QUEENSLAND COURTS

# OFFICE OF THE STATE CORONER

# FINDINGS OF INQUEST

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| CITATION: | **Inquest into the death of Vaughan Murray** |
| TITLE OF COURT: | Coroner's Court |
| JURISDICTION: | Brisbane |
| FILE NO(s): | 2009/2235 |
| DELIVERED ON: | 17 June 2014 |
| DELIVERED AT: | Brisbane |
| HEARING DATES: | 10 March 2014; 14 – 15 April 2014 |
| FINDINGS OF: | Mr John Hutton, Brisbane Coroner |
| CATCHWORDS: | CORONERS: Death of a baby – suspicious circumstances – evidence of previous inflicted injury. |

REPRESENTATION:

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| Counsel Assisting: | Miss Emily Cooper |
| For Ms Link | Mr Simon Burgess i/b Aboriginal and Torres Strait Islander Legal Service |
| For Mr Murray | Mr James Godbolt i/b Walker Pender Lawyers |

## *Findings required by s. 45*

Pursuant to s. 45(2) of the *Coroners Act 2003* I make the following findings:

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| Identity of the deceased – | Vaughan Murray |
| How he died – | It is unknown how the deceased died. |
| Place of death – | Baby Vaughan died at the Ipswich General Hospital in the State of Queensland. |
| Date of death – | 23 September 2009. |
| Cause of death – | The medical cause of Vaughan's death remains undetermined. |

## *Evidence, discussion and general circumstances of death*

### Background

At inquest, both parents, Dixielee Link (Ms Link) and Vaughan Murray (Mr Murray) provided inconsistent versions as to what occurred at their residence on the evening of Vaughan's death. However, what is consistent is the fact that Mr Murray was the one who found Vaughan not breathing and he was with Vaughan in the period leading up to his being found not breathing.

Vaughan was 14 weeks old when he died at the Ipswich General Hospital (IGH). He had been living with his parents at a residence at Bundamba.

Vaughan had been born at 38 weeks by standard vaginal delivery. Ms Link had been taking methadone and smoking throughout the pregnancy. Vaughan did not require resuscitation after birth. He was monitored for signs of drug withdrawal but these signs did not develop. He made good progress and was discharged five days after birth.

He was taken to see his GP for his one week check up; no problems were noted at this time. His next GP visit was for his two month immunisations. His third GP visit was just weeks before his death, at which time he was diagnosed with a bacterial infection of the eyes (conjunctivitis). No other problems were noted.

On the day of his death, Vaughan had been out with his parents during the day; he had not exhibited any unusual signs. They all returned home at around dusk. At some point, Vaughan was left alone in the bedroom for a period of time with Mr Murray, who then left the bedroom.

Upon re-entering the bedroom to check on Vaughan, Mr Murray realised that Vaughan was not breathing. His face was pale and he was not responding to his attempts to rouse him. He took Vaughan out into the living room and was yelling at Ms Link to call an ambulance. Ms Link engaged the assistance of some neighbours to call the ambulance.

The Queensland Ambulance Service (QAS) was called at 08:19pm and they arrived at the residence at 08:27pm. On examining Vaughan, the QAS officers found no signs of life. They continued resuscitation efforts and transferred Vaughan to the IGH at 08:45pm. Resuscitation efforts were continued at IGH until 09:07pm, but he did not show any signs of response. He was declared deceased at 09:07pm.

### Autopsy

A full internal autopsy was performed by Forensic Pathologist, Dr Nathan Milne. Dr Milne's autopsy report was tendered at the inquest.

#### *External*

There was a poorly defined pale red bruise on the right side of the face which seemed recent in appearance. There was a red superficial abrasion/excoriation of both alar margins of the nose. Externally on the central upper lip was a red abrasion/sore. Internally, there was an incomplete laceration of the upper labial frenulum.

There was a poorly defined red/purple bruise involving much of the anterior chin. There was a darker red/purple area in the left upper region and a yellow area in the

left lower region. The yellow discolouration indicated that the bruise did not occur around the time of death.

A recent appearing, red linear abrasion was also present on the left lower limb (proximal anterior thigh).

## *Internal*

A total of five partially healed rib fractures were detected at the following junctions:

- left 9th costochondral junction
- left 10th costochondral junction
- left 10th posteriorly
- left 11th costochondral junction; and
- left 11th posteriorly.

Each of the fractures had callous formation thus indicating that the healing process had begun. Each of the fractures was consistent as being between three – six weeks old. There were no recent rib fractures detected. There was also no underlying bone disease to predispose Vaughan to fractures.

Toxicology did not return any abnormal results.

