QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Tamiya Calais Lievesley**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
FILE NO(s):	2004/15
DELIVERED ON:	24 April 2015
DELIVERED AT:	Southport
HEARING DATE(s):	4, 5, 8 & 9 July 2013; 28, 29 & 30 October 2014 and 6 November 2014
FINDINGS OF:	James McDougall, Coroner
CATCHWORDS:	Coroners: inquest, death of baby, drug use, morphine

REPRESENTATION:

Counsel Assisting:	Mr Craig Chowdhury Ms Rhiannon Helsen
Counsel for Melinda Punch:	Mr A. Hoare instructed by Legal Aid Queensland

Mr Peter Lievesley &
Mrs Mary-Anne Lievesley

Introduction

At the time of her death, Tamiya Calais Lievesley was six months of age and resided with her Mother, Ms Melinda Punch, her father, Mr Peter Lievesley and her siblings Sabrina (aged 4) and Peter (aged 3) at 28 Eira Court, Edens Landing. This is the tragic story of Tamiya's life and death.

At around 8:00 am on 2 March 2004, Tamiya was found deceased in her cot by Ms Punch and Mr Lievesley. Distressed, Mr Lievesley ran from the residence with Tamiya into the street, and called for help. Neighbours subsequently called the Queensland Ambulance Service ('QAS') who attended the address. QAS officer's observed that Tamiya had been deceased for some time. Police were subsequently called to attend the scene.

A full external and internal autopsy was conducted by Dr Beng Ong. Dr Ong found that Tamiya had died as a result of morphine toxicity. Elevated levels of morphine were located in her stomach content, indicating that the morphine had been orally ingested.

A police investigation was subsequently conducted into Tamiya's death lead by Detective Sergeant Naomi Lockhart. As a result of the investigation, Ms Punch and Mr Lievesley were charged with manslaughter (s 310 *Criminal Code)* and two counts of endangering children by exposure (s 326 *Criminal Code*).

On 9 November 2011, the charges against Ms Punch and Mr Lievesley proceeded to a committal hearing in the Beenleigh Magistrates Court. Ms Punch and Mr Lievesley were committed to stand trial in the Supreme Court at Brisbane.

On 28 November 2011, Mr Lievesley was found unconscious at his residence with a butterfly cannula in his arm. Three crushed up fentanyl patches were found nearby. He was transported to the hospital by QAS. Upon arrival he had a Glasgow coma score of three with fixed pupils. A CT scan excluded an acute haemorrhage and he was in the end stages of organ failure. Despite active resuscitation measures, he continued to deteriorate and after a discussion with his family and his poor prognosis, life support was withdrawn.

An indictment charging Ms Punch with manslaughter was subsequently presented to the Supreme Court.

The Supreme Court trial before Fryberg J commenced on 14 November 2012. The jury retired to consider the matter on 19 November 2012. On 21 November 2012,

the decision was made to discharge the jury after they were unable to reach a verdict.

The Office of the Director of Public Prosecutions ('ODPP') has since decided not to proceed to trial again on the evidence as it stands. The death of Mr Lievesley after the conclusion of the committal hearing made the prosecution of Ms Punch very difficult. A nolle prosequi was subsequently entered in relation to the indictment against Ms Punch.

Delay in the Coronial Investigation

Section 29 of the Coroners Act 2003 provides that an inquest must not be held or continued in circumstances a person has been charged with an offence in which the question of whether the person accused caused the death may be in issue. The police investigation into Tamiya's death took several years and included extensive coercive hearings before the Crime and Misconduct Commission (CMC). The investigation eventually led to charges being brought against Peter Lievesley and Melinda Punch.

The Inquest

On 12 April 2013, a pre-inquest conference was held. Leave was granted to the legal representatives for Ms Punch. Mr Lievesley's parents, Mr Peter Lievesley Snr and Mrs Mary-Anne Lievesley were subsequently granted leave to appear as parties to the proceedings, in their son's absence.

The issues identified at the pre-inquest conference to be explored at the inquest were:

a) The findings required by s. 45 (2) of the *Coroners Act 2003*; namely the identity of the deceased person, when, where and particularly how she died and what caused her death;

b) The circumstances surrounding Tamiya's death, particularly the precise chronology of events on the day before her death; and

c) The means by which Tamiya came to ingest morphine, which caused her death.

The scope of the 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:-

a) whether a death in fact happened;
b) the identity of the deceased;
c) when, where and how the death occurred; and
d) 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.

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."*

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. However, 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 has some civil liability.

The Admissibility of Evidence and the Standard of Proof

The Coroners Act 2003 sets out the extent and limits of a coroners powers to investigate death. Proceedings in a coroner's court are not bound by the rules of evidence because the Act provides that the court "*may inform itself in any way it considers appropriate."(s.37.1)* That does not 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 courts. If a witness refuses to give oral evidence at an inquest because the evidence would tend to incriminate the person, the coroner may require the witness to give evidence that would tend to incriminate the witness if satisfied it is in the public interest to do so. The evidence, when given, and any derivative evidence is not admissible against the witness in any other proceeding, other than a proceeding for perjury (s.39).

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. This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, 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. *Briginshaw v. Briginshaw (1938) 60 CLR 336 at 361.*

If, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed a criminal offence, the coroner must give the information to the Director of Public Prosecutions in the case of an indictable offence, and to the chief executive of the department which administers legislation creating an offence which is not indictable (s. 48.2)

The Evidence

I do not propose to repeat or summarise all of the information contained in the exhibits or all of the oral evidence, however I will refer to all relevant and important parts of the evidence.

Morphine Addiction of the Parents

I refer at the outset to the morphine addiction of Tamiya's parents. This was the prevailing and overwhelming factor affecting every aspect of these sad events including, in particular, the credibility of the parent's evidence. There was incontestable evidence led at the inquest that the parents of the deceased infant were morphine addicts at the time of her death. Melinda Punch in her evidence on 28 October 2014 admitted as much.

Dr Stolz who gave evidence on 29 October 2014 was the doctor who principally prescribed morphine to both parents in those weeks leading up to the death of the deceased infant. Exhibits *"E12"* and *"E13"*, the records of the Dangerous Drugs Unit of Queensland Health, establish that both Peter Lievesley and Melinda Punch were being prescribed and dispensed significant quantities of morphine in the weeks leading up to the death of the deceased infant.

Dr Culliford in an addendum report which is Exhibit *"C7"* observed that Dr Stolz prescribed morphine at a rate greater than the dose he had initially prescribed. Between 21 January 2004 and 25 February 2004, he supplied 6 prescriptions for 20 capsules of Kapanol (morphine 100 mg) sustained release capsules to Peter Lievesley. In five weeks Lievesley was given 120 Kapanol capsules. Similarly, Melinda Punch over 11 days had access to 80 tablets, *"far in excess of the prescribed level"*. Dr Culliford was critical of Dr Stolz, saying this should have warned him there was an increase in dependence to the morphine.

Dr Stolz in his evidence on 29 October 2014 accepted that in hindsight he should not have prescribed the large quantities of morphine that he did. His explanation for doing so was to ensure that Lievesley and Punch did not suffer from withdrawal symptoms, and did not seek heroin from street dealers. Dr Stolz also accepted that his note keeping was poor, and that he had failed to duly record in his notes relevant information that was being told to him by Lievesley and Punch.

The critical issue arising from all of this is that Lievesley and Punch had access to significant quantities of morphine at the time of the deceased infant's death. The DDU records, Exhibit *"E12"* in respect of Peter Lievesley, establish that on 1 March 2004, Peter Lievesley was dispensed 20 100 mg tablets of morphine sulphate from the Beenleigh Discount Drug Store. No morphine tablets were located by the police when they did a search of the house on 2 March 2004; empty packets of morphine tablets were located.

