CITATION: *Inquest into the death of Michael Paul Keith Smedley* [2017] NTLC 001

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0042/2012
DELIVERED ON:	13 January 2017
DELIVERED AT:	Alice Springs
HEARING DATE(s):	12 – 13 December 2016
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Baby died of traumatic head injury, initial disagreement between medical experts, disagreement resolved, referred back to Police**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie

Judgment category classification:	B
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IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0042/2012

In the matter of an Inquest into the death of

MICHAEL PAUL KEITH SMEDLEY
ON 26 JULY 2012
AT ALICE SPRINGS HOSPITAL

FINDINGS

Judge Greg Cavanagh

Introduction

1. Michael Paul Keith Smedley (the deceased), a five month old Caucasian baby boy was born 8 February 2012 to his mother Tayla Smedley in Alice Springs. He was born at 40 weeks and three days and weighed 3.2 kilograms. In the hospital notes he was said to be a "very well-looking newborn".

2. His mother was 16 years of age at the time and found his care challenging. She sought assistance from friends. At the time of his death Michael was in the care of Tamara Cole and her partner Oliver Deighton along with Tamara's children, a boy aged 12 and a girl aged 13. Michael had been in their care for about six weeks.

3. The usual daily routine was that Michael went to day-care five days a week. The times he was in day-care differed depending upon the times that Tamara and Oliver were working.

4. On 26 July 2012 at 6.00am Michael was woken by Tamara and given a bottle. He was put back to bed at about 7.30am in his cot. Fifteen minutes later Tamara picked up her partner Oliver from work. He had just finished a nightshift. While she was out Michael was in the care of Tamara's 12 year

old son. After returning with Oliver, Tamara took her son to school. On her return, Michael woke and was placed in his walker in the lounge room.

5. Ordinarily, Tamara said she would have taken Michael to the day-care centre at that point. However, she was running late and so decided to go to work and take him to day-care a little later when she had a break. Tamara left for work at about 9.20am. She said that when she left Michael was healthy and had just one bruise that was in the middle of his back.

6. In his statement to Police later that day Oliver said that after Tamara left he sat on the couch and watched television with Michael playing in front of him. He said that at about 10.30am he saw Michael rubbing his eyes. He picked him up, took him to the bedroom where he put him on his back in his cot. He tried to give him his formula but Michael refused. He put the blankets over Michael up to and under his chin. He stated that Michael was very quiet. He said he then went back out and watched television for about 15 minutes until Tamara came home.

7. About 10.40am Tamara had a break at work and came home to take Michael to day-care. She arrived at about 10.50am. She said she was surprised Oliver and Michael were not still playing in the front room.

8. She went directly to the toilet and Oliver went to get Michael. Oliver said he found Michael not breathing and limp. Tamara said Oliver screamed and she knew something was wrong. She took Michael from Oliver and took him to the kitchen table and immediately started cardio pulmonary resuscitation.

9. The ambulance was called and paramedics arrived at 11.01am. The paramedics continued resuscitation attempts and transported Michael to hospital, arriving at 11.24am. Michael was intubated and ventilated.

10. While in hospital the doctors were concerned about the extensive bilateral retinal haemorrhages and bruising to Michael's body. They sought

explanation for the bruising and had an ophthalmological registrar provide an opinion on the retinal haemorrhages.

11. A CT Brain scan was performed that showed small areas of haemorrhage. The doctors were suspicious of non-accidental injury. The paediatrician was of the view that Michael had been "shaken vigorously".

12. The prognosis for Michael was extremely poor and in the presence of his mother and carers he was extubated at 3.40pm. He was pronounced deceased at 4.05pm.

13. After Michael's death and while cleaning him up it was noticed by the paediatrician that he had a "large patulous anus" (open anus). It was thought that may be consistent with anal penetration.

14. The following day (27 July 2012) the Forensic Medical Officer took swabs from 1.5 centimetres into the anal canal and just outside of the anal canal. It was noted at the time that there were three "very superficial" grazes on the right side of the perineum.

15. That afternoon the Police called Tamara to say they were coming to the house as they needed to take items. Tamara said to Oliver, "I feel there is something that you are not telling us because they are treating us like suspects and they want to come to our home and take stuff".

