STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of MR
Hearing dates:	12 August 2024 – 13 August 2024
Date of findings:	4 November 2024
Place of findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Magistrate Kasey Pearce, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of 4-month-old baby - child and siblings known to Department of Communities and Justice - cause and manner of death
File number:	2017/146688
Representation:	Mr C McGorey, Counsel Assisting the Coroner, instructed by Mr L Sampson (Crown Solicitor's Office)
Non publication order:	A non-publication order has been made pursuant to section 74(1)(b) of the Coroners Act 2009 (NSW) in relation to the name of the deceased and members of her family. A copy of this order is on the Registry file.
Findings:	MR died on 16 May 2017 at Sydney Children's Hospital in High Street, Randwick. The cause of MR's death was hypoxic brain injuries. MR died as a result of an unexplained, unnatural restriction of oxygen that occurred on 13 May 2017 at her home while she was in the care of her father.

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Section 18(1) of the Coroners Act requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of MR.

1 Introduction

1.1 This inquest concerns the tragic death of a four-month-old baby, MR (born 28 December 2016).

1.2 MR died at 2:10 am on 16 May 2017 at the Sydney Children's Hospital, Randwick (SCHR), as a result of hypoxic brain injuries.

1.3 MR was the third child born of the relationship between her mother, TD, and father, AR, who were aged 21 and 22 respectively at the time of her death. MR's elder siblings were aged 4 years and 1 year when MR died.

1.4 The relationship between MR's parents had many challenges. They were young parents with three children under 5 years old and were both regular users of methylamphetamine. Their relationship was also characterised by domestic violence. In the years since MR's death, it is clear that both TD and AR have made significant and positive changes to their lives.

1.5 Had MR lived, she would have been looking forward to her eighth birthday at the end of this year. Both MR's parents and members of MR's extended family attended the inquest. All were visibly emotional at various points in the evidence. At the close of the inquest, counsel assisting read a short statement prepared on behalf of MR's maternal family, which made apparent how lovingly MR is remembered and how much she is missed. Each year her family celebrates her short life with the release of balloons in her memory.

1.6 In making these findings I acknowledge the profound impact that MR's death has had, and will continue to have, on both her immediate and extended family and extend my sympathies for their loss.

2 Scope of the Inquest

2.1 Under section 81 of the *Coroner's Act 2009* (the Act) the role of the coroner is to make findings as to the identity of a person who has died, when and where they died, and the cause and manner of their death. A coroner may hold an inquest if it

appears that the manner and cause of a person's death have not been sufficiently disclosed.

2.2 Section 24(1)(c) of the Act provides that only a senior coroner has jurisdiction to hold an inquest concerning a death or suspected death if it appears to the coroner that the person was a child, or the sibling of a child, in respect of whom a report was made under Part 2 of Chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998* within the period of 3 years immediately preceding the child's death. MR falls into this category. In such cases, there is a clear public interest in ensuring that the death of a vulnerable child, who has previously been reported to the Department of Communities and Justice (DCJ),[1] is fully investigated to ascertain whether the state should have provided greater assistance to the child's family or whether missed opportunities for care and support can be identified and rectified.

2.3 The Serious Case Review (SCR) Unit of DCJ reviews child deaths and other serious cases concerning children known to DCJ. In March 2018 the SCR Unit completed an internal review of DCJ practice with MR's family before MR's death. The internal review considered the background and child protection history of MR and her family and identified areas for practice improvement. Documents that comprehensively outlined the results of the internal review and the changes to DCJ practice that resulted from the internal review were provided during the coronial process. It was encouraging to read that MR's death had played a part in significant changes being made to DCJ practice that will hopefully ensure that in the future greater support is provided to families like that of MR. The information provided by DCJ during the coronial investigation resulted in a narrowing of the focus of the inquest to issues related solely to the statutory findings to be made under section 81 of the Act.

2.4 In this inquest, MR's identity, date, and place of death were uncontroversial. However, a range of issues arose from the varying accounts given by MR's parents of events leading up to her death, and from the expert evidence, as to the manner and cause of MR's death. Most of the evidence at the inquest was contained in the

[1] I have used the acronym 'DCJ' throughout this document to refer to the organisation with primary responsibility for child protection in NSW, although in the past it has operated under various names and acronyms.

three-volume brief of evidence, which was tendered at the commencement of the inquest. I also heard oral evidence from three medical experts: Professor Robinson, Dr Sugo and Dr Bailey, as well as from MR's mother, TD.