Drugs of Dependence Unit ('DDU') Records

Police sought a statement from Drugs of Dependence Unit of Queensland Health investigator officer, Ms Rebecca Lee Thompson regarding Mr Lievesley and Ms Punch history with DDU. DDU has the responsibility for data collection and analysis concerning the prevalence of the inappropriate and unlawful prescribing and use of pharmaceutical drugs which carry a risk of dependence. The DDU also has the responsibility for overseeing the Queensland Opioid Treatment Program ('QOTP') which deals with opioid substitution therapies, such as methadone, for drug dependent person. DDU utilise the information management database called MODDS (monitoring of dangerous drugs system). MODD is intended to be used for a number of purposes including, the identification of incidences of inappropriate and unlawful prescribing, misuse of controlled drugs and patient behaviour such as doctor shopping for controlled drugs. The MODD system facilitates the provision of state-wide confidential telephone 'enquiry service' for medical practitioners.

According to Ms Thompson, Mr Lievesley met the criteria for a drug dependent person, pursuant to Part 1, s 5 of the *Health Act 1937.* He was known to DDU since 2000. Ms Punch also met the criteria for a drug dependent person under the *Health Act.* She had been known to DDU since September 2003.

Ms Thompson was asked by police to comment on whether Mr Lievesley and/or Ms Punch were Doctor Shoppers, in accordance with the DDU criteria. A doctor shopper is defined by the DDU to include a person that within any three month period consults four prescribers or obtains twelve prescriptions.

DDU records indicate that Mr Lievesley obtained no less than 39 non-QOTP related pharmaceutical prescriptions from no less than 19 prescribers between 20

July 2001 and 7 January 2010. Mr Lievesley's daily use of morphine sulphate, as extrapolated from his prescriptions, was approximately 230 mg/day. Based on the records held by DDU, Mr Lievesley would have been considered to be an active doctor shopper for a controlled drug of dependence, particularly Morphine Sulphate.

DDU records indicate that Ms Punch obtained no less than 32 non-QOTP related pharmaceutical prescriptions from no less than 9 prescribers between 29 September 2003 and10 March 2004. Ms Punch's daily use of morphine sulphate, as derived from her prescriptions, was approximately 200 mg/day. Based on the records held by DDU, Ms Punch would have been considered to be an active doctor shopper for a controlled drug of dependence, particularly Morphine Sulphate.

It is of great concern that Peter Lievesley and Melinda Punch could so readily and easily satisfy their morphine addiction. The supply of morphine in substantial quantity was readily maintained by their general practitioners, in particular Dr Stolz. The drugs were very cheap, compared to say heroin, because they were heavily subsidised under the Pharmaceutical Benefits Scheme. Their visits to the doctor (supplier) was free because of Medicare bulk billing and their addiction carried with it none of the dangers, stigmas and criminality of a heroin addiction. Yet in the end their addiction was no less destructive or fatal than an addiction to heroin. Their lives and the lives of their children was chaotic and led to them living in squalid circumstances and eventually it led to the deaths of Tamiya Lievesley and her father Peter Lievesley.

Sequence of events

Prior to Tamiya's death, Ms Punch and Mr Lievesley had been in an 'on again off again' de-facto relationship for approximately six years. They had three children together, namely Sabrina Lievesley (DOB 07/09/99), Peter Lievesley (DOB 16/08/00) and Tamiya Lievesley (DOB 13/08/03).

Tamiya was born at the Logan Hospital by way of caesarean section. At the time of her birth, Ms Punch admitted to using illegal substances. A urine screen showed that Tamiya's urine contained cannabis and opiate derivatives. Tamiya was observed in the Special Care baby unit for signs of substance abuse withdrawal symptoms. She was observed to have mild features of withdrawal. The Logan Hospital spoke to the Department of Child Safety who confirmed that they had inspected the home and did not feel there was any reason for Tamiya not to go home with Ms Punch and Mr Lievesley. She was discharged after eleven days. At the time of Tamiya's death the Department of Communities (Child Safety) ('DOCS')

had no active involvement with the family. The last active involvement 'DOCS' had with Tamiya was at the time of her birth.

Tamiya was breast feed for a period of eight weeks before being given formula. Subsequent check-ups with Ms Punch's General Practitioner and Hospital Doctors confirm that Tamiya was a healthy child who was progressing well.

At the time of Tamiya's death, Ms Punch and Mr Lievesley resided at 28 Eira Court, Edens Landing. Neighbours of the couple describe them as a very noisy family, who were always yelling at the children and fighting. They were known to consume alcohol and illegal drugs, such as heroin and prescription opiates, including Kapanol. The couple had resided at the address for a couple of months prior to Tamiya's death.

In the afternoon on the day before Tamiya's death, Ms Punch recalls feeding Tamiya a tub of yoghurt, which she kept vomiting up. Regardless, Ms Punch continued to force Tamiya to eat the entire tub.

On the evening prior to Tamiya's death at around 4:00 pm, Mr Matthew Economidis and his brother Thomas, attended Ms Punch and Mr Lievesley's residence. According to Matthew, he attended Ms Punch and Mr Lievesley's residence with his brother, twice a week. They would often consume alcohol and take drugs such as cannabis or prescription opiates. Matthew recalls that Mr Lievesley would mix up Kapanol tablets by taking the beads out of the capsule and placing them in the bottom of a can. He would then mix water with the beads and crush it with the plunger of a syringe, which would open up some of the beads letting the powder loose. Heat was then placed under the can so that the beads, which had not opened, could absorb the opiate in the water. A filter was then used to suck the liquid up into the syringe without contaminates. Matthew recalls that Mr Lievesley would keep his drugs and associated paraphernalia in a dark sports bag.

On the evening before Tamiya's death, Matthew recalls that he smoked cannabis with Thomas at Ms Punch at Mr Lievesley's address. Ms Punch and Ms Lievesley's older children were playing in the lounge room at this time. Matthew and Thomas left briefly to shower, and returned to Ms Punch and Mr Lievesley's residence around 5:00 pm. Matthew recalls that Ms Punch was nursing the baby on the couch when they returned and continued holding the baby the entire evening. He observed Tamiya to be very quiet.

According to Ms Punch, she fed Tamiya a bottle of formula, whilst sitting on the couch in the living room. She recalls that between 5:00 and 6:00 pm she put Tamiya down with the bottle in her cot as she appeared drowsy. Tamiya's cot was

in a separate room to that shared by her older siblings. Ms Punch recalls seeing Tamiya throw the bottle out of the cot a short time later.

Matthew and Thomas stayed at the residence for a couple of hours. The older children retired to bed at around 8:30 pm. Matthew claims that Tamiya was put in her cot after the older children had gone to bed. According to Matthew, Ms Punch gave Tamiya a bottle of milk before she put the child to bed.

After the children had gone to bed, Thomas and Mr Lievesley went into the kitchen to shoot up morphine. Ms Punch also went into the kitchen to have a shot. Matthew recalls that Thomas, Mr Lievesley and Ms Punch all appeared to be "stoned" after they returned from the kitchen. Thomas and Matthew left the residence at around 10:30 pm.

Ms Punch claims that she fell asleep on the couch with Mr Lievesley. When she woke at around 1:30 am she claims that she checked on Tamiya, who was lying on her belly towards the end of the cot. She was sucking her bottom lip. Ms Punch claims she placed her finger under Tamiya's nose to make sure she was breathing. She recalls placing a blanket over Tamiya's shoulders before retiring to bed. Mr Lievesley claims he also saw Tamiya sucking her bottom lip.

Ms Punch was woken the following morning by Sabrina at around 8:00 am (2 March 2004). When Ms Punch realised the time she went to check on Tamiya and noticed Sabrina coming out from underneath of Tamiya's cot, yelling "*Tamiya's a monster mum".* Ms Punch claims she saw Tamiya was face down on the mattress and her left arm was bent up by her head. According to Mr Lievesley, Ms Punch picked Tamiya up and saw that her face was blue and squashed. He attempted to perform CPR before running from the house to get assistance.