16. Oliver then said, "I need to tell you something. I need to change my statement. Do you remember when Shaun came to get the keys for the ute? I was in the middle of changing Michael's nappy. I heard a knock at the door. I left Michael on the change table. I gave Shaun the keys. I came back and Michael was rolling off the change table. I caught him."

17. When the Police arrived Oliver said, "I need to change my statement, I didn't put in about Shaun coming to the door. I was changing Michael on the

change table, went to the door, Shaun was at the door. Michael fell off the change table, I caught him".

18. Oliver was taken back to the Police Station where he provided a record of interview. In that interview he said that after Tamara left for work at about 9.15am he stayed watching television until about 9.45am, when Michael started to rub his eyes. He picked him up and took him to the change table.

19. Then "over the music" he heard a knock at the door. He turned the music off, went to the front door and gave Shaun the keys. As he was coming back to the change table, Michael had wriggled down so that his legs were over the edge and then he slipped over the end of the table and as he did so his head came forward.

20. Oliver said that he caught him (he later demonstrated that to be under the arms). He said at that stage Michael was hiccupping. He put him to bed and pulled the blankets up to his chin. He said he was still hiccupping. He left him in the cot and went back to watch television. Half an hour later Tamara came home. He went to get Michael and found him unresponsive and took him to Tamara.

21. At no time during any of his interviews with Police did Oliver indicate why he had the music turned up so loudly. Tamara said that Oliver didn't like loud music.

22. Shaun said he went to pick up the keys at about 9.45am. As he drove up he could hear loud music playing. He knocked on the front door and got no response. He went to the window of the room from which he thought the music was coming and knocked on the window. He then went back to the front door and knocked harder. The music was turned down and Oliver came to the front door. He opened the door and gave Shaun the keys. Shaun did not hear or see Michael at all. He assumed he must have been asleep.

23. I also heard ‘second hand’ evidence from Tamara that some weeks after the death of Michael, a friend of Tamara’s, Kelly told her that while she was at the hospital on the day Michael died, Oliver was sitting next to her. When they saw Police attend Oliver said, “they will be coming to speak to me about the unexplained bruising Michael had”.

24. At 10.00am on 28 July 2012 an autopsy was conducted by Dr Eric Donaldson. He found a significant number of bruises and abrasions on the deceased’s body:

> **“Signs of recent injury:**
>
> 1. The following contusions were present:
>
> (i) Over the right cheek, pinkish purple and poorly defined approximately 20 x 8mm.
>
> (ii) Under the left side of the jaw line, pinkish purple 22 x 13mm.
>
> (iii) Anterior aspect of the right shoulder, pinkish purple 25 x 15mm.
>
> (iv) Anterior aspect of the right upper chest, just below the clavicle, pinkish purple, 15 mm in maximum extent.
>
> (v) Anterior aspect of the left upper chest, just below the clavicle, pinkish purple 30 x 20mm.
>
> (vi) Left mid back, light brown and obliquely orientated, 55 x 9mm.
>
> (vii) Right mid to lower back, light brown 20 x 12mm.
>
> (viii) Left and right thenar eminences, each 10mm.
>
> (ix) Sole of the right foot, purple 55 x 20mm.
>
> (x) Lateral aspect of the left foot, below the ankle, 20 x 10mm.

(xi) Lateral aspect of the left foot, anterior to (x) above, 10mm in maximum dimension.

2. The following abrasions were present:

(i) Lower left occipital region, 11 x 5mm.

(ii) Over the sternum, linear scratch 3mm in length.

(iii) Dorsum of the right hand, linear scratch, 7mm in length."

25. In addition he found subdural haemorrhage and subarachnoid haemorrhage. Dr Donaldson was of the opinion that the deceased died of traumatic head injury.

26. The summary of Dr Donaldson's autopsy report reads:

"1. At autopsy, significant findings (including those identified at neuropathological examination by Dr A Tannenberg; see attached report) identified were:

(i) Diffuse bilateral subdural haemorrhage.

(ii) Subarachnoid haemorrhage.

(iii) Cerebral swelling.

(iv) Bilateral retinal haemorrhages.

(v) Contusions over the upper left side of the neck, upper left and right anterior chest, back, thenar eminences, lateral aspect of the left foot and sole of the right foot.

(vi) Normally developed male infant aged 20 weeks, at the 90th weight for length percentile.

