OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Jakai Ryan BOND**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 1557/06(8)
DELIVERED ON:	10 April 2008
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HEARING DATE(s):	3 March 2008, 2-4 April 2008 & 7 April 2008
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Inquest – sudden death of an infant, co sleeping, asphyxia, head injuries

REPRESENTATION:

Ms Julie Wilson	–	appearing to assist the Coroner
Mr Rick Taylor	–	representing Mr Jai Bond; instructed by Hayley Ritchie Solicitors
Mr M Pieterse	–	representing Ms Sarah Bond; instructed by Gill & Lane Solicitors

Findings of the inquest into the death of Jakai Ryan Bond

Table of contents

Introduction

> *Shortly before midnight on 25 May 2006, Jai Bond fell asleep in a lounge chair while nursing his ten week old baby son, Jakai. When he awoke at around 4.00am, the baby was face down in his lap and not breathing. Frantic resuscitation attempts by his parents and paramedics failed to revive Jakai. An autopsy discovered two fractures to the baby's skull. Accordingly, the death was treated as suspicious and investigated by Child Protection Investigation Unit detectives. No charges were laid.*
>
> *These findings seek to explain how the death occurred*.

The *Coroners Act 2003* provides in s45 that when an inquest is held, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system or other agencies with responsibility for the areas of administration referred to in any comments or recommendations. These are my findings in relation to the death of Jakai Ryan Bond. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Because Jakai's death was sudden and unnatural it was reported to the Redcliffe coroner in accordance with the requirements of s8(2)(a) and (3)(b) of the Act. When suspicions were raised by the autopsy findings and no charges were preferred, it became obvious an inquest was warranted and the matter was transferred to me as the workload of the Redcliffe magistrate/coroner prevents him from being able to conduct inquests.

The scope of a Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death but as that issue was not contentious in this case I

need not seek to examine those authorities here. I will say something about the general nature of inquests however.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [1]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[2]

A coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or civilly liable for something.[3] However, if, as a result of considering the information gathered during an inquest, a coroner reasonably suspects that a person may be guilty of a criminal offence; the coroner must refer the information to the appropriate prosecuting authority.[4]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[5]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[6] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence,

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s46
[3] s45(5) and 46(3)
[4] s48
[5] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[6] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J

the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[7]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[8] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[9] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation. However, in *R v Tennent; ex parte Jager*[10] the Supreme Court of Tasmania held that this obligation did not extend to hearing submissions for the subject of a potential referral to the DPP prior to such a referral being made.

The investigation

A number of general duties police officers attended the scene, arriving before the ambulance officers. Once Jakai was transported to the Redcliffe Hospital those officers obtained versions from the parents and other family members as to what had transpired. The house was examined and photographs taken. Jakai's body was also photographed at the hospital. There were no obvious signs of trauma on the body and the versions of the parents and relatives were consistent. This initially led police to believe the death was the result of natural causes.

When the autopsy revealed two skull fractures, the investigation was taken over by officers of the Child Protection Investigation Unit and the death was treated as suspicious.

Jakai's parents were interviewed a number of times as were the other occupants of the house, neighbours and associates of the parents. A paediatrician with extensive forensic experience was consulted; she reviewed the autopsy report and provided an opinion as to the likely causes of the injuries etc.

I am satisfied the investigation was thorough and competently undertaken. I commend Detective Sergeant Leyendeckers and the officers who assisted him for their efforts.

The inquest

A directions hearing was convened on 3 March 2008. Ms Wilson was appointed counsel assisting. An issues list was distributed and a tentative list of witnesses discussed. The matter was then adjourned for hearing on 2 April 2008 when it proceeded over three days. When the inquest commenced, leave to appear was granted to Jakai's mother and father. They were

[7] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[8] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[9] (1990) 65 ALJR 167 at 168
[10] (2000) 9 Tas R 111

separately represented. One hundred and two exhibits were tendered and 16 witnesses gave evidence.

At the close of evidence, counsel assisting and the legal representatives of those granted leave to appear made oral submissions on the findings I might make. I found them to be of great assistance.