Neighbours of Ms Punch and Mr Lievesley recall hearing screams coming from the street at around 7:00 am on 2 March 2004. Mrs Iris Asher, who was staying with her daughter, Ms Leanne Mapley at 37 Eira Court, Edens Landing (across the street from Ms Punch and Mr Lievesley's residence), recalls hearing a male voice repeatedly screaming, "*my fucking baby's dead*" and "*my fucking kids have killed my baby*". She also heard a female yelling out, "*my baby*". Mrs Asher went to the front of the house and looked out the kitchen window. She recalls seeing a man and woman in the front yard of her daughter's property. The male person was wearing a small backpack. She saw a baby on the floor and thought that the woman was attempting to resuscitate it. The woman appeared to be distressed. Her daughter subsequently left the residence to assist with the child and called the QAS.

Kaye Becker was a neighbour who lived at Eira Court, Edens Landing, the same street the deceased infant lived with her family. She recalled the morning of 2 March 2004 when she heard her next door neighbour on the phone talking to someone quite loudly. She heard lots of screaming coming from the road, and she walked out of the front door of her house to see if anyone needed help. She saw two ambulances parked outside or near Leanne Mapley's house. She saw the young woman who lived at number 28 Eira Court. She was holding a baby and yelling at a male person, whom she thought was her partner. She heard the lady yell out *"I hope she hasn't got any of your stuff because I didn't vacuum the floor yesterday"* and *"If I find out this is your fault you mongrel, I'll kill you"*. She could hear there was a lot of swearing between these two comments. She described the man *"Just walking around, looking quite dismayed, but also swearing back at her a lot."*

Ms Mapley recalls that as she spoke to the QAS operator, as Ms Punch attempted to resuscitate Tamiya. She was advised to place Tamiya's hands above her head, which she was unable to do as the child was stiff. In Ms Mapley's opinion, the child appeared to have been deceased for some time. During this time, Ms Mapley describes Mr Lievesley as "*going stupid and cracking up all the time.*" He was blaming his other children for killing the child, stating things like *"look what you've done to your sister. You've killed her."*

Mrs Asher recalls that during the commotion (and prior to QAS arrival) the male person with the backpack (Mr Lievesley) approached the doorway and asked if he could leave his backpack in the house. Mrs Asher's husband, Mr Robert Asher, allowed the male to leave the bag. The male stated, "*Make sure no one looks in it."* He left the bag for only a few seconds and then returned to rifle through it, before picking it up and taking it with him. Mrs Asher recalls that the male appeared to be frantic and nervous about the bag. The male then proceeded to move the bag around the outside of Mrs Asher's daughter's house. Mrs Asher did not touch the backpack or see its contents. A number of other neighbour's also saw Mr Lievesley holding a black backpack, which he seemed to be attempting to hide.

QAS subsequently attended Eira Street. The dispatch description was of a child not breathing. The first QAS officer's to arrive at the scene were Advance Care paramedic Steven Wagner with fellow paramedic Renay Downey. Upon approaching the street, Mr Wagner and Ms Downey both recall seeing a group of people on the footpath that appeared to be performing CPR upon a child lying on the dirt near a driveway. The people seemed to be distressed. Upon approaching the group, Mr Wagner and Ms Downey saw that the child appeared to have been deceased for some time and was mottled in appearance.

Intensive care paramedics Cheryl Stace and Troy Carrothers subsequently attended the scene. Ms Stace describes the scene as "pandemonium" with people screaming and yelling. Ms Stace, as the senior QAS officer on the scene, recalls briefly examining the child and determining that resuscitation was not a viable option as the child had been deceased for some time. Mr Wagner subsequently declared Tamiya to be "life extinct".

Mr Wagner recalls seeing a female, who he assumed to be mother of the child, speaking to a male and repeating words to the effect of, "*you better not be responsible for what's happened and you better not have left any of your stuff laying around."* Ms Stace recalls hearing Ms Punch state words to the effect of, *"if you've fuckin killed this baby, I'll kill you."* She also recalls the Mother stating words similar to, *"if you've given it something".* Paramedic, Mr Troy Carrothers also recalls hearing the Mother say to the Father words to the effect of, *"did you give my child something, or did you drug my child".* Mr Carrothers observed Mr Lievesley to be quite erratic in his movements.

Mr Wagner recalls attempting to remove the child from public view, so that he could wrap it in a blanket. He initially entered the wrong residence. When he attempted to enter Ms Punch and Mr Lievesley's house, he was refused entry by Ms Punch.

Tamiya was subsequently transported to the Logan Hospital with Ms Punch by QAS officer's Mr Wagner and Ms Downey. Ms Downey recalls that during the trip, Ms Punch was trying to discern how this could have happened. She told Ms Downey that Tamiya may have found one of her father's tablets on the floor, and picked it up. She also suggested that one of her other children may have hurt Tamiya. Ms Punch also stated that Tamiya had been face down in the cot when she had found her in the morning.

Ms Punch's mother, Mrs Christine Punch recalls that whilst at the Logan Hospital, after Tamiya had died, Mr Lievesley stated that he "*was not going down for this*" and had gotten rid of the evidence.

It is apparent from the evidence of independent witnesses and the QAS paramedics that Melinda Punch was accusing her partner of giving drugs to Tamiya. It is somewhat extraordinary that this information was not immediately passed on to the police. Had this information been passed on it would have made an immediate difference to the way in which Tamiya's death was investigated and that in turn would have led to a different outcome, as will become apparent.

Police also attended the Logan Hospital to speak to Ms Punch and Mr Lievesley. Investigating Officer, Detective Sergeant Naomi Lockhart observed Ms Punch to be

visibly upset and holding Tamiya in her arms. Mr Lievesley also appeared to be visibly upset and was being quite loud and obtuse in his distress. The paternal and maternal grandparents of the child were also at the hospital.

Ms Punch told police that she had provided Tamiya with a bottle of formula at around 6:00 pm the previous evening. She drank approximately ¾ of the bottle and was put to bed in the same clothes as she was found in the following morning. Ms Punch watched television with Mr Lievesley until around 1:00 am. When they retired to bed they walked past Tamiya's room and saw that she was sucking her bottom lip. Ms Punch pulled a blanket up around her. Ms Punch stated that Tamiya usually woke for a 5:00 am feed. However, the morning of Tamiya's death, Ms Punch and her two other children did not wake until 8:00 am. Ms Punch claimed she rushed into Tamiya's room and saw her face down on the mattress with her head jammed into the corner of the cot and one arm between the slats. Upon turning Tamiya over, she saw that one arm was stiff and her face was yellow and purple with pursed lips. Mr Lievesley then attempted CPR.

Officer Lockhart requested that the forensic medical officer, Dr Elizabeth Culliford attend to examine Tamiya. At 10:10 am, Dr Culliford conducted a medical examination of Tamiya, which concluded at 11:00 am. In Dr Culliford's view, Tamiya appeared to be poorly nourished and had poor hygiene. Dr Culliford estimated Tamiya's time of death to be less than 24 hours, consistent with having died sometime overnight or early morning. No signs of external injuries were observed aside from blood around the nose. Dr Culliford recommended that an internal autopsy be conducted in order to determine Tamiya's cause of death.

Autopsy

An external and full internal examination was performed by Dr Beng Ong on 3 March 2004. A number of histology and toxicology tests were also undertaken.

The internal post mortem examination revealed that Tamiya's airway contained a quantity of thick yellow mucus. The stomach was found to contain a quantity of a yellowish milk curd like substance. Whilst some minor injuries were noted to Tamiya's nose and face, the internal and external examinations undertaken by Dr Ong did not disclose any anatomical cause of death.