(vii) Mild mucosal inflammation at ano-rectal junction.

(viii) Focal excoriation of peri anal skin.

2. Samples of cardiac blood and urine as well as bile and liver were taken at autopsy for toxicological analysis. No alcohol or drugs were identified within the blood.

3. There were no features at post mortem examination to indicate natural disease or drug toxicity as a cause of death. Rather, there was strong evidence to indicate that traumatic brain injury has caused his demise. In the absence of evidence of discreet localised injury to the head/scalp, skull or brain, the injuries as indicated above would be in keeping with having been sustained by severe acceleration/de acceleration force applied to the head. The contusions/bruises to the neck, anterior chest, thenar eminences and feet were fresh (having a macroscopic appearance of being of more recent origin than those on the back). The peri anal skin lesions had an appearance consistent with small foci of excoriation, having occurred prior to death. The buttock rash had appearances suggestive of nappy rash. There was mild mucosal inflammation at the ano-rectal junction. The histologic appearances were non-specific and the cause of the inflammatory change is uncertain. The bruising to the sole of the foot was due to haemorrhage in the very superficial layer of the skin ie. intraepidermal. This is quite an unusual type of contusion, always associated with trauma/physical injury such that the designation 'post-traumatic cutaneous intracorneal blood' has been proposed. The bruise was fresh such that the haemorrhage leeched out of the epidermis leaving the empty intracorneal spaces seen in the histology slides."

27. He sent the brain, spinal cord and eyes of the deceased to Dr AEG Tannenberg, a Forensic Neuropathologist at the Queensland Medical Laboratory.

28. Doctor Tannenberg in his report concluded:

"**Summary of neuropathological findings:**

1. Increased brain weight with evidence of cerebral swelling (brain weight 806 grams, expected 660 grams).

2. Minor subarachnoid haemorrhage.

3. No evidence of contusional damage.

4. Normally developed brain.

5. Retinal haemorrhages.

6. From General Forensic Autopsy – Dr E Donaldson:

    - Small bilateral subdural haemorrhages (approx. 20ml).

    - No scalp bruising, no skull fractures.

Interpretation

The constellation of findings are consistent with the 'shaken baby syndrome' with short survival. This constellation includes brain swelling, retinal haemorrhages and small subdural haemorrhages.

There was no evidence of blunt trauma to the skull, scalp or brain."

29. In evidence he said in his opinion the scenario proffered, of the child slipping off the table and being caught:

> "would be too brief and the kind of acceleration/deceleration force over that very short period of a fall, wouldn't be enough to produce these changes".

30. Doctor Tannenberg sent the slides and paraffin blocks to Dr T Robertson, the Director of Neuropathology at Royal Brisbane & Women's Hospital, for Amyloid Precursor Protein Staining.

31. Dr Robertson is an anatomical pathologist and specialises in Forensic Neuropathology. He supported the findings of Dr Donaldson and Dr Tannenberg. He commented:

> "There is evidence of a significant head injury with short survival including: Cerebral swelling, extensive bilateral subdural haemorrhages, subarachnoid haemorrhage, and bilateral retinal and optic nerve sheath haemorrhages".

32. In his opinion the pattern of the Amyloid Precursor Protein Staining was overall indicative of hypoxic-ischaemic injury secondary to brain swelling which he believed to be consistent with the non-accidental injury indicated by the findings of Dr Donaldson and Dr Tannenberg.

33. Meanwhile, the samples collected from inside and outside of the anus (along with other samples from the child, the house and Oliver were sent to the pathology laboratory for analysis.

34. On 14 August 2012, a forensic scientist tested the samples with the confirmatory test for semen but the test returned a negative result in all cases.

35. The scientist then looked under the microscope at a slide taken from the sample from inside the anal canal of the deceased. She saw seven spermatozoa heads. The tails were not seen, but they degrade quickly and so were not expected to be seen. She gave evidence that at that point in time the laboratory for which she worked did not have the equipment to take a photograph of the slide.

36. However, she asked a fellow scientist at the laboratory to confirm what she saw. The confirmation was provided.

37. The slide had been heat-fixed which ordinarily preserves the slide. However when she went back to look at it once more on 27 August 2012 the slide had degraded. There were no sperm heads able to be positively identified on that occasion.