3 MR's life

MR's parents

3.1 MR's parents, TD and AR, met at a young age, in or about September 2011 when TD was 15 years old, and AR was 17. TD ran away from home about 2 weeks after meeting AR and lived with him and his family in Temora. They began having children early in their relationship, with their eldest child born in December 2012. By that time MR's parents were living in their own flat in Temora. There were difficulties in the relationship, which led to DCJ becoming involved with the family. For a period, MR's eldest sibling was placed into the care of her maternal grandmother, although she was eventually returned to the care of her parents.

3.2 By the time the couple had their second child, in September 2015, they had moved to Wagga Wagga. TD described her relationship with AR as 'hectic' which, she explained, meant physically and emotionally abusive. Both parents had begun to use methamphetamines regularly from the time their eldest child was about 1 year old. There was also domestic violence in the relationship, running both ways. Although some instances of violence were reported to police, many were not.

3.3 At the time of MR's death there was a 12-month apprehended domestic violence order in place for the protection of TD from AR, which had been made at Wagga Wagga Local Court on 23 August 2016 in terms of the mandatory conditions only. This related to an incident said to have occurred on 6 August 2016 when TD alleged that AR had kicked her in the stomach when she was 5 months pregnant with MR.

MR's birth

3.4 TD was first seen by midwifery staff at the Leeton Health Service on 8 November 2016 in relation to her pregnancy with MR, and a booking was made for her to give birth at Wagga Wagga Rural Referral Hospital (WWRRH). An assessment done at this time identified that TD was vulnerable and experiencing various psychosocial issues. A note was made that the social worker at WWRRH should follow up to offer services to TD once the baby was born.

3.5 MR was born at WWRRH on 28 December 2016 after a short labour. TD disclosed that she had been using 'ice' in the first 20 weeks of the pregnancy, so MR stayed in hospital for 7 days after her birth so she could be monitored for symptoms of withdrawal. There were no signs of withdrawal.

3.6 On 28 December 2016 a social worker spoke to TD at WWRRH. TD reportedly said that she did not want to be linked to any support services. The same day the Murrumbidgee Local Health District (MLHD) notified DCJ about its concern for TD's other children. DCJ advised that it had determined that a statutory response was not warranted. On 29 December 2016 the same social worker again spoke with TD at the hospital. TD again said that she did not want to be linked to support services. This appears to have been the social worker's last contact with TD before her discharge from WWRRH on 30 December 2016.

3.7 An incident occurred on 1 January 2017 that resulted in AR being charged with assaulting TD and breaching the AVO that was in place for her protection.

3.8 Following TD's discharge from WWRRD, the hospital notified her general practitioner of MR's birth and reported the domestic violence incident that had occurred between MR's parents on 1 January 2017.

3.9 MR was discharged from WWRRH on 2 January 2017.

After MR's discharge from hospital

3.10 On 7 January 2017 Midwifery Community Care had contact with MR. She was noted to be 'settled' with no concerns being identified. After this a referral was made to the Wagga Child and Family Health Nursing Service (WCFHN). On 9, 10 and 11 January the WCFHN attempted to contact TD without success.

3.11 On 16 January 2017 DCJ caseworkers with the Wagga Wagga Community Service Centre carried out a face-to-face assessment with TD. The caseworkers assessed the children to be at 'high risk but safe with a plan'. A 'safety plan' was agreed to by MR's parents.

3.12 On 17 March 2017, following the WCFHN advising DCJ that it had been unable to contact the family over a 9-week period, caseworkers assessed MR and her siblings to be at 'high' risk'. Because of the 'high risk' assessment, on 24 March 2017 at a weekly allocation meeting, caseworkers discussed MR and her family. The DCJ file was closed, however, on 29 March 2017 due to 'current competing priorities'.

MR's health up to 13 May 2017

3.13 MR was seen by Dr Snyman, consultant paediatrician at WWRRH about a month after her birth. Dr Snyman noted no concerns for either MR or her mother at that time.

3.14 MR received her 2-month immunisations on 13 February 2017. At the time of her death, MR had not yet received her 4-month-old immunisations as, according to TD, she was unwell at the time the immunisation was due.

3.15 MR was bottle fed from birth. She had difficulties with reflux and her parents changed her formula several times to address these difficulties. According to TD, she had taken MR to 'all the paeds' to obtain some assistance in relation to the reflux issues.