Results of toxicological testing on samples taken from Tamiya during the autopsy, however, found that she had 2.9 mg/kg of morphine in her blood, with a total of 6.2 mg/kg of morphine and morphine glucuronides (the main metabolites of morphine). Testing conducted of urine samples found that the immunoassay was positive for opiates. 2300 mg/kg of morphine was also present in Tamiya's stomach content, which is equivalent to approximately 30 mg of morphine.

According to a statement by Chemist Mark Stephenson, who is employed in the Toxicology section of Queensland Health Scientific Services, Tamiya's stomach content consisted of approximately 15 g of thick, cream coloured liquid, similar to yoghurt in appearance. Examination of the stomach content revealed the presence of a small object weighing approximately 0.5 g and measuring 1.5 cm in diameter, which had the same chemical composition and structure as polyurethane foam.

The cause of Tamiya's death was found to be morphine toxicity. The external examination did not identify any needle marks on Tamiya's body. As such, Dr Ong inferred that Tamiya had ingested the morphine orally rather than by injection.

In an addendum statement provided by Dr Ong on 11 December 2006, he notes that according to medical literature, it would only take between 0.2 mg to 2.3 mg/kg of total morphine in the blood to cause the death of any individual. There is no evidence in this case which suggests that the morphine was administered to Tamiya in any way other than orally. In relation to the level of morphine present in Tamiya's stomach, this would have certainly been administered recently before death. However, Dr Ong was unable to say exactly how long before death the morphine was consumed.

An analysis was subsequently conducted at the Forensic Toxicology Laboratory on the clothing worn by Tamiya at the time of her death. Morphine was found on her blue top (0.2 mg) and on her blue singlet (0.2 mg). The contents of her nappy were not examined.

Police investigation

At approximately 8:30 am on 2 March 2004, Police attended Ms Punch and Mr Lievesley's address. At 9:05am, Plain Clothes Senior Constable Matthew Phillips, in the company of Plain Clothes Senior Constable Tenisha Furlong, entered Ms Punch and Mr Lievesley's residence though an open sliding glass door. Officer Phillips observed the house to be messy and generally untidy. On the floor of the main bedroom he observed a glass smoking utensil. In the first bedroom, he observed a wooden cot with a mattress and bedding in it. The bedroom floor had belongings spread all over it, which made it hard to walk around. In the kitchen, Officer Phillips also located one empty packet of Kapanol capsules (50 mg of Morphine Sulphate), with 20 tablets per pack. These tablets were prescribed to Ms Punch and were dated 18 February 2004. An empty blister pack of the same name was observed to be in the recycling bin.

Near the sliding glass backdoor, Officer Phillips found a rubbish garbage bag which contained three empty boxes of 'MS-Contin'. Two of the packets were 60 mg

tablets of Morphine Sulphate, with 20 tablets per packet. Both packets appeared to be dated 28 January 2004. The remaining packet contained 10 mg tablets of Morphine Sulphate, with 20 tablets per packet. The packet was dated 29 December 2004. All prescriptions were in Ms Punch's name.

After a conversation with Mr Peter Loch Lievesley Snr, Officer Phillips opened a recycling wheelie bin situated in the driveway of the dwelling. He observed a white baby's bib without any staining. Empty syringe wrappers and three sharps containers full of used needles were also located inside the bin.

At Officer Phillips' direction a number of photographs were taken of Ms Punch and Mr Lievesley's residence. Unfortunately, items such as Tamiya's bottle and the containers of formula were not seized by the police. Accordingly, no forensic testing was conducted on these items. Had the police been aware of the allegations being made by Melinda Punch, an assumption that this was a S.I D.S death would not have been made and a more thorough investigation would have ensued. I will make further comment about this later.

Later that day, Officer Lockhart conducted s 93A interview with Sabrina Lievesley. Attempts were also made to engage with Sabrina's younger brother Peter (aged 3) in order to assess his ability to participate in an interview. However, due to great difficulty experienced by police, a statement was not able to be obtained.

On 12 April 2004, Ms Punch attended the Beenleigh CPIU office and provided a partial statement to police. Ms Punch attended the office the following day to complete her statement

Statement to Police by Ms Punch – 12.04.04

(a) Ms Punch admits that she has blank spots from the day before Tamiya died. She recalls attending the Edens Landings shopping centre and buying takeaway food for the children. Upon arriving home, she recalls feeding Tamiya a tub of yoghurt which she kept throwing up. Regardless, Ms Punch admits that she forced her to eat the entire tub. Afterwards, she recalls giving Tamiya a bottle of formula whilst sitting on the couch. She placed Tamiya in her cot between 5:00 and 6:00 pm as she appeared drowsy.

(b) Ms Punch and Mr Lievesley fell asleep on the couch that evening. Ms Punch recalls waking up at around 1:30 am, at which time she checked on Peter and Tamiya. She noticed that Tamiya was lying on her stomach and was sucking her bottom lip. She recalls placing a blanket

over her and checking that she was breathing by putting her finger under her nose.

(c) She was awoken by Sabrina the following morning at around 8:00 am. When Ms Punch realised the time she went to check on Tamiya and noticed Sabrina coming out from underneath of Tamiya's cot, yelling "*Tamiya's a monster mum".* Ms Punch claims she saw Tamiya was face down on the mattress and her left arm was bent up by her head.

(d) Ms Punch admits that she was prescribed MS Contin shortly after she gave birth to Tamiya. She continued to take the drug until two weeks after Tamiya's death. Ms Punch claims she then went into a de-tox program at the Royal Brisbane Hospital and was now on a "subutex program". Before Tamiya's death, she admits to taking two tablets of MS Contin a day. She would either ingest the tablets orally or inject them after heating the tablet with water on a spoon. Ms Punch recalls having blank spots for the four days prior to Tamiya's death as a result of the MS Contin. She also took 50 Valium tablets over the four day period, prior to Tamiya's death.

On 17 April 2004, Ms Punch again attended the Beenleigh CPIU office with Mr Lievesley. She discussed her statement. An appointment was subsequently made for Mr Lievesley to attend and provide a statement about the matter.

On 18 April 2004, Mr Lievesley attended the Beenleigh CPIU office and provided a statement to police. As Mr Lievesley died before this inquest commenced I propose to summarise his statement in some detail.

Statement to Police by Mr Lievesley – 18.04.04

(e) Mr Lievesley admits that he was taking pain medication for his back as well as morphine in the four days prior to Tamiya's death. He recalls that he was having around 200 mg of morphine a day.

(f) The night before Tamiya's death, Mr Lievesley recalls that Ms Punch put Tamiya to bed at around 6:00 pm with a bottle. The family then had dinner and watched a film. He recalls falling asleep on the floor with Ms Punch whilst watching television. Sabrina had put herself to bed and Peter was sleeping on the couch.

(g) He recalls retiring to bed with Ms Punch. He saw Ms Punch place a blanket over Tamiya and could see that she was sucking her bottom lip.

Mr Lievesley suggested that Tamiya be brought into bed with Ms Punch and himself, however, Ms Punch objected as she was afraid of waking Tamiya.

(h) Mr Lievesley recalls being woken the next morning by Sabrina at around 8:00 am. He followed Ms Punch into Tamiya's room shortly after he saw Sabrina run out of it. He saw that Tamiya was face down on the mattress and her left hand was poking outside the cot. When Ms Punch picked Tamiya up he saw that her face was discoloured and she seemed squashed. He grabbed Tamiya out of Ms Punch's hands and attempted to perform CPR. Mr Lievesley recalls running out of the back door of the residence and calling for help. Ms Punch continued to perform CPR at this time.

On 8 May 2004, a video re-enactment was conducted with Ms Punch, Mr Lievesley and his Mother, at their residence in Edens Landing.

On 16 February 2006, Ms Punch refused to participate in an electronic record of interview with police.

On 4 May 2006, further electronic statements were obtained from Sabrina and Peter Lievesley.