## *Cause of death*

Dr Milne could not determine a cause of death. Sudden Infant Death Syndrome (SIDS) could not be considered given the various findings which gave rise to a suspicion of previous and recent non-accidental injury.

In his report, Dr Milne listed the injuries that gave rise to suspicion of previous non-accidental injury as follows:

- Rib fractures – there were a total of five rib fractures all of which appeared four – six weeks old based on x-rays and CT scans, and three – six weeks old on microscopic examination. There was no underlying bone disease. Rib fractures, in the absence of such disease or a history of significant trauma, are a strong indicator of non-accidental injury. They typically result from an infant being held and squeezed;
- Iron deposition in the lungs seen microscopically – this is an indicator of previous haemorrhage. The finding is non-specific, however lung haemorrhage can result from episodes of asphyxia. There was also recent haemorrhage in the lungs which could have resulted from recent asphyxia or from aspiration.

Dr Milne also listed the injuries that gave rise to suspicion of recent non-accidental injury as follows:

- Injuries to the face – there were injuries to the upper lip and frenulum. The frenulum injury could have occurred after death. Injuries to the lips and frenulum generally result from a blow to the mouth, but can also occur during resuscitation. There was bruising on the right side of the face which appeared recent. This injury raises the possibility of smothering.

Dr Milne opined that infants who die from asphyxial deaths, whether it be accidental (e.g. overlaying), or non-accidental (e.g. smothering) typically show no specific findings. Such causes of death usually cannot be excluded.

Dr Milne could not identify a cause of death in this case. He opined that there is a high suspicion of death from non-accidental means, such as smothering. In the absence of any evidence of accident, the healing rib fractures also need to be considered as being the result of non-accidental injury.

Dr Milne confirmed that there were no injuries to the brain, spinal cord or the eyes so as to indicate any significant head impact or shaking.

The autopsy findings were reviewed by an independent pathologist from the Victorian Institute of Forensic Medicine, Dr Linda Iles. Dr Iles' report was tendered at the inquest.

Dr Iles agreed with Dr Milne's opinion that the cause of death must remain as undetermined. There were no findings at autopsy to indicate a cause of death. There were features of past non-accidental injury, but no definitive features of acute non-accidental injury that ultimately caused Vaughan's death.

Both Dr Milne and Dr Iles gave evidence at the inquest; the entirety of this evidence is dealt with further on in my findings.

## Police Investigation

Vaughan's death was investigated by the Ipswich Child Protection and Investigation Unit. The investigation was lead by Detective Sergeant Nathan McIntosh who provided a total of three reports detailing the findings of the investigation. These reports were tendered at the inquest. Detective Sergeant McIntosh also gave evidence before me at the inquest.

The investigation was informed by recorded interviews with both parents at the hospital on the night of the death. Thereafter, Ms Link agreed to be formally interviewed again. Mr Murray declined to participate in any further formal interviews with police.

Statements were obtained from Vaughan's maternal grandmother and uncle. A Paediatric Specialist from the Royal Children's Hospital, Dr Catherine Skellern, was also approached to provide an opinion as to the likely cause of Vaughan's injuries.

The medical records from the IGH relating to both mother and baby were obtained. Records relating to Vaughan's visits to the General Practitioner were also obtained.

The entirety of the investigation revealed insufficient evidence with which to substantiate a prosecution against any person in connection with Vaughan's death.

## Medical Evidence

In addition to the assistance provided to the inquest by Dr Nathan Milne and Dr Linda Iles, Dr Catherine Skellern, Paediatric Specialist at the Royal Children's Hospital, also provided a report and gave oral evidence. Dr Skellern's report detailed her opinion with respect to the most likely cause of Vaughan's physical injuries and when they were most likely inflicted.

I will deal with the evidence of each of the medical witnesses separately.

## *Dr Nathan Milne*

Dr Milne is a forensic pathologist employed by Queensland Health Forensic and Scientific Services.

Dr Milne performed an external and full internal autopsy. He gave evidence that Vaughan was a healthy looking child with measurements within the normal range for his age.

His evidence at the inquest concurred with his written reports. He said that the rib fractures were highly suspicious and, in the absence of any explanation, were considered as non-accidental injuries. The evidence of Ms Link with respect to how, on a number of occasions, Mr Murray was seen to throw Vaughan up in the air, and then catch him around the chest area, was put to Dr Milne as a possible cause of the fractures. Dr Milne said that this action would not be significant enough to cause the fractures, unless there was a significant squeeze around the chest area following the catch. Vaughan would have appeared distressed at the time the fractures were sustained and for some time afterwards.

Dr Milne said that the bruising on the right side of Vaughan's face was consistent with an impact to the face, or the face falling onto a surface. The shape of the bruising was a lot bigger than a thumb. Dr Milne said that it might be consistent with the shape of the side of a hand. He opined that the bruising could have been caused by smothering. The age of the bruise could be up to three days prior to death.

