for TF to be reviewed. During this second examination it was noted that papilloedema (optic disc swelling caused by raised intracranial pressure) was present and arrangements were made for TF to be urgently admitted to hospital for an MRI examination to be performed.

30. TF presented to The Children's Hospital at Westmead (**Westmead Children's Hospital**) on 27 October 2004. An MRI was performed the next day. It revealed right frontoparietal fluid

[25] An inflammatory gastrointestinal disorder.
[26] Exhibit 1, tab 7, page 4.

(probably blood) collection which had been present for 1 to 2 months.[27] There were also subdural haemorrhages, along the floor of the left anterior, middle and posterior fossa, which had occurred more recently, possibly within 1 to 2 weeks of TF's admission. A skeletal survey on 29 October 2004 and CT scan of the head and neck on 1 November 2004 did not reveal any fractures. A neurosurgery consult was sought and an opinion was expressed that TF had intracranial haemorrhages of different ages which were most likely due to trauma.[28]

31. In an assessment report prepared by the paediatric fellow and senior social worker of the Child Protection Unit (**CPU**) at Westmead Children's Hospital, it was noted that no significant history of trauma for TF was identified by Ms AKF. It was also noted that no psycho-social issues suggesting harm or risk of harm to TF were identified.[29] The report noted that observation of interaction between TF and Ms AKF suggested no obvious concern, although it was noted that Mr AC had not been seen individually for any length of time.

32. Ultimately, the assessment report recommended that TF attend medical follow up as advised by the ophthalmological, neurological and general paediatric teams. The report also recommend that a risk of harm report be sent to the Department of Community Services (**DOCS**) (as it was known at the time) noting that whilst trauma (including non-accidental injury and through neglect) could not be confirmed as the cause of TF's injuries, it remained a possibility in the absence of other explanations.

33. TF was readmitted to Westmead Children's Hospital on 7 March 2005 for 2 days. She presented with headaches on both sides of the front of her head but was clinically stable and a CT scan of the brain did not identify any ongoing problems. TF was referred to a consultant paediatrician for follow up and was also scheduled to see a paediatric neurosurgeon. The head of the CPU, Dr Paul Tait, recommended to the manager of DOCS Blacktown that DOCS visit TF's family and evaluate them in more detail to see if risk factors were present. Dr Tait noted that the CPU remained concerned about the nature of the injuries and was unable to say whether they were the result of accidental or non-accidental injury.[30]

34. In August 2006 TF was referred to a gastroenterologist to investigate the possibility that she suffered from Crohn's disease. The gastroenterologist found nothing remarkable. However, being aware of AF's death due to peritonitis from a bowel perforation, the gastroenterologist raised the question[31] whether TF might have a leukocyte adhesion disorder.[32]

Related criminal proceedings and later involvement of the Coroner's Court

35. In June and July 2008 TF disclosed to Ms SG and other family members that Mr AC had allegedly been sexually and physically abusive to her and AF. These disclosures were reported to the police who commenced an investigation. This resulted in charges being laid against Mr AC and an eventual trial in the Sydney District Court. Mr AC was later found guilty of a number of offences, and convicted and sentenced on 28 March 2014.[33]

[27] Exhibit 1, tab 7, page 6.
[28] Exhibit 1, tab 7, page 7.
[29] Exhibit 1, tab 7, page 8.
[30] Exhibit 1, tab 8, page 2.
[31] Exhibit 1, tab 23.
[32] A disorder that causes the immune system to malfunction resulting in a form of immunodeficiency leading to recurrent infections.
[33] Exhibit 1, tab 54.

36. Three of the 11 offences that Mr AC was charged with related to allegations that, between about July 2005 and June 2008, he had assaulted TF by standing, or jumping, on her stomach. On two occasions this caused TF to defecate in her pants. Mr AC was convicted of two out of the three offences.

37. Mr AC was also charged with 2 offences relating to allegations that, sometime between July 2004 and February 2005, he had forcibly made TF insert a hairbrush into AF's anus. Mr AC was convicted of these two offences.

38. On 31 August 2012 Ms AKF wrote to her Honour, former State Coroner Jerram advising that Mr AC had been charged with the offences, and others, described above. Given the autopsy finding of laceration to AF's anal margin, and the abdominal pathology in the form of a bowel perforation, the nature of the offences that Mr AC had been charged with raised the possibility that his alleged actions towards TF might be causally connected to AF's death.