38. There was also insufficient DNA to produce a profile despite amplification using the Identifier Kit. Another forensic scientist gave evidence that a more sensitive kit, the Powerplex 21, should have been used to analyse the DNA as it is much more sensitive. However, I heard evidence that the kit was not available until April 2013 (well after the time the sample was tested in August 2012).

39. The final outcome is that although spermatozoa heads were visualised on the swab, DNA testing was unable to determine who it was that produced them.

40. The Police investigator also obtained an opinion from a Structural Engineer. He was of the opinion that the "fall and catch situation" described by Oliver may have been sufficient to give rise to the injuries. However that opinion appeared contrary to medical opinion generally to do with shaken baby syndrome and was not supported by the medical experts in this case.

41. The Police Investigator then provided the evidence to Dr Terence Donald, a paediatric forensic physician from the Women's and Children's Hospital in Adelaide. His report dated 10 June 2013 provided a great deal of information. He indicated that a "patulous anus" was not indicative of sexual assault but a common finding in children under anaesthetic or when deceased. He was of the opinion that the bruising was suspicious. However he cast doubt on whether or not the head injuries were of traumatic origin. He concluded that the cause of death must remain open.

42. That left the Police investigation at a difficult juncture. The investigator obtained an opinion on the prospects of a prosecution from the DPP. That was to the effect that further expert opinions should be obtained.

43. They were obtained, but those opinions related to further testing of the DNA samples. Those tests were unsuccessful. There was not sufficient DNA remaining. The final report in relation to that further testing only became available on 5 May 2016.

44. Due to the contradictory nature of the expert evidence the mother of the deceased sought that the evidence be heard at an inquest. In the exercise of my discretion to hold an inquest the matter was listed for 12 and 13 December 2016.

45. At the inquest the medical experts were called to clarify their opinions. Doctor Donald gave evidence that having reviewed the report of Dr

Robertson he was of the opinion that the injuries were in fact traumatic in origin. That was very much different from the opinion expressed in his report of 10 June 2013 and overcame the previous contradictions in the evidence of the medical experts.

46. He also indicated that the "fall and catch" scenario could not have caused the injuries. Indeed he was of the opinion that even if the deceased had not been caught and had fallen to the hard floor surface, he would not have sustained the injuries that led to his death.

47. Dr Donald was even more expressive about the bruising and stated that the bruising to the sole of the deceased's left foot was "sinister".

48. Oliver Deighton was summonsed to give evidence. He stated he thought the bruising would have taken 18 hours to develop and so might have been inflicted the day before. When asked why he didn't mention to Police in his first statement that he had the baby on the change table and that he had slipped off, Oliver said that he didn't wish to say anything further on the grounds that it may incriminate him in the death of Michael.

49. Section 38 *Coroners Act* provides that a person may be compelled to answer questions if a certificate is provided. However the certificate prevents his answers being used in any other proceedings.

50. I refused to issue a certificate and excused Oliver from answering further questions.

51. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

    (i) The identity of the deceased was Michael Paul Keith Smedley, born on 8 February 2012, in Alice Springs, Northern Territory.

    (ii) The time of death was 4.05pm on 26 July 2012. The place of death was Alice Springs Hospital in the Northern Territory.

(iii) The cause of death was traumatic head injury.

(iv) The particulars required to register the death:

1. The deceased was Michael Paul Keith Smedley.

2. The deceased was of Caucasian descent.

3. The deceased was five months old at the time of his death.

4. The death was reported to the coroner by the Alice Springs Hospital.

5. The cause of death was confirmed by Forensic Pathologist, Doctor Eric Donaldson.

6. The deceased's mother was Tayla Smedley and his father is not known (it was found through DNA testing that the person named on the birth certificate was not the father).

52. I may make recommendations pursuant to section 35(1), (2) & (3):

> "(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> (2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.
>
> **(3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."**

53. The original issue that confronted the investigator was the contradictory medical opinions. Those contradictions have resolved. I therefore intend to return the matter to Police.

Report

54. I believe that offences may have been committed in connection with the death of Michael Paul Keith Smedley and in accordance with section 35(3) I report my belief to the Commissioner of Police and the Director of Public Prosecutions.

Dated this 13th day of January 2017.

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JUDGE GREG CAVANAGH
TERRITORY CORONER