The evidence

I turn now to the evidence. Of course I can not even summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Family background

Jakai Bond was born on 17 March 2006. He was 10 weeks old at the time of his death

Jakai was the son of Jai Bond and Sarah Sutton. At the time of Jakai's death, the couple lived at 67 Bancroft Terrace Deception Bay with Jakai and Sarah's two children from a previous relationship. Also living there at the time of Jakai's death was Sarah's mother, Kathryn Gyorosi, and her son, Sarah's 20 year old brother, Brett Sutton.

Jai and Sarah met in late 2004 when Sarah was pregnant with her second child. Her relationship with the father of the two older children ended in early 2005. She took up with Jai soon after and became pregnant with Jakai a couple of months later.

On 11 November 2005, Jai was convicted of a number of property offences and a breach of a suspended sentence in the District Court at Brisbane. He was sentenced to nine months imprisonment. Jakai was born while he was in jail. When he was released in April 2006, he moved into the Bancroft Terrace house with Sarah, her mother and brother.

Neither of Jakai's parents was in paid employment. Sarah spent most of her time caring for the three children and socialising with friends. Jai seems to have assisted with the children to a lesser extent, socialised with his friends and hung around the house playing video games. He acknowledged he smoked marihuana frequently - "*whenever I could can get my hands on it",* and, according to Ms Gyorosi and police intelligence, he also used amphetamines.

Criminal history and domestic violence history of Jakai's parents

Mr Bond has a criminal history stretching back to 1999. Since then he has been before various courts on 20 occasions, been convicted of over 70 offences including break and enter dwelling, wilful damage, assault occasioning bodily harm and breaches of domestic violence orders.

He has been sentenced to imprisonment on eight occasions, most recently for a range of offences including breaches of a domestic violence order, receiving stolen property and assault occasioning bodily harm. In the Redcliffe Magistrates Court on 4 January 2008, a head sentence of 12 months imprisonment was imposed with a court ordered parole release date of 4 April 2008.

Ms Sutton also has some criminal history. She was first before the courts in 2002 when she was 18 years old. Since then she has been convicted of approximately 16 offences ranging from contravening a lawful direction and shop stealing to fraud. Most recently she was prosecuted for failing to appear in accordance with a bail undertaking in connection with dishonesty offences.

Mr Bond has been convicted of breaching a domestic violence order on five occasions.

Circumstances surrounding the death

All was not harmonious in the Bancroft Terrace household on the morning of Thursday 25 May 2006: Ms Sutton was angry and upset that Mr Bond had stayed out late the evening before, socialising with friends and leaving her to care for the children. Indeed this was the continuation of an ongoing dispute that had resulted in Mr Bond pushing Ms Sutton into a sofa a day or so before. It is clear theirs was a volatile relationship characterised by frequent noisy arguments.

When she awoke, Ms Sutton decided to go out; either to the local shops or to visit Mr Bond's mother with whom she had a close relationship. She told him she was taking Jakai but he would need to care for the other two children.

This displeased Mr Bond as he was short of sleep and hung over. It seems likely he expressed his displeasure by shouting at Ms Sutton and/or the children. She left on foot. Sometime later, Jakai's grandmother, Ms Gyorosi also started shouting. Whether this was in response to Mr Bond abusing the children or for some other reason I was not able to establish. In any event her shouting aggravated Mr Bond's already unhappy disposition and they came into conflict. The shouting woke Brett Sutton and he joined in the exchange of loud abusive remarks.

It seems Ms Gyorosi was in the back yard and Mr Bond confronted her there. I am unable to say exactly what transpired during the confrontation: I consider Ms Gyorosi lied about it when she went to the local police station to make a complaint and told an officer Mr Bond punched her in the face and lied about to this court when she said there was no physical contact. Mr Bond also denied any physical contact but I have no reason to disbelieve the neighbour who says she saw Mr Bond push Ms Gyorosi while they were yelling at each other.

As a result of this incident, Ms Gyorosi left the house and went to the Deception Bay police station. She was driven there by Natasha Harrison, a

friend of Mr Bond and Ms Sutton who, as usual just turned up to visit Sarah. It seems she spent most of her days at the Bancroft Terrace house.