39. In response to the matters raised by Ms AKF, the former State Coroner directed that further investigation be conducted into the circumstances surrounding AF's death. This investigation included seeking further opinion from two experts: Dr Hugh Martin, a paediatric surgeon, and Dr Susan Marks, a paediatrician specialising in child protection.

40. As former Deputy State Coroner Milovanovich had retired from office by this time the option to have his Honour hold an inquest on the basis of the discovery of new evidence was not available. Accordingly, on 9 May 2017 his Honour, State Coroner Barnes, after obtaining the consent of the Chief Magistrate, made a direction pursuant to section 29(1) of the Act that I hold an inquest into AF's death. This requirement arose because the further evidence gathered from 2012 suggested that AF might have died as a result of homicide.[34]

Further expert reports

41. As noted above, in the course of the coronial investigation of AF's death from 2012 onwards a number of further expert reports were obtained. These further reports are summarised below.

42. Associate Professor Langlois prepared a statement dated 18 September 2013[35], supplementary to his original autopsy report, in which he noted:

    (a) Because the bowel perforation which AF suffered occurred in the mid-line overlying the spine it raised the possibility that the perforation occurred due to compression of the small bowel between the abdominal wall and the spine;

    (b) Compression leading to perforation of the small bowel could have arisen from a blow, blows, or hard pressure, including from one or more foot stomps.

    (c) The absence of bruising of the abdominal wall did not exclude blows, pressure or stomps as having caused the perforation as bruising may not occur because the laxity and softness of the abdominal wall could have caused it to deform and not bruise.

[34] Section 27(1)(a), *Coroners Act 2009*.
[35] Exhibit 1, tab 44.

(d) The perforation could have occurred from ingestion of a foreign body or from a fragment of bone that may have been present in food.

43. In a report dated 23 September 2013 Dr Marks opined that, in the absence of a history of major trauma (such as injuries sustained from a motor vehicle accident) AF's presentation with a bowel perforation was highly suspicious for inflicted injury. Dr Marks went on to explain that the injury would have required a significant amount of force, such as a kick, punch or stomp by a person of adult size and strength. Dr Marks further opined that AF's presentation would not be adequately explained by the actions of TF reportedly sitting on her stomach.[36]

44. Dr Martin was commissioned to consider some of the issues raised in the autopsy report and in the further statement of Associate Professor Langlois, and the report of Dr Marks. In his report[37] dated 16 February 2016 Dr Martin noted the following:

(a) Whilst there is no reliable method to determine the date of the onset of the peritonitis, it likely started at least 2 or 3 days before AF's death, and probably not more than 5 or 7 days beforehand.

(b) For a child in Australia, there are only a few causes of small bowel perforation with the most common being blunt or penetrating trauma. Penetrating trauma can be caused by foreign bodies. However, as no foreign body was found at autopsy, the peritonitis was generalised, and there was no penetrating wound, Dr Martin concluded that the cause of the perforation was blunt trauma.

(c) Blunt trauma to the stomach could have caused the bowel perforation. The factors relevant to Dr Martin's opinion included the large size of perforation, the site of the perforation over the prominence of the vertebral column, and the absence of any other cause. Dr Martin noted that the absence of bruising on the anterior abdominal wall did not exclude serious intra-abdominal injury from blunt trauma.

(d) Dr Martin excluded the possibility that swallowing a foreign body or hard object or bone fragment in food caused the perforation as the size of it was not compatible with a foreign body. Dr Martin noted that no foreign body was found at autopsy and one could not have disappeared after causing a perforation.

Results of the expert conclave

45. As the further reports from each of the 3 experts mentioned above raised a number of issues, a conclave involving Dr Langlois, Dr Marks and Dr Martin was convened on 13 December 2016. The experts were invited to consider a number of questions.[38] The significant results from the conclave are summarised below:

(a) All the experts agreed that the peritonitis arose directly from the perforation of the small bowel, with Dr Langlois noting that there was no other reason for AF to have peritonitis.[39] Dr Martin noted that the perforation was a free perforation, meaning that it was open to the

[36] Exhibit 1, tab 46, para 37.
[37] Exhibit 1, tab 49.
[38] Exhibit 1, tab 51.
[39] Exhibit 1, tab 52, T3.40.

whole abdominal cavity. This in turn implied that it was an immediate event and that there was no other antecedent event such as a swallowed foreign body, or intrinsic disease of the bowel (such as Crohn's disease) that would cause the perforation.[40] Associate Professor Langlois could not identify any natural disease process that could account for the perforation and Dr Martin specifically referred to the mention of Crohn's disease as a "*red herring*".[41]