On 8 June 2006, Mr Lievesley refused a request to participate in an electronic interview with police.

On 30 August 2006, Ms Punch provided an addendum statement to police with a microcassette of her conversations with her daughter, Sabrina. Transcript of the tape is largely inaudible.

On 7 October 2008, CMC coercive hearings were conducted. These hearings concluded on 16 October 2008.

On 17 November 2009, further CMC coercive hearings were held in order to interview Matthew and Thomas Economoidis. Mr Thomas Economoidis has refused to provide a statement to police. He was not called to give evidence during the criminal trial.

On 17 October 2008, Police attended upon Ms Punch for the purpose of a prearranged interview. Records indicate that this interview did not take place.

On 7 July 2010, Ms Punch was arrested and charged with Tamiya's death.

On 8 July 2010, Mr Lievesley was issued with a notice to appear in relation to Tamiya's death. At the time, he was in custody for other unrelated offences.

Medical Advice sought by Police

Dr Elizabeth Culliford:

Following receipt of the autopsy and toxicology results, Police sought further opinions from Dr Culliford regarding a number of issues, including the effect of a child's ingestion of morphine, breast feeding and an overview of Tamiya's, Mr Lievesley and Ms Punch's medical files. Dr Culliford is the Deputy Director of the Clinical Forensic Medicine Unit for South East Queensland Region. Dr Culliford notes that Morphine is a narcotic analgesic which is used for the treatment of moderate to severe pain. It is a central nervous system depressant and the cause of death in morphine toxicity is commonly due to respiratory depression.

Dr Culliford notes that the free morphine level of 2.9 mg/kg and the total morphine level of 6.2 mg/kg found in Tamiya's blood was extremely high and would have been associated with her death.

According to Dr Culliford, determining the amount of morphine taken by an individual before death is an inexact science as there are many unknown variables, such as absorption, distribution and metabolism. However, Dr Culliford does opine that it is likely Tamiya did not die immediately and was alive for some hours (possibly about three) after she was given the morphine, as about half of the morphine had metabolised to glucuronides.

Dr Culliford expresses the view that it is likely that Tamiya consumed morphine rather than heroin, as there was no codeine or 6-MAM (6-monoacetylmorphine) present in her urine. The absence of needle marks on Tamiya's body and the presence of morphine in Tamiya's gastric contents also suggested that the morphine had been consumed orally rather than by injection.

In relation to the dose given to Tamiya, Dr Culliford made a calculation based upon the blood levels of total morphine, her body weight, the volume of distribution and the bioavailability of oral morphine. She reaches the view that Tamiya was given as little as 64 mg of morphine, or possibly a significantly greater dose. However, Dr Culliford does state that it is unlikely that Tamiya was given only one 30 mg tablet of MS Contin, as the 30 mg found in the stomach was what was left after much of the morphine had been absorbed. Thus, the dose given to Tamiya would have been 30 mg plus at least 64 mg, suggesting that one 100 mg tablet or more was taken.

The content of Tamiya's stomach was described as 'yellowish milk-like curds', which Dr Culliford says could have been milk curds plus MS Contin. If a person dies after taking either Kapanol or MS Contin, the stomach contents may reveal the source. MS Contin may be noticeable as sludge or whole tablets especially if a number of tablets were taken and death ensued fairly quickly. However, if death occurred some hours after ingestion, it is likely that most of the stomach contents would have emptied into the small bowel, despite the reduced gut motility experienced after morphine. Kapanol tablets, however, dissolve quickly. In Tamiya's case, it is not possible from the description of the stomach content to determine whether the morphine was given in the form of Kapanol capsules, an MS Contin tablet or extracts taken from either form prior to ingestion.

Dr Culliford's opinion was also sought on whether Ms Punch could have transferred the morphine to Tamiya by way of breast milk, if she was breast feeding. Dr Culliford notes that even if the concentration level of morphine in Ms Punch's body was high, the total dose presented to the infant would still be minimal and cannot account for the amount of morphine found at autopsy.

Dr Culliford also conducted a review of Ms Punch and Mr Lievesley's medical records in order to comment on whether they were appropriately managed by their general practitioner, Dr Stolz. Dr Culliford notes that morphine prescriptions began in September 2003 for both Mr Lievesley and Ms Punch and continued until 10 March 2004 for Ms Punch and 22 March 2004 for Mr Lievesley. Mr Lievesley obtained a prescription for Kapanol 100 mg x 20 tablets on 1 March 2004, the day before Tamiya died. Ms Punch's last prescription before Tamiya's death was for MS Contin on 27 February 2004.

It should be noted that according to the statement of Dr Timothy Chan, from Edens Landing Medical Centre, he prescribed Mr Lievesley 100 mg of Kapanol x 20 tablets on 1 March 2004.

After reviewing Mr Lievesley and Ms Punch's medical records, Dr Culliford reached the following conclusions:

- Both Mr Lievesley and Ms Punch received multiple scripts of morphine in the form of MS Contin and Kapanol from September 2003 to March 2004.

- They both had access to morphine at the time of Tamiya's death.

- There is evidence that both subjects exhibited drug seeking behaviour. This should have been recorded and acted upon by the treating doctors. However, despite this a large number of morphine

prescriptions were supplied by Dr Stolz and other doctors in Logan and Beenleigh.

- Neither Mr Lievesley nor Ms Punch appeared to have been properly assessed for their escalating substance use. Had this been done in a timely fashion, with appropriate drug management instituted, they may have been able to deal with their opioid dependence in a more responsible manner. It is rarely possible to deal with severe opioid dependence without help and support form appropriately qualified health professionals.

- Dr Culliford notes that the prescription of MS Contin and Kapanol to Mr Lievesley and Ms Punch was clearly outside the guidelines of management of an opioid dependant person. They were never referred to any agency which may have assisted in the treatment of their substance use.

- Tamiya died of morphine toxicity. It is not possible for Dr Culliford to state how the morphine got into her body.

Dr Culliford was also asked to consider the likelihood of a number of scenarios. Her findings were as follows:

Scenario 1: Tamiya was given a slow release morphine tablet with her bottle or yoghurt between 5 and 6 pm. She was stated to be alive at 1:30 am. She was deceased with rigor at 8:20 am.

- Dr Culliford notes that absorption would commence fairly soon after the morphine was taken and continue for some hours. A toxic level may not be reached for some hours because of the delayed release from the sustained release medication. The amount of morphine in her system at the time of autopsy means that she was alive for at least three hours from the time she had morphine as it absorbed into her blood.

- In Dr Culliford's opinion, this scenario is possible but less likely because of the seven to eight hour period between possible dosing and when the infant was reported to still be breathing. If the infant died after 1:30 am, sufficient time must have elapsed to allow full rigor to have set in by 8:20 am.

Scenario 2: Tamiya was given a slow release morphine tablet with her bottle or yoghurt between 5 and 6 pm. She was deceased at 1:30 am when the parents looked in on her. She was deceased with rigor at 8:20 am.

- Tamiya would have died some hours after the morphine was ingested. Therefore her death could have occurred any time from 9:00 pm onward. Rigor would set in four to six hours after death and certainly becomplete at 8:20 am, the following morning.

In Dr Culliford's opinion, this scenario is more likely because of the shorter time between dosing and the likely time of Tamiya's death, however, it is still not possible to state exactly when Tamiya died.

Scenario 3: Tamiya ingested the morphine accidentally whilst playing on the floor, or was given the morphine by her sibling prior to her feed at 5-6 pm.

- If this had occurred, it is unlikely that Tamiya would have been alive at 1:30 am when the parents claim they checked on her. However, if the parents were mistaken, it is possible that this may have occurred.

Dr Culliford notes that it is not possible to state exactly when Tamiya took, or was given morphine but it would have been sometime in the evening and certainly before midnight (to allow for absorption, metabolism and rigor to occur). If it was given to her with her feed between 5:00 and 6:00 pm, then she would have died some hours later (at least 3 hours). It is likely that she would have died sometime before midnight.