Meanwhile, Ms Sutton had come across Ms Bond, her partner's mother at the local shops and went to her place with Jakai. After socialising there for some hours, Ms Sutton, Ms Bond and Ms Bond's partner walked back to Bancroft Terrace.

There they found Jai Bond and Brett Sutton playing video games. It seems both were already "stoned": Mr Sutton says they had a couple of "cones" soon after he woke. The two older children were not there. From Ms Harrison, Ms Sutton discovered they were with her mother at the police station and so she asked Ms Harrison to take her there.

At the police station, Ms Sutton found Ms Gyorosi in the process of applying for a domestic violence order.

Ms Sutton, Ms Harrison and the two older children then returned to the Bancroft Terrace residence. Jakai had stayed there in the care of his paternal grandmother.

Ms Sutton told Mr Bond what had transpired at the police station. He was upset by this and stormed off. Ms Sutton, Ms Bond and her partner walked to Ms Bond's house pushing the three children in two strollers. Mr Bond joined them there later in the afternoon.

At about 7.00pm, a friend of Ms Bond drove Sarah, Jai and the three children back to Bancroft Terrace.

Soon after they arrived home, they were joined by Ms Harrison, her boyfriend and another male, mutual friend. Ms Harrison and Ms Sutton then went shopping. When they returned to Bancroft Terrace the group sat around talking and playing video games. Mr Sutton and Mr Bond smoked marijuana in the kitchen or on the back veranda. Ms Sutton and Ms Harrison deny knowing this was occurring but I don't believe them. The neighbours say during the evening numerous cars came and went at short intervals and this was not unusual.

The guests left at around 10.00 – 10.30pm. Ms Harrison says when she left Jakai was asleep on a lounge chair in the lounge room, propped up with a pillow. Soon after, Ms Sutton took Jakai into the main bedroom where she, Mr Bond and the three children usually slept, to feed him.

She says as she was doing this one of the other children woke up and began crying. She was not able to settle either child and so called out for Mr Bond to come and help her. They had not been speaking much during the day as she was still angry with him for going out the previous night. He was watching television in the lounge room and heard the commotion in the bedroom but acknowledges he did not go in until Ms Sutton called to him a couple of times.

Ms Sutton is adamant that until the other child awoke, Jakai was feeding normally and was showing no signs of any trauma or distress. She acknowledges he had some type of chest infection. He was, according to her "a bit chesty" and she had sought some medical attention for him the week before but had missed an appointment at the outpatients' clinic at the Redcliffe Hospital scheduled for 24 May.

Mr Bond says he took the baby out into the living room and held him in an almost upright position against his chest as he reclined in a lounge chair. Mr Bond apparently fell asleep. He says when he woke, Jakai was in his lap; face down with his face resting on Mr Bond's right thigh. He turned the baby over and could see he wasn't breathing and looked bluish. He knew something was seriously wrong and jumped up and ran to the main bedroom.

Ms Sutton and her brother both recall being woken by Mr Bond running down the hallway screaming words to the effect "*He*" or "*Jakai is not breathing".*

Mr Bond says he put Jakai on the floor in the living room and brought Ms Sutton to him but Ms Sutton says the baby was brought into the main bedroom. She attempted to resuscitate him. They then all moved into the lounge room. Jakai was placed on the floor and the ambulance was called. The call was received at 4.09am.

Jai and Sarah were clearly in distress when the first 000 call was made. Shortly after Ms Sutton called back and the operator was able to give her instructions to perform CPR on the child which she did. At that stage she told QAS the child was still warm and his mouth was wet, however he was not breathing.

Numerous neighbours reported hearing lots of screaming and wailing. A comment that could amount to an acknowledgment of guilt "*It's my fault*" was heard spoken by a female and rejected by a male.

Loud banging noises were also heard. These were later found to be Mr Bond and Mr Sutton punching holes in the wall sheeting.

Brett Sutton ran downstairs and told his mother what had happened. She claims he told her Mr Bond had killed the baby. She ran next door and asked neighbours to call an ambulance. She repeatedly alleged someone had killed the baby. She told the QAS operator:

> *"He's killed the baby, the baby's dead.*
>
> *I don't know what's happened; I can't get to them* (the other children*).*
>
> *She's* (Ms Sutton) *stuck in the house with him. He's probably going to kill her too.*
>
> *Please hurry, before he kills somebody else."*

Her comments gave the impression Mr Bond wouldn't let anyone near the other children, or there was difficulty getting the other children out of the house. However Brett Sutton in fact brought one of the other children over to her at the neighbours' place.