3.16 MR's medical records show that TD had taken MR to see Dr Preddy at Riverina Paediatrics on 24 January 2017. TD reported bottle feeding MR, although she was vomiting with every bottle. MR was assessed to be 'alert and well' and 'clinically well and gaining weight'. The paediatrician recommended a reduction in the volume of individual feeds.

3.17 TD also took MR to see Dr Zahiri at the Glenrock Country Practice on 2 March 2017 in relation to what is described as 'projectile vomiting' and 'slow gain of weight'. As a result of this consultation, Dr Zahiri referred MR for an ultrasound to investigate the possibility of pyloric stenosis, a condition that blocks food from entering the small intestine. No evidence of pyloric stenosis was found during the ultrasound, which was conducted on 2 March 2017.

3.18 A further consultation on 20 March 2017, this time with Dr Sedrak, records that MR was 'improving since changing formula'.

3.19 MR had no difficulties with sleeping or any other health problems. According to her mother she did not consume as much formula as was recommended for a child her age. Despite this, her mother described MR as 'still healthy' and 'a big girl'.

4 Events of 13 May 2017

Triple 0 call

4.1 At 5:19 pm on 13 May 2017 AR made a call to triple 0 requesting emergency assistance for MR.

4.2 During this call AR says *'…there's something wrong with our baby…Um, we, she's actually stopped breathing. We've just fed her a bottle and then she's like and started like she was spewing it back out but it started coming out her nose.'*

Ambulance records

4.3 Paramedics arrived at MR's home in response to the triple 0 call at 5:24 pm. On arrival AR was holding MR and is recorded as stating to ambulance officers '*she's breathing now. She just vomited*.'

4.4 In relation to MR's presentation at this point, ambulance records note *'Pt breathing spontaneously, full body cyanosis. Pt eyes open…unresponsive to pain. Pt body stiff? Decorticate posturing. Rapid extrication to ambulance. Immediate oxygen therapy applied. O/E 100% O2 therapy administered via BVM – without ventilating patient. No obvious airway obstruction. Mother states 'baby was having a bottle when she stopped breathing. She went floppy then I gave her CPR and mouth to mouth then she vomited.'*

4.5 According to ambulance records TD told paramedics *'baby has had a cold and wouldn't take bottle today.*' The ambulance records further note '*Pt has small marks/bruising to mouth area and bruising to left arm*'.

Wagga Wagga Regional Referral Hospital

4.6 TD travelled with MR in the ambulance, which arrived at WWRRH at 5:42 pm. MR was triaged at 5:48 pm by a team of medical specialists that included Paediatric Registrar, Dr Paul Hotten. Consultant Paediatrician, Dr Natalie Snyman, attended at 6:30 pm.

4.7 On arrival at WWRRH MR was noted to be moving all her limbs initially then become symmetrically stiff with arms and legs in extensor posture. MR had clinical signs of respiratory distress. She was placed on a Neopuff to provide more breathing support, oral suction was performed to clear any obstructions to her airway, and her stomach contents were removed to help with breathing capacity. She was given intravenous antibiotics and antiviral medication for the management of possible sepsis. She was also given intravenous fluid for resuscitation and maintenance hydration and intravenous anti-seizure medication due to possible seizure activity.

4.8 Dr Hotten described seeing an abrasion to MR's upper and lower lip but no intraoral injury. MR is also recorded as having a small abrasion to the nose and an elliptical C shaped 'yellow-brown bruise' to her left upper arm about 4 cm in diameter.

4.9 The following history given by TD is noted in the WWRRH records of 13 May:

> *This morning 0400 mother concerned about baby being stiff in the arms and legs extended with hands and toes clawed. Lasted about 1 hour then was quite sleepy during the day today, not feeding and only 1 wet nappy. Says she told her partner that the baby was not right. This evening mum in shower while baby being fed a bottle by father. He brought baby into mother – blue, unresponsive, not feeding and floppy. Mother commenced CPR – 1 breath to 3 compressions for 10-20 seconds, then baby vomited. Ambulance called. Mother describes further episode of stiffening when the ambulance arrived.*

4.10 The medical records note the following history taken by Dr Hotten from MR's father, AR:

- Father was feeding the baby.
- Baby took 180 ml of formula.
- He reports that the baby was feeding well today, says there was nothing wrong.
- He was burping the baby, patting back.
- Baby vomited all the milk.
- Does not describe choking from the vomit – became floppy and not breathing.
- Baby went blue.
- Reports mother entered the room when baby floppy and commenced CPR while he called the ambulance.
- Father report that the bruise to the lip has been there for 2 days – he reports that the 4 yr old sister gave her the wrong bottle, does not describe forcing bottle.
- Does not know how the baby got a mark to the left arm – says maybe [the second sibling] did it, she is often rough with the baby.