(b) All the experts agreed that the site of the perforation being in the midline over the spine helped in determining the cause of the perforation. Whilst Dr Langlois noted that the small bowel is mobile, if it could be trapped between the anterior abdominal wall and spine it could be perforated due to a crush injury, Dr Martin noted that the small bowel has an average position. This meant that if it was found over the prominence of the spine (as it was in AF's case) then this was its usual location. Dr Martin went on to explain that the site of the perforation was "*classical of blunt trauma*".[42]

(c) Associate Professor Langlois believed that the absence of haemorrhage suggested that the perforation was not traumatic but this absence did not exclude trauma as the cause of the perforation. However, Dr Marks pointed out that focal haemorrhage of the serosa was detected microscopically at autopsy. Dr Martin pointed to the fact that the perforation had necrotic edges, which implied that the bowel was so crushed it died. Dr Martin went on to explain that blunt trauma could have either split the bowel wall, or it could have crushed it to the point where it became necrotic, resulting in later perforation a matter of hours, not days, later.[43] Dr Marks and Dr Martin later agreed that it was more probable that a traumatic perforation occurred and the bowel was ruptured at the time of the blunt trauma and that the edges subsequently underwent necrosis and autolysis[44] and disappeared.[45]

(d) All the experts agreed that it was impossible for the perforation to have been caused by a swallowed foreign body.[46]

(e) Dr Marks noted that immunology tests showed no evidence of leukocyte adhesion disorder and Dr Martin doubted that the possibility of AF suffering this disorder even needed to be raised because it was such a rare condition.[47]

(f) All the experts agreed that the bowel perforation and the forcible insertion of a hairbrush into the anus were two separate events with no connection between them.[48] All the experts also agreed that it was impossible for the perforation to have been caused by a 3 year old inserting their finger into the anus.[49]

(g) Associate Professor Langlois noted that there was no positive clinical evidence of trauma but qualified that by stating that an absence of injury (such as bruising) did not imply that trauma had not occurred. Associate Professor Langlois went on to explain that he initially did not factor in to his contemplation that the trauma might not have been a punch or kick,

[40] Exhibit 1, tab 52, T5.30.
[41] Exhibit 1, tab 52, T12.27.
[42] Exhibit 1, tab 52, T7.22.
[43] Exhibit 1, tab 52, T9-T10.
[44] The destruction of cells and tissues by their own enzymes.
[45] Exhibit 1, tab 52, T11.15.
[46] Exhibit 1, tab 52, T14-T15.
[47] Exhibit 1, tab 52, T16.42.
[48] Exhibit 1, tab 52, T18-T19.
[49] Exhibit 1, tab 52, T20.37.

but a crush or slower application of pressure. This could have perforated the bowel without leaving a trail of bruising.[50] Dr Martin pointed out that whilst there was no bruising at the site of the perforation, there was a large haematoma further down the small bowel which was evidence that trauma had been applied to the abdomen.[51] Associate Professor Langlois was less certain and said that whilst the area (described as reddened with inflammation, with the red discolouration present through the full thickness of the bowel wall) may be a haematoma or may be inflammation of the bowel, he eventually conceded that, whilst it was not conclusive, the area was likely to have been another area of blunt trauma.[52] Dr Martin indicated that he could not envisage any mechanism other than trauma as being responsible for the area.[53] Dr Marks also stated that the absence of visible bruising did not change her view that it was due to trauma.[54]

(h) Associate Professor Langlois described the two injuries (one at the perforation site and the other more distally) in the absence of bruising as being consistent with a crush injury. By this, Associate Professor Langlois meant the sustained application of force, such as somebody standing on the stomach or applying pressure with a hand for a sustained period.[55] However, both Dr Martin and Dr Marks thought that the blow would have to be delivered quickly if the mobile small bowel was to be trapped against the vertical prominence in order to perforate it.[56] Dr Martin explained by simply standing on the stomach would cause the bowel to "*squish away*".

(i) All the experts eventually agreed that blunt force trauma was the cause of the perforation with Associate Professor Langlois acknowledging that he "*should have come down more strongly on this at the time [of the autopsy]*".[57]

(j) In terms of the age of the trauma Associate Professor Langlois acknowledged that ageing of injuries is difficult overall and that children may heal at different rates to adults. However, looking at the healing response time following inflammation, Associate Professor Langlois indicated that perforation was at least 3 to 5 days old and suspected that it was older.[58]

What was the cause of AF's death?