Whilst it is possible that Tamiya may have been alive at 1:30 am when her parents claim they checked on her as she clearly did not die immediately, this is less likely.

Professor Olaf Drummer

A statement was subsequently sought by police from Professor Drummer, who is employed at the Victorian Institute of Forensic Medicine, Forensic and Scientific Services. He is also an Adjunct Professor and Head of the Department of Forensic Medicine, Monash University. He is a forensic pharmacologist and toxicologist who has been involved in the analysis of drugs and poisons for over 30 years.

Professor Drummer was asked to comment on a number of matters including, Tamiya's likely time of death, the strength of tablets administered to leave 30 mg in the stomach, whether the drug in the stomach was MS Contin or Kapanol and what amount of morphine would normally cause death in a child of Tamiya's size and age.

Professor Drummer concurs with Dr Culliford's statement that the time of death following absorption of a fatal dose of morphine is quite variable. Oral administration of morphine could have caused a relatively slow but sustained absorption over several hours. The absorption is slow because it takes some time for the morphine to reach the small intestine and be absorbed. This would take at least 15 minutes but could take hours since morphine reduces the motility of the gastro-intestinal system. If the morphine was dissolved in milk it is likely that absorption would be more rapid. Significant amounts of morphine will slow breathing and cause respiratory distress and even put the child into a coma, but death might not occur for some hours.

Professor Drummer notes that the amount of tablets administered to Tamiya cannot be determined definitely, although he did agree that it would have been in excess of 30 mg. The concentration of morphine and its metabolites in Tamiya's blood was very high and would certainly be capable of causing death. The fatal dose of morphine in a child of Tamiya's age could be as little as 5 mg.

Professor Drummer notes that it is not possible to distinguish the source of the morphine.

Pharmacist Stefanie Nicholls

A statement was also sought from Pharmacist, Stefanie Nicholls. Ms Nicholls states that if an MS Contin tablet was broken, crushed or chewed, it would be expected that the taste upon ingestion of the contents would be very bitter.

Statement of Mr Lievesley's GP, Dr Stolz:

Dr Stolz confirms that he had prescribed Mr Lievesley with 100 mg of Morphine Sulphate tablets on the 25 February 2004. He states that he had seen Mr Lievesley on multiple occasions in February 2004 with acute withdrawal symptoms. He prescribed Mr Lievesley with the high amount of morphine to assist with withdrawal symptoms, whilst he was trying to find a long-term program for his addiction. He was aware Mr Lievesley was a heroin addict. Dr Stoltz states that, "*it was very difficult to make a judgment on his demeanour and mental state because he always came in during an acute withdrawal faze with tremors, agitation and adnominal cramps. The visit on the 22/02/04 was in that regard no different to any of his other visits in February 2004.*"

Statements provided by Ms Philippa Wijk & Kelly Weir

The précis provided by the police indicates that statements were obtained from Ms Wjik and Ms Weir.

Ms Wjik is an Occupational Therapist who was asked to comment on Tamiya's ability to grasp objects in her fingers, at her age. Ms Wjik states that it would be unusual for children of Tamiya's age to have developed the fine grasp necessary to pick up small pellets, such as MS Contin tablets, and then successfully place the object in their mouths.

Ms Weir is a Speech Pathologist who was asked to provide an expert opinion regarding Dr Elizabeth Culliford's findings. Ms Weir noted that children develop the ability to reject bitter tastes between the ages of 14 to 180 days of age. If an infant is given a tablet which has a bitter taste, they may respond by gagging and possibly vomiting.

How was the Morphine Administered to the Deceased Infant?

Melinda Punch in both her evidence to the Crime and Misconduct Commission and her evidence at the inquest on 28 October 2014 said that the morphine tablets were melted down on a spoon using water and heat from a cigarette lighter, and then injected. Matthew Economidis gave a similar description in his evidence at the earlier hearing on 5 July 2013.

Ms Punch gave evidence both before the CMC and at the inquest that on occasions Peter Lievesley would inject her while she was asleep. Apparently this was done as a kindness, to ensure that she didn't wake feeling sick.

There is no evidence to indicate that there were any needle marks on the body of the deceased infant, and as noted by Dr Ong in his report above, it is most likely that the morphine was administered orally. Unfortunately neither parent of the deceased infant took responsibility for this. On the evidence the only persons who could possibly have done this were the parents.

Dr Olaf Drummer gave oral evidence on 29 October 2014. He gave the following essential evidence:

A morphine sulphate tablet, with the trade name *"MS Contin"* was a slow release tablet. It is designed to release morphine in a slow rate over many hours. In healthy persons the consumption of a tablet leads to *"a reasonably rapid transit from the stomach into the small bowel. Most of the tablet contents are absorbed in the small intestine; almost no drug is absorbed in the stomach itself. The rate of*

transit of tablets into the small intestine is normally relatively short but depends on the volume and type of material ingested, a range of physiological variables, and presence of drugs." It was not possible to provide a time frame for the tablet in the child's stomach.

Kapanol is another morphine medication, but is a capsule rather than a tablet. The capsule would dissolve within several minutes releasing the contents into the stomach. The contents would remain in the stomach until transferred into the small bowel, with the same variables in respect of the MS Contin tablet. The contents of the capsule would be harder to detect in the stomach than an intact tablet.

As about 30 mgs of morphine remained in the deceased infant's stomach, then it was possible that some remnants of either a MS Contin tablet or Kapanol pellets may have been present. The presence of other contents in the stomach such as milk may have made a detection of the tablet or pellets difficult.

Given that 30 mgs of morphine remained in the stomach indicated that a greater dose had been administered to the deceased infant.

He was unable to provide a time frame as to when the ingestion of the morphine occurred. It was possible that it occurred when the deceased infant was given her last bottle sometime between 6pm and 7pm on 1 March 2004. It was also possible that it could have occurred shortly before her death sometime in the morning of 2 March 2004. It was impossible to say which scenario occurred.

There was a suggestion in the evidence that the deceased infant may have picked up a morphine tablet or capsule that had been dropped on the floor, and accidentally ingested it. It is submitted that on the evidence that possibility should be rejected. Philippa Van Wijk, an Occupational Therapist gave evidence at the earlier hearing on 8 July 2013. She considered that it was unlikely that a 6 month old infant would have developed the fine pincer grasp required to pick up a tablet or pellet and then put it in her mouth. She considered it unlikely that an infant of 6 months *"would have the fine motor skills to pick up say a small tablet but no only just pick it up but also bring it to their mouth, put it in their mouth and then swallow it .... Lots of steps that would - would likely fail at that age, where as an older child you wouldn't have as many steps that could - that fail."*

A further report was sought from an experienced Consultant Paediatrician, Dr Johanna Holt, who provided a report dated 13 May 2014, and who also gave evidence on 29 October 2014. She had vast experience of examining children of various ages, from birth upwards, and in particular infants of the age of the deceased. She considered it very unlikely that a 6 month old infant would be able to pick up a small object such as a tablet or capsule, using the pincer movement,

and then able to bring it to the mouth. She made an important comment in the course of her evidence that even if that could occur, it was unlikely that the infant would swallow the tablet or capsule. The infant's teeth would not be fully developed, they would be unable to do more than *"gum"* the tablet or capsule, and as they are designed to be unpleasant to the taste it was likely that it would be spat out.

The evidence of Melinda Punch on 28 October 2014 discounted the suggestion that a tablet or capsule could have been left on the floor. She was adamant that she and Peter Lievesley made sure that the drugs were kept out of the children's reach, on top of a cupboard in the kitchen. She was careful to ensure that items were picked up off the floor so that the deceased infant could not accidentally ingest small objects. She described one occasion on the evening of 1 March 2004 in the presence of Matthew Economidis, where a 100 mg tablet was dropped to the floor. A concerted search was conducted for the tablet until it was found; one of the reasons for the search was to ensure that the children didn't pick it up.