These allegations are now said to have been made as a result of a misunderstanding. It is difficult to comprehend how such serious allegations could be made without any foundation. It may be a reflection of Ms Gyorosi's hysterical personality or her disregard for the truth.

Because of these allegations, the QAS officers asked that police also be requested to attend. Because an available police vehicle was nearer than the ambulance station at Petrie they in fact arrived first, at about 4.15am and the ambulance arrived at 4.20am.

The scene encountered by police and QAS officers was described as confused and volatile with numerous persons milling around and loud wailing and swearing coming from within the house.

The first police officers to arrive say that when they entered the house Ms Sutton was performing mouth to mouth resuscitation on Jakai while obtaining instruction over the telephone from the QAS. Advanced Paramedic Douglas Buchanan states Jai Bond was standing at the top of the stairs when they arrived. He was looking out across the road and appeared dazed and distressed. Police assisted QAS officers to "get through the crowd" and to the child.

The ambulance officers say their examination of Jakai found he was not breathing, had no pulse or heart beat and had fixed, dilated pupils. He felt warm and was limp. They noted no signs of trauma. They continued CPR and quickly concluded the baby should be transported to hospital. QAS officer Buchanan gave evidence he picked up Jakai with two hands and cradled him in his left arm with his head in the crook of his elbow and his bottom in the palm of his left hand. He continued external heart massage with his right hand. The officer is adamant that contrary to a suggestion later made by the baby's mother, the infant's head did not come into contact with the wall or door jam as he was carrying Jakai out of the house. His version is corroborated by the other QAS officer and a police officer who was assisting them. I have no hesitation in accepting Mr Buchanan's evidence in this regard.

Soon after the two QAS officers took Jakai into the back of their vehicle an intensive care paramedic arrived. He intubated the baby and administered adrenalin via an endotracheal tube and via an intra-osseous needle inserted into Jakai's tibia. Despite these efforts the child at all times remained asystole. He was lifeless and stiff on arrival at the Redcliffe Hospital. Jakai was pronounced dead at 5.15am. Jakai's parents identified his body to a police officer in attendance.

I am satisfied that Jakai's parents and the QAS officers did all that was reasonably possible to revive the baby. I find he was already dead when discovered by Mr Bond shortly after 4.00am.

Medical evidence concerning cause of death

On 29 May, an autopsy was conducted on Jakai's body by Dr Nathan Milne, an experienced forensic pathologist with experience in paediatric pathology. His examination was conducted in accordance with the international standardized autopsy for sudden unexpected infant death protocol. He arranged for a full radiological examination, histology of selected organs, neuropathology, microbiology, metabolic screening, toxicology and forensic biology to be undertaken.

He found an extensive sub galeal haemorrhage extending over much of the right parietal bone, an indentation to the peak of the occipital bone and two non-displaced linear fractures to the right parietal bone that ran at 90 degrees to each other and ended at the saggital suture and the lambdoid suture respectively.

The absence of acute inflammatory infiltrate or margination of acute inflammatory cells within the blood vessels associated with the fracture and the haemorrhage convinced Dr Milne the injuries had occurred before death but they were "*very recent*"; at most four to six hours before death but more likely less than that.

He is of the view the injuries would have required moderate force. He thought it unlikely that the infant falling from the arms of a seated adult onto a carpeted floor or a coffee table would result in such fractures but he could not exclude it. He said he considered two applications of force were more likely but one was possible.

Other significant injuries present at post-mortem are large petechial haemorrhages in the thymus, lung and heart and congestion in some organs.

Histology identified small foci of bronchopneumonia in the lungs and microbiology isolated a bacteria associated with this disease in samples of lungs, blood and brain. At the inquest Dr Milne described the bronchopneumonia as "*relatively mild".*

Dr Milne considered he could not ascertain the cause of death from his examination and the other tests but he listed the head injuries and bronchopneumonia as "*other significant conditions*".