46. None of the evidence and expert opinion gathered since Associate Professor Langlois' original autopsy report of August 2005 indicates that anything other than peritonitis was the cause of AF's death. Similarly, the totality of the medical evidence establishes that the peritonitis was caused by the perforation of AF's small bowel. The more difficult question to answer, at the time the autopsy report was prepared, was what caused the perforation.

47. In his autopsy report Associate Professor Langlois raised 3 possible causes of the perforation which were relevant to determining the manner of AF's death: Crohn's disease, trauma, and the swallowing of a hard object or foreign body. His Honour, former Deputy State Coroner Milovanovich reasoned that, in the absence of any evidence of AF being assaulted, it was more

[50] Exhibit 1, tab 52, T21.12.
[51] Exhibit 1, tab 52, T21.30.
[52] Exhibit 1, tab 52, T23.34.
[53] Exhibit 1, tab 52, T24.19.
[54] Exhibit 1, tab 52, T25.3.
[55] Exhibit 1, tab 52, T25.28.
[56] Exhibit 1, tab 52, T26.17.
[57] Exhibit 1, tab 52, T27.40.
[58] Exhibit 1, tab 52, T30.40.

probable than not that the peritonitis was due to a natural cause. On the basis of Associate Professor Langlois' opinion, and information gathered following TF's hospital admissions, the possibility of either Crohn's disease or leukocycte adhesion disorder were raised.

48. The combined expert evidence gathered from Associate Professor Langlois, Dr Martin and Dr Marks has excluded either of these natural diseases as being the cause of the perforation. Dr Martin described Crohn's disease as a "*red herring*" as the perforation was an immediate event and not one due to some intrinsic bowel disease. The possibility of leukocyte adhesion disorder was also discounted given the rarity of the condition and the fact that immunological testing of TF demonstrated[59] that she did not suffer from the disorder, which in turn meant that it was unlikely that AF would have either. Having regard to this evidence I conclude that the manner of AF's death was not due to a natural cause.

49. The possibility that the perforation was caused by a swallowed foreign body can also be excluded. All of the experts agreed that this was impossible with Dr Martin noting that such a mechanism of injury could not account for the size of the perforation and that if the injury had occurred in this way the foreign object which caused it would have been detectable at autopsy and was not.

50. **CONCLUSION:** Instead, the expert evidence overwhelmingly points to trauma as being the cause of the perforation. All the experts agreed that the absence of bruising did not exclude trauma as a possible cause. More importantly the finding of a haematoma in a distal area of the small bowel was, according to Dr Martin, due to trauma. This in turn added weight to the probability that the perforation itself was also due to trauma. The location of the bowel over the vertical prominence of the spine gave rise to the high likelihood that the perforation was caused when the bowel was trapped between this area and the abdominal wall. Given the agreement of all the experts, I conclude that bowel perforation was caused by trauma, with the blunt force which caused the perforation having been delivered quickly.

What was the manner of AF's death?

51. Unfortunately, the available evidence does not, however, allow for a conclusion to be reached as to how the trauma was occasioned; that is, whether it was the result of an accident, or whether it was the result of non-accidental, inflicted injury. Part of the difficulty arises from the fact that the combined expert evidence is unable to place an accurate timeframe on when the perforation occurred. Dr Martin and Associate Professor Langlois opined that the perforation was at least 2 to 5 days old (relevant to AF's death) with the possibility that it could have been older. In terms of the timing of events, this means that the perforation could have occurred whilst AF was in Victoria, or at some point in time after she returned to Sydney on 30 January 2005. Whilst there is no direct evidence that AF suffered some accidental trauma (such as an accidental fall[60]) which could account for the perforation, this cannot be excluded given the scarcity of evidence surrounding events during at least the period between about 30 January 2005 and 7 February 2005.

52. Mr AC's convictions for assault offences against TF (which involved standing, or jumping, on her stomach) during a period relatively proximate to AF's death, raises the possibility that the perforation was a non-accidental, inflicted injury. The possibility that the perforation was

[59] Exhibit 1, tab 23.
[60] Exhibit 1, tab 52, T27.21.

caused by TF sitting on AF's stomach can be excluded generally given Dr Marks' opinion that the force required for a blow significant enough to cause a perforation would have had to be delivered by a person with adult size and strength. The possibility that the perforation was caused by TF sitting on AF's stomach specifically on 9 February 2005 can also be excluded given the age of the perforation according to Dr Martin and Associate Professor Langlois. However, for the same reason as noted above, there is insufficient evidence regarding the period from about 30 January 2005 and 7 February 2005 to allow for a conclusion to be reached in this regard.