This evidence is in contrast to the evidence given by the ambulance officer Renay Downey at the earlier hearing on 4 July 2013. She recalls that while the ambulance was on route to the hospital, Melinda Punch was in the ambulance. She said that "*She'd found the father's tablets, the baby's father's tablets, on the floor the day before. She was asking maybe that the baby had swallowed those. She said that maybe the older kids had suffocated the child."* Ms Downey said that she appeared to be *"going through all different sorts of scenarios"* (R1-48, L.20). It is significant that Ms Punch considered morphine poisoning very early on following the death of her infant daughter. More will be said of this later.

In the light of the evidence of Dr Van Wijk and Dr Holt, and to a lesser extent the evidence of Ms Punch on 28 October 2014, I can properly exclude any accidental swallowing of a tablet by the deceased infant. On all the evidence I find that there was a deliberate administration of morphine to the deceased infant, by one of her parents, perhaps with the knowledge of the other.

Who was Responsible for Administering the Morphine to the Deceased?

Neither Melinda Punch nor Peter Lievesley have admitted to administering the morphine: Ms Punch expressly denied it in evidence, and expressly denied having any knowledge that the deceased infant was being drugged.

Peter Lievesley was examined by the CMC on 15 October 2008. In essence, Peter Lievesley gave the following evidence:

- He had been hit by a car in an accident, and as a result his brain had been damaged. One of the consequences was that his memory was affected. He could recall *"basically the day my daughter died but I don't know if youse are going to get all the details"*; (p.7 of 34).

- He described the process of melting the MS Contin tablets at p.15 of 34.

- He recalled that on the evening of Monday 1 March 2004 he had been watching a movie, lying down together with his two older children. He felt that earlier in the night the deceased infant was put down to sleep. He recalled Melinda Punch waking him up later, and he took Sabrina, his eldest daughter to the bedroom and left his young boy out on the couch asleep. The next morning he was awoken by Sabrina saying something was wrong with Tamiya, and he and Melinda Punch went into Tamiya's bedroom, and saw that something was wrong. He grabbed Tamiya out of Melinda's arms and ran outside across the road, to the neighbours to call an ambulance.

- Melinda Punch was the usual person who put Tamiya to bed at night; he had never seen how she did that.

- On his recollection he had not taken any morphine that day, as from what he recalled they had no morphine in the house; he thought that he and Melinda Punch had *"probably"* taken a Benzodiazepine.

- He considered that there was a conflict in the medical evidence about whether the deceased infant had died from morphine intoxication; in his mind that's not what she died from (p.31 of 34).

- He was certain that Melinda Punch would not have administered morphine to her own daughter, and as far as he knew they had no morphine in the house that night.

The examination continued after a break. The continued examination is Exhibit *"F15"*. He gave the following essential evidence:

- He denied having any knowledge of filling a script for Kapanol 100 mg capsules on 1 March 2004. He accepted that he would not have gone through 20 tablets in one day (pp.13-14 of 29).

- He could not recall dealing with a black bag or backpack on the morning of the deceased infant's death.

- He did not believe that he had said outside the house, *"My fucking kids have killed my baby"* (p.16 of 29).

- He did not recall Melinda Punch saying to him, *"If I find out this is your fault you mongrel I'll kill you."*

- He did not believe that Melinda Punch said to him that morning, *"I hope she hasn't got any of your stuff because I didn't vacuum the floor yesterday."* (P.24 of 29).

- He did not believe that any of his children contributed to the death the deceased infant.

I refer again to the evidence Kaye Becker was a neighbour who lived at Eira Court, Edens Landing, the same street the deceased infant lived with her family. She recalled the morning of 2 March 2004 when she heard her next door neighbour on the phone talking to someone quite loudly. She heard lots of screaming coming from the road, and she walked out of the front door of her house to see if anyone needed help. She saw two ambulances parked outside or near Leanne Mapley's house. She saw the young woman who lived at number 28 Eira Court. She was holding a baby and yelling at a male person, whom she thought was her partner. She heard the lady yell out *"I hope she hasn't got any of your stuff because I didn't vacuum the floor yesterday"* and *"If I find out this is your fault you mongrel, I'll kill you"*. She refers to 'a man' walking around looking dismayed and swearing back. The evidence of all of the independent witnesses has been summarised above.

Renay Downey, another paramedic with the Queensland Ambulance Service, referred to above, provided a statement which is Exhibit *"B24"*. She also gave evidence at the inquest. She recalled that Melinda Punch was asking a lot of questions as to *"Why?"* During the conversation Melinda Punch told her that *"She had found dad's tablets on the floor and felt perhaps the baby had picked one of them up."* She also said the following:

"The father had been to the doctor and that these tablets had altered him. She said this to me several times. She also said that maybe the other two children had hurt the baby; she felt perhaps they had suffocated the baby. She then got quite angry towards the other children and made it clear she didn't want them around."

Melinda Punch was an unsatisfactory witness. Her evidence was contradicted by a number of other reliable witnesses, and she made a number of contradictory

statements within her own evidence. She said in evidence that in the months leading up to the death of the deceased infant she was seeing Dr Stolz every 10 days. This was clearly contradicted by the objective evidence from Dr Stolz and the DDU records. She asserted that she did not think at the time when the deceased infant was discovered that she had been drugged. This is contrary to statements made to other persons on the morning, that evidence she gave to the CMC.

Her account of how Tamiya was discovered on the morning of 2 March 2004 shifted. In the police interview of 2 March 2004, the transcript of which is Exhibit *"D3"*, she said that the children were still asleep when she woke up and discovered Tamiya in the cot. In her statement to police dated 12 April 2004, Exhibit *"B66"*, she stated that she was woken up by her daughter Sabrina, yelling *"Tamiya's a monster mum"*. In neither the first interview nor the statement did she mention the fact that on the morning she awoke to Peter Lievesley injecting her with morphine. This did not reveal itself until the CMC interview in 2008.

In her sworn evidence she said that despite her addiction she was able to manage reasonably well with the running of the household and the care of the children. This is clearly contradicted by a statements of Krystal Axtell, Mary-Anne Lievesley and Christine Punch and the photographs of the house taken by police on 2 March 2004. It is also inconsistent with a statement she made to the Department of Children Services on 2 March 2004 where she stated that *"She has been asking for family support as she felt that she could not cope with the three children, however no-one has responded"*.

In the course of her oral evidence, for the first time, she stated some weeks before the death of the deceased infant Peter Lievesley had a psychotic episode, where he was eating his own faeces in the shower stall of the bathroom. When asked why she did not tell either Mrs Lievesley or her own mother, Christine Punch about this, she then changed her evidence to suggest that this incident occurred on the weekend before the deceased infant's death that is the weekend of 28 and 29 February 2004. She denied telling Jasmeet Bharaj, a Senior Complaints and Review Officer with the Department of Communities, that Peter Lievesley did not do drugs. She accepted in evidence that if she had said that, that was a lie.

She could not explain how the deceased infant came to ingest morphine. She said that she was the person who usually gave the deceased infant her bottle of formula. In her type-written statement to police dated 12 April 2004 she said that on the evening of 1 March 2004 she recalled giving the deceased infant some yoghurt; she vomited up little bits of yoghurt, that she forced her to eat it. She then made her a bottle of formula, and fed the deceased infant the bottle while she sat on the couch in the lounge room. The deceased infant managed to keep this down

without vomiting. This was *"between 5 and 6 o'clock by this time, and I could see that she was drowsy, so I placed her in the cot. She seemed tired."* Sometime later when she went to the toilet and walked past the deceased infant's bedroom, she had seen that the bottle had been thrown out of the cot. She went and picked up the bottle, and saw the deceased infant was asleep. She next checked on the deceased infant at about 1.30am according to a clock on the microwave.