Dr Milne gave evidence that the bronchopneumonia and the skull injuries could both negatively impact on the respiration of the infant.

A report was also obtained from Dr Catherine Skellern, a specialist paediatrician who holds a consultant position at the Royal Brisbane Hospital Child Advocacy Service. She also gave evidence at the inquest. Dr Skellern is of the opinion the fractures were due to the application of blunt impact(s) of

moderate force to the right side of the head. She thought it possible the two fractures were the result of a single impact but equally, could be the result of two impacts. There was no indication of shaking and Dr Skellern said it was not possible to say whether the impacts were the child hitting a hard surface or a blow or blows by an object in motion. Dr Skellern says some features of the injuries are consistent with abuse cases, but other factors present in such cases are absent here.

In her report, she said the injuries were "*very recent and close to the time of death".* When giving evidence Dr Skellern expressed the view the injuries most likely occurred "*a few hours before death"* but when pressed to be specific she deferred to Dr Milne's expertise in this regard.

Dr Skellern states the child would have felt pain as a result of the injuries which might have manifested as crying and a reluctance to feed. She says the child might have experienced a concussion as a result of the blow or blows and if so the child would have appeared stunned, dazed or floppy. A brief period of unconsciousness is possible with concussion.

Dr Skellern also gave evidence the bronchopneumonia was not sufficiently extensive to cause death.

Time of death and responsibility for the head injuries

Important to an understanding of the circumstances of the death is the ascertainment of the time it occurred. This may also enable a finding as to who is likely to have caused the head injuries. I have found that Jakai was dead when Mr Bond awoke at about 4.00am and I accept his evidence the child was alive when he took him into the living room between 11.00 and 11.30.

Initially, neither parent (nor any other witness) provided any explanation for the skull fractures. After they were brought to her attention, Ms Sutton advanced several possible explanations. She suggested the older children might have inflicted the head injuries during play. However there was no reliable evidence these incidents occurred as Ms Sutton described them and in any event if they did occur it was at a time well outside the possible time frame suggested by Dr Milne. Ms Sutton has also suggested a paramedic hit the baby's head against the wall or door on the way out of the house. She acknowledged when giving evidence that she did not see this happen but suggested she heard a noise that may have been caused by it. I consider she is lying about this.

No precise conclusion as to the time of death can be drawn from the fact the baby felt warm when he was found because he had been lying on his father's lap and a heater was on near by. However, there is also the evidence of the doctor who issued the life extinct certificate at 5.15am that the body was stiff at that stage. Dr Milne said it is extremely difficult to extrapolate the time of death from the on-set of rigor mortis in babies. However, it is obvious the onset of the condition at 5.15am makes it more likely the death occurred later.

Nevertheless, accepting the injuries to Jakai's head may have occurred up to six hours before death, I am of the view the time of death can not be stipulated with sufficient precision to exclude the possibility the injury occurred before the guests left the house at around 10.00 to 10.30. I consider this very unlikely to have occurred; the ensuing crying would surely have attracted the mother's attention. I believe the most likely scenario involves some injury to the baby when the mother was struggling to cope with two of the children in the bedroom at around 11.00pm. This would explain her expression of remorse on the night and her subsequent fabrication attempting to inculpate the ambulance officer.

However, the seriousness of a finding to that effect means compelling evidence would be required in accordance with the *Briginshaw* principle. It does not exit in this case; therefore I am unable to specify the time of death or the cause of the head injuries.

Conclusions as to cause of death

I accept the medical opinion that the head injuries did not directly cause the death. It is apparent Jakai was suffering from bronchopneumonia but both medical experts say it was not sufficiently serious or widespread to cause his death. The autopsy also revealed physical evidence consistent with asphyxia being the cause of death.

Counsel for the husband and counsel for the wife submitted that as there was insufficient or no evidence found at autopsy to sustain a finding that asphyxiation was the cause of death. An analogy may best demonstrate why I consider those submissions misconceived. If a known non-swimmer is found floating face down in the sea and an autopsy reveals no physical trauma and no disease that could cause death and toxicology reveals no toxins; a finding of drowning as the cause of death will usually be made even though there is rarely any physical evidence found at autopsy positively supporting such a conclusion. It is inaccurate to say there is no evidence to support such a finding. Rather the finding is based on all of the circumstances. The autopsy results are only one source of that evidence and negative autopsy findings may be equally relevant to determining a cause of death.