4.11 MR's condition did not improve while she was in the hospital. Ultimately the medical team at WWRRH decided that she required tertiary level paediatric care and support, and the Neonatal and Paediatric Emergency Transport Service (NETS) was contacted. MR underwent a CT of her brain before NETS retrieval to make sure

there was no acute bleeding. The CT was reviewed by the on-call radiologist who did not see any evidence of intracranial haemorrhage.

4.12 At the time of her discharge from WWRRH the cause of MR's presentation was unclear. Dr Snyman thought it most likely MR had an infective process such as encephalitis/meningitis, although she considered a non-accidental injury/hypoxic event because of the facial and arm bruising. A referral to the Child Protection Unit (CPU) at SCHR was recommended due to the need for more clarification around the injuries noticed on MR's skin.

4.13 MR was discharged from WWRRH at 11:45 pm on 13 May and was airlifted to SCHR. Neither parent was permitted to travel in the aircraft with MR. Both parents travelled by bus to Sydney the following morning.

5 Events of 14 May 2017 – 16 May 2017

Sydney Childrens' Hospital, Randwick

5.1 MR was admitted to the SCHR at 2:15 am on 14 May 2017. It appears that MR's parents arrived at the hospital sometime that afternoon. At 7:58 pm Senior Medical Officer Annie Bye made a progress note recording the history given to her by MR's parents

- Runny nose for 2 days
- Yesterday not herself all day
- Woke 4:30 am
- Probably had feed
- Episode of tonic stiffening of arms and legs for 2 minutes
- Slept all day
- Small noises but not much crying
- Fed 3 times – 120 mls, 60mls, 120 mls
- 5:30 pm: Father fed her.
- [MR] vomited out of mouth and nose
- Floppy
- Purple
- Not breathing
- Mother gave CPR

- 2 other children – normally well, all have flu like illness, 2 x female siblings

5.2 MR had clinical features of raised intracranial pressure. She was managed for the raised intracranial pressure and suspected infection. The SCHR medical notes record that there were a few features noticed on MR's skin of suspected non-accidental injury. MR's condition worsened during her time in hospital. An MRI of her brain showed extensive brain injury such that medical staff determined that neurological intervention should not be pursued.

5.3 On 15 May MR's parents were advised that the injuries that had occurred to MR's brain were non-survivable. MR's parents agreed to provide only comfort care to MR. As a result of this, at 1:30 am on 16 May all ventilation and monitoring devices were removed.

5.4 MR died in her mother's arms at 2:10 am on 16 May 2017.

6 Accounts given by MR's parents after her death

TD's account to police on 16 May 2017

6.1 Hospital staff contacted police soon after MR's death and a number of police officers arrived at the hospital.

6.2 At about 4:10 am Leading Senior Constable (LSC) Kelly Gatt and Senior Constable (SC) Robert Townsend from Maroubra Detectives spoke to TD in a room at SCHR. SC Courtney James was also present. LSC Gatt made handwritten contemporaneous notes of her conversation with TD. She records TD as giving the following account of the circumstances leading up to the triple 0 call on the evening of 13 May.

- The whole house has had the flu- all the kids and us as well since Wednesday – treated [MR] with Children's Panadol drops in her milk
- [MR] had a runny nose but was otherwise she was fine and feeding as normal
- Not herself during the day – very sleepy
- 5:30 pm [AR] feeding her
- I was in the shower with the two other girls and when he came in holding her she was purple and floppy
- I put her on the floor and felt her chest. There was no movement.
- I gave her one breath and two compressions then another breath.

- She spewed heaps of formula from her mouth and nose.
- [AR] was on the phone to 000 at the time.
- She came to but was dazed and her eyes were only half open.
- She was trying to breathe but was struggling.
- Then the ambulance got there.
- The bruise on the arm could be from [the second sibling]– she may have hit or kicked [MR] – [the first sibling] tries to mother her all the time – she could have done something – or from the bouncer.
- The bruise on the lip could be from [the first sibling] – she tried to feed her with the Baby Born bottle which is a hard toy bottle.