There is no direct evidence of an intention to kill the deceased infant by either of her parents. However, the level of morphine found in Tamiya's blood does indicate a high dose was given and it is reasonable to assume the parents were aware of the risks associated with ingesting that amount of morphine, provided they were able to make rational decisions.

It seems mostly likely that morphine was given to the deceased infant to put her to sleep for longer periods. One would expect the mother of the deceased infant to be aware of unusually long sleep patterns, and whether the deceased infant was drowsy upon waking.

Matthew Economidis gave a statement to police dated 17 October 2008. He stated at para 44 that he quickly spoke to Melinda Punch on the morning of 2 March 2004 when the ambulance was present. Significantly, he claimed that Melinda Punch told him the following: *"I had just checked her half an hour before and she looked to be okay and then half an hour later she was lying next to a pile of vomit and she was blue."* That statement was signed by Economidis and sworn that the contents were true to the best of his knowledge and belief. When he came to give evidence in the Supreme Court trial and at the inquest, he denied speaking to Melinda Punch or Peter Lievesley, he said that because of the commotion with the police and the ambulance he simply drove on. His evidence should be viewed with a degree of scepticism.

Plain Clothes Senior Constable Matthew Phillips in his statement said he observed that when he examined the house at 28 Eira Court, Edens Landing, he observed that the house was untidy and messy. This is confirmed by the photographs taken of the house, which are Exhibit *"D12"*. Three empty boxes of MS-Contin were located, two packets being 60 mg tablets x 20, and one packet being 10 mg tablets x 20. Each packet was labelled with the name of Melinda Punch. On examination of the wheelie bin in the driveway revealed empty syringe wrappers, and 3 sharps containers which were full.

Photographs taken by the Scenes of Crime Section showed 2 baby bottles in the house; one containing white liquid in the refrigerator, and one container white liquid in the room where the deceased infant slept. An open tin of Karicare Infant Formula was found on a bench next to the stove in the kitchen, and another tin of

Karicare Infant Formula was found in a pantry cupboard. A tin of Nestle Lactogen and a tin of S-26 Toddler Gold formula mix were also found in the kitchen. Unfortunately neither the bottles nor the tins of formula were seized by police for further forensic examination.

Counsel for Melinda Punch submits that the behaviour of Melinda Punch immediately after discovering Tamiya was deceased are inconsistent with her having given the morphine to Tamiya. It does not demonstrate any knowledge of Peter's deliberate actions. I accept that her behaviour could lead to that conclusion on the balance of probabilities.

Adequacy of the Police Investigation

Plain Clothes Senior Constable Matthew Phillips in his evidence considered that as at 2 March 2004 there was no written policy that required him to seize items such as the baby bottles and the cans of formula. He said he had been advised by senior officers that he did not need to take those items; he said he had been to other SIDS related deaths where he hadn't taken items of property, based on that same reasoning.

Under questioning by me he said that he had investigated a number of so-called SIDS deaths previously. He agreed that that diagnosis should only been given when all other causes of death had been excluded. He admitted that he had investigated the death of the deceased infant on the assumption it was a SIDS related death, and not suspicious. He conceded in hindsight that was an error.

Detective Acting Senior Sergeant Naomi Lockhart gave evidence at the inquest. She said the first response was to get to the scene at Eira Court, liaise with general duties officers and establish what had occurred. She did not enter the house when she arrived. She received a short briefing from uniform police, and had been told that the deceased infant had been removed from the scene.

She did not give a thorough briefing to Plain Clothes Senior Constable Matthew Phillips and Plain Clothes Senior Constable Tanisha Furlong, *"because at that stage we weren't really sure what had occurred."* She was not aware of any police policy or protocol in place at that time in relation to seizing items during a search of a residence in which an infant had died unexpectedly. She said that she took time to take the clothing from the deceased infant.

Upon receipt of information in 2006 that Sabrina Lievesley had been given a tablet in her yoghurt by Peter Lievesley, and it seemed Peter Lievesley had put a tablet in the deceased infant's bottle; she conducted an interview with Sabrina on 4 May 2006. As a result of her interview and other investigations she considered that

they were little use in a criminal proceeding. Very small quantities of morphine were detected on the clothing of the deceased infant.

Detective Senior Sergeant Christopher Hansel, provided a statement. Importantly, he states that as at January 2004, the Operation Procedures Manual of the Queensland Police Service had specific provisions concerning the investigation of sudden deaths of children. Section 7.14 of the Manual set out the particular investigations to be conducted, and these are clearly set out paragraphs 15 and 16 of Detective Senior Sergeant Hansel's statement. The relevant extracts from the 2013 manual were also provided. At para 2, a comparison of the two policies in existence in 2004 and 2013 identify that is was substantially the same in its wording and physical procedure. It was noted at para 23 that whether items are seized by police is at the discretion of the investigator, once the investigator believes suspicious circumstances do exist.

I note the concession made by Plain Clothes Senior Constable Phillips that there was a hasty decision that the death of the deceased infant was one of SIDS, and proper procedures following the manual in existence in 2004 should have resulted in the seizing of at least the bottles, the formula, the bedclothes.

The Supreme Court Trial -14 November 2012

On 14 November 2012, Ms Punch was arraigned in the Supreme Court at Brisbane in relation to a charge of manslaughter before Fryberg J. The prosecution called eleven witnesses. Ms Punch did not give evidence. Evidence was called during the trial from Professor Drummer. He was asked to comment on the effect 50 tablets of Valium would have on a person, if consumed over a four day period (per Ms Punch's statement). Dr Drummer stated that twelve 5 mg tablets of Valium is a substantial dose. If it was taken with Morphine, it would significantly add to the sedation effect of the morphine.

Professor Drummer conceded during cross-examination that after a child has been administered morphine it could fall into a coma, however, would still give the appearance of breathing. Matthew Economidis described Ms Punch and Mr Lievesley as "everyday users". He denied that he had given morphine to Tamiya or any of the other children. At the conclusion of the Crown's case on 19 November 2012, defence submitted that there was no case for the defendant to answer. Fryberg J rejected this submission, ruling that on the Crown's evidence, Ms Punch did have a case to answer. The jury retired on 19 November 2012. On 21 November 2012, the jury was discharged after being unable to reach a verdict.

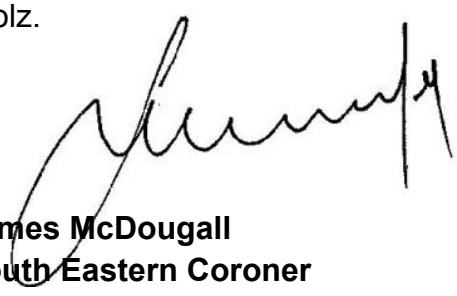
Conclusions

A positive finding that a particular person administered the fatal dose to the deceased infant is one of the utmost gravity. Care must be taken in making such a finding. I have had regard to the *"sliding scale"* arising out of Briginshaw -v- Briginshaw (1938) 60 CLR 336, where a serious adverse finding needs to be based on significant reliable evidence. I am not able, on the available evidence to make a positive finding that one particular parent administered the drug but I find, on the balance of probabilities, that one them did do so, with or without the knowledge of the other.

I am required to find, as far as is possible, who the deceased was, when and where she died, what caused the death and how she came by her death. I have already dealt with the last of these issues, being the circumstances of Tamiya's 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 death.

a) The identity of the deceased person is Tamiya Calais Lievesley.
b) The place of death was 28 Eira Court Edens Landing
c) The date of death was 2 March 2004
d) The cause of death was Morphine toxicity

There is insufficient evidence to warrant a report to the Director of Public Prosecutions under s.48 (2) of the *Act*. I direct that these findings be sent to the Office of the Health Ombudsman for review of the prescription of opioids by Dr Stolz.



James McDougall
South Eastern Coroner