Similar deductive reasoning can be used to reach a finding of asphyxia. Especially in neonates and infants, asphyxia frequently leaves no evidence that can be seen at autopsy but the absence of any other reasonable cause and the circumstances in which a death occurs enables it to be found as the dominant cause of death in some cases.

In this case, there are numerous factors that indicate asphyxia was the most likely cause of death. The baby was found in a position in which his breathing is likely to have been restricted; he was in the care of a fatigued and drug affected adult who would not have been responsive to his impact on the baby or any distress it manifested; the baby was suffering from a chest infection that would have compromised his respiration and head injuries that could compound this respiratory impairment. When these factors are married with the petechial haemorrhages and congestion found at autopsy and the

absence of evidence of any other natural cause, they persuade me asphyxia was the primary cause of death.

Findings required by s45

I am required to find, as far as possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with this last aspect of the matter, the manner or circumstances of the death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the matter.

Identity of the deceased – The deceased person was Jakai Ryan Bond

Place of death – He died at 67 Bancroft Terrace, Deception Bay, Queensland

Date of death – Jakai Bond died on 25 or 26 May 2006

Cause of death – He died from positional asphyxia contributed to by bronchopneumonia and head injuries

Referral to DPP pursuant to s48

The Coroners Act by s48 requires a coroner who, as a result of information obtained while investigating a death, "*reasonably suspects a person has committed an offence"* to give the information to the appropriate prosecuting authority.

This matter was investigated by officers of the Queensland Police Service who specialise in child protection matters. They conducted it as a criminal investigation. While I regret the distress of Jakai's parents, I consider it was appropriate in the circumstances to conduct the investigation and this resulting inquest. Infants are extremely vulnerable. When they are unlawfully killed, the perpetrator is most often a parent or an intimate of a parent. Naturally then, Mr Bond and Ms Sutton came under close scrutiny, particularly when they could offer no reasonable explanation for the head injuries their baby suffered while in their care.

In this case there is no evidence indicating any person intentionally caused the death. The identity of the person responsible for the head injuries suffered by Jakai can not be proven. I consider it is unlikely to have been Mr Bond. He has given a consistent account of his actions from the outset and his initial and spontaneous response did not indicate any understanding of how the injuries may have been caused nor demonstrate any intention to conceal any of his actions. Nursing a baby while fatigued and affected by cannabis may arguably be negligent. However, the dead baby's father was not aware the baby was also suffering from other conditions that predisposed him to asphyxiation. Any negligence that could be established would not amount to such a grave departure from the standard of care expected of a reasonable parent as to amount to criminal negligence.

For these reasons I do not intend to refer this matter for the consideration of the DPP.

Concerns, comments and recommendations

Section 46, in so far as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

As a result of considering all of the information to come before this inquest, I consider I have an obligation to have regard to the safety of Jakai's siblings. While I have no doubt that Ms Sutton and Mr Bond loved their son deeply and were extremely distressed by his death, I cannot ignore the circumstances under which the death occurred. For example, Ms Harrison, who seemed prepared to say almost anything she thought might be in her friends' favour irrespective of the truth, casually indicated the older children frequently went to sleep wherever they might be when they became exhausted. Further, there is no doubt the household was frequently disturbed by low level violence, emotional abuse and illicit drug taking. Jakai suffered serious unexplained injuries while in his parent's care. As has been detailed earlier, those parents have continued to commit criminal offences. His father has continued to commit acts of domestic violence and abuse illicit drugs. I am concerned that their household would not be one in which children are likely to be safe.

Fortunately, it is not my function to make decisions about child welfare issues. However, I do consider that I am obliged to refer the information which causes concern about them to the authorities charged with those responsibilities.

Recommendation to the Department of Child Safety

I therefore recommend the Department of Child Safety review the information put before this inquest when deciding what action if any should be taken by it in relation to any children of either parent.

Michael Barnes
State Coroner
Brisbane
10 April 2008