6.3 SC James also makes a record of this conversation, which accords with the notes made by LSC Gatt, with the following exceptions:

- [the second sibling] tried to feed [MR] with baby born bottle
- '[the second sibling] is the only one that is rough with her'
- '[the second sibling] climbs into the cot sometimes'
- '[the second sibling] was daddy's girl + maybe jealous'

6.4 MR's parents and extended family clearly did not respond well to the involvement of police in the immediate aftermath of MR's death. TD is recorded as saying to Sergeant Morgan words to the effect of *'If you think I've done something to her there's something wrong with you.'* The notes made by SCH Social worker, Maria Coelho, record that TD and AR '*spoke of the pain of losing [MR] and of their difficult experience with the Police process*' and that MR's paternal grandmother '*spoke of feeling that the whole family was being treated as criminals*.'

6.5 Despite repeated attempts on the part of police to obtain formal statements from MR's parents over the months following MR's death, neither TD nor AR gave a statement to police. However, on several occasions between June and September 2017 TD is recorded as commenting to DCJ caseworkers that MR would still be alive if AR had allowed her to take MR to the hospital.

TD's recorded interview with police on 9 July 2021

6.6 On 9 July 2021, more than four years after MR's death, TD, who was by now 25 years old, participated in an interview with then SC (now Sergeant) Tim Brakenridge and SC Michael Hoogvelt. According to TD, she and AR had separated in February

2020 when TD was sentenced to a period of full-time custody for breaching an apprehended violence order for AR's protection. AR's criminal history suggests that at the time this interview took place, AR was serving a 15-month full time custodial sentence for domestic violence offences, although it's not clear whether these offences related to TD.

6.7 In July 2021, TD's recollection of the events of 13 May 2017 was that she and AR had slept most of the day and then gone down the road to AR's mother's house with their three children for dinner. According to TD, she left with the two older children after an incident at AR's mother's house. About 5 pm, after they arrived home, TD had a shower with the older two children for about 30 minutes. AR was meant to be feeding MR. At some point AR came to the bathroom door with MR. According to TD, she could see that MR was starting to go blue and her eyes were rolled into the back of her head. She grabbed MR out of AR's arms, put her on the bedroom floor, and began to give her CPR. She yelled at AR to call an ambulance. TD said she commenced CPR with her fingers and then MR '*done this big power spew of water*' but '*she wasn't all there'*. She said the conversation AR had with 000 was on speaker. The ambulance arrived 'within seconds', they placed oxygen on MR and took her to hospital.

TD's recorded interview with police on 1 July 2022

6.8 TD gave a further recorded interview to police a year later, on 1 July 2022. This interview took place in the context of police advising TD of the contents of an expert report from Professor Robinson into the cause of MR's death, in which he opined that MR had died due to hypoxic brain damage due to an unexplained physiological restriction of oxygen to the brain. While at the time of the July 2021 interview TD had still been using drugs, by the time of this interview, TD had been free of illicit drugs for 12 months.

6.9 TD gave an account of a time when AR told her that the second sibling had pulled MR off the lounge onto a mattress and other occasions when the father had been sleeping with MR on the lounge and the father had told TD that MR had fallen off the lounge.

6.10 In relation to the 'stiffening event' during the early hours of 13 May 2017, TD stated that MR had woken up crying at about 3 am on 13 May 2017. TD had made MR a bottle but she refused to have it. She then said:

She was doing this really weird thing where she was putting her body out, straight like that, and crying, like, just screaming for, like two or 3 minutes, and then she would stop, and then she'd do it again…and because of her reflux and prior constipation issues with her, I thought, maybe she's constipated…So I gave her some of that Infacol, didn't help. She done it, like four or five times. I woke [AR] up, and I said to him, She's doing this really weird thing, and it's really worrying me. I want to take her to the hospital, and he told me, No she'll be fine, look, she's gone back to sleep. And then that night is when she stopped breathing.

6.11 TD also described another event that occurred when MR was about 2½ months old.

'…[AR] was in the shower with her, and I was out in the back, hanging clothes on the line, and there was…there was a fire out the back, and it was coming towards the house. And I went inside and was tell, er, like, told him, and he got out of the shower, and he come outside to look too. And when I went back inside, she was face down in the bath, and when I got out of the bath, she wasn't OK, and I pat like, I whacked her on the back a couple of times, and she spat it out, like all this water. And I said to him then, as well, she needs to go to the hospital, she needs to go to the hospital, she needs to go to the hospital, er, and he refused to let me take her.'