The bruising detected on the chin and the right side of the jaw could have also been caused up to three days prior to the death. Dr Milne could not rule out all of the facial bruising being inflicted at the same time.

With respect to the haemorrhage detected in the lungs, Dr Milne said that there was evidence of old and recent haemorrhage. The more recent haemorrhage could have been caused by smothering.

Dr Milne was asked about SIDS and agreed that Vaughan being at an age of 14 weeks, placed him in the period of highest risk of SIDS. Dr Milne gave evidence that SIDS is a collective term for infants that die with no cause or other factors. He agreed that the risk factors relating to SIDS include circumstances where the infant is:

- male
- around people who smoke
- sleeping with excessive bedding.

SIDS could not be determined as the official cause of death given the evidence of physical injury. However, Dr Milne did accept that a natural cause of death could not be excluded in this case.

Dr Milne agreed that none of the physical injuries on their own caused Vaughan's death. His opinion was that, with all of the medical evidence considered as a whole, smothering was the most likely cause of death.

## *Dr Catherine Skellern*

Dr Catherine Skellern is a Consultant Paediatric Specialist at the Royal Children's Hospital. She holds a consultant position in the Child Advocacy Service and has appeared in court many times on child protection matters.

Dr Skellern's evidence at the inquest did not alter from her written report. She said that the bruising around the face and jaw-line could not have been self-inflicted given that he was only 14 weeks old. The mechanism of bruising of this type was due to excessive pressure or possibly impact. In this location, bruising is typically caused by caregivers gripping Vaughan around the face.

When asked at the inquest whether the shape of the bruising to the right side of the face was consistent with a hand, Dr Skellern said that it could be. If this bruising was recent, it could be consistent with smothering. Dr Skellern gave evidence that the bruising would have been the result of a force of some kind. She could not say with any certainty where the force came from, as the bruise was not patterned.

Dr Skellern agreed that the abrasions on the chin could have been self-inflicted from Vaughan's fingernails. The linear scratch abrasion on the left lower leg could have also been self-inflicted from fingernails.

The healing abrasion on the upper lip is an injury which is commonly seen on infants. Dr Skellern opined that it is generally caused by sucking.

The rib fractures were caused by chest encirclement and chest compression. These injuries cannot be self inflicted. The fractures arise when persons grip infants around the chest and squeeze them. This causes the ribs to fracture posteriorly due to the rib levering on the transverse process of the spinal column. Dr Skellern provided a diagram of the squeezing motion required to cause these fractures. This diagram was tendered at the inquest.

The rib fractures were weeks old and in an advanced stage of healing when seen at autopsy. They would have caused pain which may have made Vaughan difficult to feed and handle. Crying would have also been painful due to chest expansion with deep inspiration.

Dr Skellern agreed that a number of factors were present in this case to make Vaughan a high risk of SIDS. However, a finding of SIDS could not be made given the evidence of physical injury.

With regard to the medical evidence as a whole, Dr Skellern agreed that there was no precise way to determine a cause of death. Dr Skellern said that with a smothering cause of death, it is possible to leave no evidence, thus the possibility of smothering must always be considered in a case such as this.

### *Dr Linda Iles*

Dr Iles is a specialist forensic pathologist employed by the Victorian Institute of Forensic Medicine. Given that Dr Milne was unable to determine a cause of death, Dr Iles was requested to conduct a review of the autopsy findings, with a view to clarifying the cause of death.

Dr Iles also gave evidence that Vaughan was a healthy looking child with measurements within the normal range for his age. Her evidence at the inquest did not alter from her written report.

Dr Iles opined that the bruising to the face was indicative of blunt trauma. The features of the bruising to the chin and left jaw were consistent with an older bruise (i.e. sustained more than 12 hours before death). Dr Iles' opinion altered to Dr Milne's with respect to the bruising to the right side of the jaw. Dr Iles opined that this bruising appeared similar to the left side of the jaw, meaning that the bruising to each

side may have been sustained at the same time (i.e. potentially more than 12 hours before death). However, Dr Iles did qualify her opinion in this regard by deferring to Dr Milne's opinion as to the age of the bruising. This was due to the fact that Dr Iles had only seen photographs of the bruising, whereas Dr Milne had seen the bruising in person.

The presence of the bruising around the chin and jaw was indicative of blunt force to the lower part of the face. This may have resulted from a blow(s) or excessively firm gripping around the jaw. Dr Iles confirmed that no account had been given as to how the bruising was caused. Given the distribution of the bruising, Dr Iles opined that it should be considered as an inflicted injury given that Vaughan was not independently mobile. Dr Iles confirmed in her evidence that there was nothing specific about the bruising to the right side of the face to indicate a cause, i.e. hand/finger. She agreed that the bruising to the chin could have been caused by a pinching or a flicking action.