53. It should also be noted that during the conclave Associate Professor Langlois acknowledged that his consideration of trauma in the form of a crush injury was, to a degree, influenced by his knowledge of the facts of the criminal proceedings involving Mr AC.[61] Therefore, the possibility that Associate Professor's opinion regarding the way in which the traumatic injury occurred was affected by hindsight bias, cannot be discounted.

54. **CONCLUSION:** The mechanism by which the traumatic injury, resulting in bowel perforation, was occasioned cannot be determined with any precision on the available evidence. Therefore, whilst the manner of AF's death was due to traumatic injury, it is not possible to distinguish whether the injury occurred accidentally or was intentionally inflicted.

Possible systemic issues

55. TF's presentation to Westmead Children's Hospital with serious, and possibly non-accidental, neurological injuries less than 4 months before AF's death raises the question of whether intervention at that point in time might have resulted in a different outcome for AF. Of course, it is impossible to know the answer to such a question. However, investigation of this question involves identifying whether a sufficiently effective protective system exists to ensure that children and young persons are adequately protected from harm, and the risk of harm.

56. Consideration of this issue necessarily requires a review of what occurred after DOCS was advised of TF's injuries, what actions were taken by DOCS, whether those actions were adequate and appropriate, and whether, if a similar report were made today about any child, the response by the Department of Family and Community Services (**FACS**) would be adequate and appropriate.

Action taken by the former Department of Community Services

57. DOCS were first advised of TF's injuries and her admission to Westmead Children's Hospital on 5 November 2004, the day that she was discharged. This advice was provided by way of a report to the DOCS Helpline. Caseworkers from the Helpline visited TF's home at about 8:00pm that day but found no one home. As part of a case plan, they intended to interview TF separately, interview Ms AKF and Mr AC separately, consult with their team leader, and take any legal action necessary. Further follow up action would have involved obtaining further information about TF's admission to hospital and future medical treatment, and assessing the care arrangements for the children and adequacy of supports.[62]

58. Later on 5 November 2004 and on 6 November 2004, the caseworkers sought further information from Westmead Children's Hospital regarding TF's admission. On 6 November 2004

[61] Exhibit 1, tab 52, T25.35.
[62] Exhibit 1, tab 55, pages 4-5.

the caseworkers also attempted to contact Ms AKF 3 times by phone but were unable to reach her. The report regarding TF was later transferred from the Helpline to the Blacktown Community Service Centre (**CSC**). Further information was also sought by Blacktown CSC from the CPU at Westmead Children's Hospital and from the NSW Police in relation to Mr AC.

59. Apart from what is described above no other casework was conducted by the Helpline or Blacktown CSC, and no other attempts at a home visit were made, until AF's death on 9 February 2005.

Was the response from the former Department of Community Services adequate and appropriate?

60. Megan Beckett, the current Director Community Services for FACS, is responsible for the delivery of child protection and out of home services for the Western Sydney District. This area includes Blacktown CSC. In a lengthy statement made in preparation for the inquest, in response to questions posed by the Crown Solicitor's Office, Ms Beckett acknowledged that the 2004 report regarding TF is a "*tragic example of a failure by FACS to adequately assess the risk to TF and her siblings*".[63] Ms Beckett also makes the following concessions:

(a) It would have been sensible for DOCS caseworkers to have spoken to Ms SG and other members of TF's extended family (in particular Ms AKF's sister) in order to gather information regarding how Ms AKF and the twins were coping;

(b) Despite the uncertainty from the clinical staff at Westmead Children's Hospital regarding the cause of TF's injuries, an assessment of TF and the other children in the household should have been completed by Blacktown CSC. This should have occurred in order to determine if there was any harm or neglect, or any risk of harm or neglect present in the household in which TF and AF were living.[64]

What changes have been made since 2004 and what would be the response today?

61. Ms Beckett explained that if an identical report to the 2004 report regarding TF was received by the Helpline today a number of procedural steps would be followed in accordance with current FACS polices and guidelines. These steps include:

(a) The report would be categorised as a Risk of Significant Harm (**ROSH**). Furthermore, injuries such as the ones suffered by TF would warrant entry of a ROSH report under the category of serious non-accidental injury.[65] A similar ROSH report would be created for any sibling in the household such as AF.