6.12 In both the 2021 and 2022 interviews TD was at pains to emphasise that although AR had been violent towards her (that is, TD), she had never witnessed him being violent towards any of the children. She described him as a 'brilliant dad' and an 'amazing dad.' She explained that the reason she hadn't told the police some of the information contained in her 2021 and 2022 interviews earlier was because she didn't want to get either herself or AR in trouble.

TD's evidence at the inquest

6.13 TD gave oral evidence at the inquest, in which she was taken to various parts of the previous accounts she had given medical staff and police about relevant events in MR's short life and the circumstances leading up to the triple 0 call on 13 May 2017.

6.14 TD's evidence was that at the time MR died, she and AR were using 'ice' intravenously several times a week. Further she explained that she, AR, and the

children were living away from TD's extended family and friends, and her only support nearby was AR's mother, who lived down the road. She described a division of labour between her and AR in relation to caring for the children, where she was primarily responsible for the older children and AR was primarily responsible for MR. She agreed that although there had been violence in her relationship with AR, that she had never witnessed AR be violent or excessive in terms of his interactions with any of the children.

6.15 TD described that at the time of MR's death MR was taking a bottle of about 200 ml at each feed, comprising 180 ml of boiled water and 2 scoops of formula. MR could not, however, consume the whole bottle at once, but would need to have her feeds broken down with breaks in between to allow for her reflux, meaning that a single feed might take an hour or more. She said there was no possibility that MR had consumed 180 ml of formula when fed by AR on the evening of 13 May 2017 because of the difficulties she had with reflux and the time it took to feed her because of this.

6.16 In relation to the events of 13 May 2017, TD's account was that she was sleeping on a mattress in the loungeroom with MR and her two older siblings when she woke up at about 3:00 am to MR crying/screaming and straightening out her limbs. She did this for two or three minutes at a time and then she'd stop for a minute or two and then do the same thing again. According to TD she 'thought maybe it was just the constipation' so she tried Infacol to see if that would settle MR, and she settled after about an hour and a half. TD agreed that during the remainder of the day MR didn't feed much at all and was sleepy. She said her cry after the early morning incident was normal. TD said that she had suggested at the time to AR that they should take MR to the hospital but that she didn't suggest it again later in the day because she was fearful of AR.

6.17 TD's evidence was that she had never had cause to question AR about what had happened immediately prior to the triple 0 call on 13 May 2017 because up until the second interview she had given police, she was under the impression that MR had died from meningitis or some other natural cause. She said that she had not noticed any of the injuries to MR's face and did not know of the healing rib fractures until they were brought to her attention during the 2022 interview. She confirmed however that there were times when she had seen the second sibling put a 'Baby Born' bottle

into MR's mouth, that the second siblings did climb into MR's cot sometimes, that she had been told by AR that the second sibling had pulled MR off the lounge, and that there had been an occasion/s where AR had been sleeping with MR on the lounge and he told TD that MR had fallen off, although she never had cause to believe that MR was injured in any way.

6.18 TD also gave evidence about the occasion when there had been a fire and she had found MR face down in the bath. Her evidence was that the fire had been at a nearby property and that AR had been having a shower with MR who was in a shower chair. AR left the bathroom because of the fire and when TD returned to the bathroom, she found the water outlet in the bath was blocked with a face washer and MR was face down in the bath. According to TD she tapped MR on the back a couple of times, and she brought up some fluid. MR was about two and a half months old when this incident occurred. TD described the fire as having occurred in the property behind the house in which MR and her family were living. She recalled that firefighters had been called to the fire. TD explained that she had not mentioned this incident in her first interview with police because '*it actually come back to me in a nightmare after a period of time, and up until I had found out about the hypoxic brain damage, I tried my hardest not to think of or remember things from back then.'*

6.19 Inquiries made by the OIC, Detective Sergeant Tim Brakenridge revealed that the only record of a fire occurring at a property that shared a boundary with the home that MR lived in with her family, was of a fire that had occurred on 21 September 2018, more than a year after MR's death.

6.20 TD was candid in admitting that her drug use over a long period of time had affected her memory and her ability to gauge time. She said *'…the one thing I do know is, I regret my drug use, I regret putting my children through what they went through, and if I had had just stayed with my mum when I was pregnant with [MR], she'd probably still be here today.'*

7 The Cause of MR's death

Report of death to the Coroner

7.1 In a written report of MR's death to the coroner, dated 16 May 2017, Dr Mun Tiong (SCHR Registrar) listed the cause of death as hypoxic ischaemic brain injury with worsening cerebral oedema. The cause of this was 'uncertain' but the doctor noted

'infection/inflammatory cause still possible'. The possibility of meningitis/sepsis was also noted. The significance of the markings to the lips and nose and what was described as a 'bite mark' on the left arm was 'unclear'.

Post mortem report

7.2 On 17 May 2017 forensic pathologist, Dr Kendall Bailey, conducted an autopsy on MR's remains. In her report Dr Bailey noted that although MR was small for her age (59 cm, 5.243 kg), she was well developed, well-nourished and hydrated. Dr Bailey relevantly noted the following:

1. a bruise on the right side of the lower lip and small abrasions over the right side of the nose;
2. an L shaped area of bruising on the left upper arm, which after consultation with a forensic odontologist, Dr Bailey did not consider to be a bite mark;
3. remote reactive changes in the anterior ribs (left 6-8 and equivocal changes in right rib 9) strongly suggestive of healing rib fractures;
4. a radiological area of calcification in the right tibial plateau, although histological examination of this region could not confirm any abnormality;
5. a swollen brain in keeping with hypoxic brain injury, but without evidence of intracranial haemorrhage, fracture or subdural haematoma;
6. rhinovirus in the trachea and lungs;
7. well established inflammatory changes in the lungs including pneumonitis, pneumonia and possible early diffuse alveolar injury; and
8. no evidence of blunt force trauma

7.3 Dr Bailey concluded:

While hypoxic/ischaemic brain injury is the demonstrable cause of death, the underlying pathological process that caused the initial apnoeic arrest is unclear and in the presence of remote and recent unexplained injuries the cause of death is best left as unascertained as precipitating factors may be natural or potentially unnatural.

7.4 Ultimately Dr Bailey recorded MR's cause of death as 'unascertained'.

Evidence of rib fractures

7.5 In the opinion of Dr Nasreddine, Radiologist, radiological scans revealed expansion of the anterior margin of the left 6th, 7th, and 8th ribs with chronic fractures as a differential. Dr Bailey noted that the underlying cause was unclear and could

potentially relate to parturition (giving birth) or postpartum injury (accidental or non-accidental).

7.6 Further expert evidence in relation to this issue was obtained from specialist paediatric radiologist, Dr Padma Rao. Dr Rao's opinion was that the chest X rays showed abnormal expansion of the anterior left 7th rib and to a lesser extent the anterior left 6th rib with appearances suggestive of fractures.

7.7 Dr Rao confirmed that although any fracture can occur in non-accidental injury (NAI), the rib fractures that are most commonly associated with NAI are located in the posterior or posterolateral aspect of the rib. While noting that the aging of fractures is not an exact science, Dr Rao suggested that the injuries were acute and had occurred up to 4 days prior to MR's death.

Expert evidence on cause of death

7.8 To further explore MR's cause of death, reports were obtained from two experts, being Dr Ella Sugo, a paediatric pathologist, and Professor Philip Robinson, a paediatric respiratory physician. Dr Sugo prepared three reports in relation to MR's death, dated 4 March 2019, 28 June 2020, and 19 October 2020. Professor Robinson prepared two reports in relation to MR's death, dated 30 August 2021, and 26 June 2024.

7.9 Dr Bailey, Dr Sugo, and Professor Robinson gave evidence in a conclave at the inquest. The following emerged from the evidence of the three experts.

- MR suffered a severe hypoxic brain injury.
- At the time of her death MR had a rhinovirus infection (that is, she was infected with the virus that causes the common cold), although this infection was not of sufficient severity to explain MR's sudden collapse.
- Further evidence of early inflammation present in MR's lungs at the time of autopsy is likely evidence of aspiration that occurred during the process of resuscitation and intubation of MR after the respiratory event that precipitated her hypoxic brain injury.
- The presence of iron in MR's lungs indicates that there has been bleeding in the lungs in the past, which could possibly have been caused by an episode of asphyxia or potentially a near drowning episode. There is no connection between this potential episode and the episode that led to the hypoxia.