(b) These reports would be transferred to Blacktown CSC. The matter would be referred to the After Hours Crisis Response Team (**CRT**) and the reports would be escalated to senior management level within Helpline and Blacktown CSC to ensure appropriate supervision.

(c) As part of its response Blacktown CSC would:

(i) conduct a joint home visit along with a Joint Investigative Response Team;

[63] Exhibit 1, tab 55, page 13.
[64] Exhibit 1, tab 55, page 7.
[65] Exhibit 1, tab 55, page 8.

(ii) conduct face-to-face assessments of TF and her siblings;

(iii) conduct a safety assessment to determine if TF or her siblings were in immediate risk of harm;

(iv) develop a safety plan to reduce any immediate dangers identified by the safety assessment or develop protective intervention strategies if a safe home environment could not be provided;

(v) conduct a risk assessment within 30 days of the first home visit.

62. One of the concerning features regarding the 2004 report in relation to TF is that after some preliminary steps being taken, no further casework was performed until AF's death. In her statement Ms Beckett pointed to a number of features of the current systems which ensure compliance with timeframes and policies, and to ensure that timely decisions are made, particularly in relation to allocation of reports and assessments. Some of these features include:

(a) the creation of the After Hours CRT, which did not exist in 2004, which allows for action to be taken and followed up outside of core hours;

(b) the escalation of appropriate matters to ensure greater oversight and monitoring at a senior level within FACS;

(c) the development of new triage and assessment guidelines for ROSH reports;

(d) the creation of a Safety and Risk Assessment (SARA) tool to identify risks to children, taking into account the circumstances of all members of the household with policy requirements to ensure that assessment and intervention occurs within a timely manner and that a matter cannot be closed without thorough review by a senior FACS employee[66]; and

(e) legislative changes since 2009 now allow for greater information sharing and open communication between government and non-government agencies to ensure a collaborative approach to conduct accurate and effective assessments.

63. Given the frank concessions made by Ms Beckett it is clear that the response by DOCS to the 2004 report relating to AF was neither adequate nor appropriate. This response appears to have resulted from a number of systemic shortcomings. Since 2004 a number of changes and improvements have been made to address these shortcomings. Resource considerations will always be a consideration in the delivery of any governmental service. However, the expectation for children at risk within our community is that an adequate protective framework, driven by appropriate policies and quality control, exists to ensure that children are protected from harm, or the risk of harm.

[66] Exhibit 1, tab 55, page 16.

64. **CONCLUSION:** The changes made by FACS since 2004 address the shortcomings that were present in TF's case. It is impossible to know whether, had these shortcomings not been present in 2004, and if earlier intervention had occurred at that time, there would have been any difference in the outcome for AF. However, the evidence establishes that if an identical report to TF's were made today, the risk of similar shortcomings would be mitigated by the system improvements made since 2004. This in turn would mitigate the risk of a child the subject of such a report (and any of their siblings) being exposed to harm, or the risk of harm. Accordingly I conclude that the available evidence does not indicate that it is necessary or desirable for any recommendation relating to public health and safety to be made pursuant to section 82 of the Act.

Findings

65. Before turning to the findings that I am required to make, I would like to acknowledge and thank Ms Donna Ward, Counsel Assisting and Ms Carolyn Berry, instructing solicitor from the NSW Crown Solicitor's Office. I am extremely grateful for their enormous assistance, insight and diligence both during the inquest and during the many months spent preparing for it. I would also like to thank and express my appreciation for the efforts of the police officer-in-charge of the investigation, Detective Sergeant Christian Olivares and his team of investigators.

66. The findings that I make under section 81(1) of the Act are

Identity
The person who died was AF.

Date of death
AF died on 9 February 2005.

Place of death
AF died at Marayong NSW 2148.

Cause of death
AF died from peritonitis.

Manner of death
The peritonitis was caused by the perforation of AF's small bowel. The perforation was a traumatic injury and not due to a natural disease process or misadventure. However, the available evidence does not allow for a finding to be made as to the mechanism of injury.

Epilogue

67. Mere words cannot describe the devastating impact that AF's death has had on her family, and in particular on Ms AKF and TF. There is no doubt that the more than 12 years that have passed since AF's death has not lessened their painful and traumatic memories. To have the life of a beautiful girl, a beloved daughter, granddaughter and great-granddaughter, and loving twin sister, taken away at such a young age is truly heart-breaking.

68. On behalf of the Coroner's Court, and the counsel assisting team, I offer my most sincere and respectful condolences to AF's family for their tragic loss.

69. I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
1 December 2017
NSW State Coroner's Court, Glebe