- The description given by MR's mother of episodes MR had at about 4 am on 13 May 2017 (that is, before the events immediately preceding the triple 0 call) do not suggest that MR suffered a seizure or seizures and is unlikely to be related to any respiratory event.
- It is inconceivable that the consumption of formula by MR and any associated vomiting/aspiration resulted in complete obstruction of MR's airways sufficient to cause prolonged hypoxia.
- Although it's impossible to be precise, irreversible, and lethal hypoxic brain damage could have been caused by a complete loss of cardiorespiratory function for a period time measured in minutes, as opposed to seconds, in an otherwise previously healthy child.
- The absence of a significant amount of foreign material (for example, formula) in MR's lungs suggests that aspiration is not the major contributing factor to the respiratory event.
- The absence of any evidence of an organic cause for the restriction of oxygen to MR's brain suggests that someone or something, or both, restricted MR's ability to maintain oxygen.
- Newborn screening was performed on MR and did not identify any genetic abnormalities that are routinely screened for.
- There was evidence of anterior rib fractures, which should always be of concern in children, particularly children who are not mobile.
- The absence of chest injuries is not evidence of an absence of compression of MR's chest.
- There is no clear direct explanation as to what caused the hypoxic terminal brain injury.

8 Conclusions

8.1 The hypoxic brain injury MR suffered was caused by an unexplained, unnatural physiological restriction of oxygen delivered over a significant period, that is, somebody or something actively interfered with the ability of MR to take sufficient respiration to maintain oxygen levels. The presence of the rib fractures is very unusual, and concerning, particularly in such a young child, as are the injuries to MR's lips and nose, and the bruise on her left arm. However, it is difficult to

determine the significance of the injuries to MR's lip, nose and arm, or the rib fractures in the hypoxic event. Although the medical experts were unable to determine the mechanism by which MR's respiration was restricted, clearly they had considerable difficulty in reconciling the history given by AR of MR 'choking' while taking a bottle with the subsequent presentation of the child when she was brought to her mother just after 5:00 pm on 13 May 2017.

8.2 Any determination as to what caused MR's death and the circumstances leading to her death are complicated by differences between the accounts given by each of her parents at a time proximate to her death, and by differences in the accounts given by her mother, TD, at the time of MR's death, in two interviews several years later, and in her oral evidence during the inquest. TD admitted in her oral evidence that her recollection of events in 2017 was hampered by her drug use at the time and the effects of that drug use on her short-term memory. Ultimately I found it difficult to determine the accuracy of the accounts given by each of the parents of the events of 13 May 2017.

8.3 Both parents had been involved with DCJ and police and felt that their history with both organisations would follow them for the rest of their lives. Their relationship with each other was characterised by domestic violence, and both were regular intravenous drug users. Because of this, they were understandably wary of either themselves or their family coming to the attention of police or DCJ, which may explain their reluctance to be as forthcoming as might be hoped about all relevant circumstances leading up to the triple 0 call on 13 May 2017.

8.4 Although there was reported physical and verbal abuse as between the parents in the presence of their children or in the home where the children lived, before MR's death there is no known evidence of the parents being reported, or suspected, by police of causing physical harm to their children. The impression I was left with was of a somewhat isolated family under considerable stress, due to several psycho-social factors: young parents with three children under five years old, drug use, domestic violence, and unemployment, living a somewhat chaotic existence. It is possible, in these circumstances, that MR suffered injuries to her ribs, lungs, lip, nose and arm, and experienced the restriction of oxygen that preceded the hypoxic brain injury, in circumstances that do not indicate any deliberate infliction of harm to MR on the part of either of her parents.

8.5 Ultimately, I find myself unable to determine, except in general terms, the cause and manner of MR's death.

9 Findings

9.1 I would like to express my thanks to the officer in charge, Detective Sergeant Tim Brakenridge and to counsel assisting, Chris McGorey, and his instructing solicitor, Luke Sampson, for their thoroughness and diligence in investigating this matter, and throughout all stage of the coronial process.

9.2 The findings I make under section 81(1) of the Act are

Identity

The person who died was MR.

Date of death

MR died on 16 May 2017.

Place of death

MR died at the Sydney Children's Hospital, High Street, Randwick NSW 2031.

Cause of death

MR died as a result of hypoxic brain injuries.

Manner of death

MR died as a result of an unexplained, unnatural restriction of oxygen that occurred on 13 May 2017 at her home while she was in the care of her father.

9.3 On behalf of the Coroners Court of New South Wales I again offer my sincere and respectful condolences to MR's family.

9.4 I close this inquest.

Magistrate Kasey Pearce
Deputy State Coroner
Coroners Court of New South Wales

4 November 2024