The position of the rib fractures was highly suggestive of non-accidental injury; the mechanism of fractures in this location being squeezing. Dr Iles said it was extremely unlikely that the fractures were sustained during the birthing process. Dr Iles disregarded the example given of Mr Murray throwing Vaughan in the air and catching him as a potential cause of the fractures. Dr Iles opined that the fractures were unlikely to have been caused during that activity, unless of course there was a significant squeeze involved in the catch. Nevertheless, Dr Iles opined that the injury does not occur during the normal handling of an infant.

Dr Iles confirmed that there was the presence of haemosiderin containing macrophages within the lungs, which indicated previous bleeding in the airways and lungs. The cause for the bleeding was non-specific. The incidence of it in the sudden death of infants is increased when there is evidence of non-accidental injury. However, it is also seen in instances where there are no signs of non-accidental injury. Dr Iles confirmed at the inquest that it could be due to a deliberate obstruction of the airways.

Dr Iles agreed with Dr Milne that SIDS could not be determined as the official cause of death given the evidence of physical injury. However, Dr Iles accepted that a natural cause of death could not be excluded.

Dr Iles confirmed that smothering can never be excluded as a cause of death as there need not be any signs to indicate it. Dr Iles agreed that the rib fractures and facial bruising raise the suspicion of a non-natural death, but this point could not be taken any further.

Dr Iles agreed with Dr Milne's opinion that the cause of death must remain as undetermined. There were no findings at autopsy to indicate a cause of death. There were features of past non-accidental injury, but no definitive features of acute non-accidental injury that ultimately caused Vaughan's death.

## Evidence leading to Vaughan's death

The parents were the last persons to see Vaughan alive. They both gave evidence before me at the inquest and were each legally represented. Neither applied for privilege prior to giving their evidence.

### *Ms Link*

Ms Link was 24 years of age when she gave birth to Vaughan. It was her first child. Ms Link had been in a relationship with Mr Murray for about 9 – 12 months when Vaughan was born.

Ms Link initially spoke to police at the IGH on the evening of the death. It was a brief interview, during which she said that earlier that evening they (meaning herself, Vaughan and Mr Murray) had arrived home from her cousin's house at about 5:30pm. She settled Vaughan down and placed him on the bed like she normally did. She gave him his feed, dressed him and he fell asleep. She put him on the bed and placed a blanket on him after which she went into the lounge room to watch a DVD.

They then went in (to the bedroom) and checked on Vaughan. Mr Murray gave him the rest of the bottle; Vaughan was 'sooking'. Mr Murray then put the bottle in Vaughan's mouth and quickly went to the bathroom. He came back from the bathroom and started screaming. Ms Link asked Mr Murray what he was screaming about. He came out of the hallway with Vaughan who was blue. He said 'looks like Vaughan's not breathing'. The ambulance was then called.

Ms Link was not interviewed by police again for some time. That interview was tendered at the inquest.

At the inquest, Ms Link gave evidence that she was using marijuana on a daily basis whilst pregnant and also after the birth. She said that she and Mr Murray would smoke marijuana together. She was also taking methadone to help with her addiction to heroin. She was adamant that she was not using heroin whilst pregnant.

Ms Link gave evidence about the night of the death. She was unsure about whether she bathed Vaughan once they all arrived home from her cousin's house, but it was possible that she did. She was quite certain that she changed him, and then put him down on the bed in the bedroom before she and Mr Murray went out to the lounge room to watch a movie. They smoked a quantity of marijuana whilst in the lounge room.

Ms Link said that, during the course of the movie, she went into the bedroom and checked on Vaughan approximately two-three times. Each time she went to check on him, she did so because he had cried out. She gave evidence that on the second or third occasion she was trying to settle him, Mr Murray came into the bedroom and said that he wanted to take over. He was worried that she was doing everything and that Vaughan wouldn't know who his father was. She said that Mr Murray's demeanor was angry at this time.

Ms Link allowed Mr Murray to take over and left the bedroom to go back into the lounge room. She said that Mr Murray was in the bedroom with Vaughan for about half an hour before she heard Mr Murray enter the toilet. She did not hear any noises coming from the bedroom. He was only in the toilet for a short time before he re-entered the bedroom and started screaming out.

Ms Link said that each time she left Vaughan on the bed, he had a pillow next to him and she would use a towel to prop his bottle on. The towel and bottle were positioned in front of his face so that he could drink from the bottle without anyone having to hold the bottle. When she left Vaughan with Mr Murray she did not notice any bruising to the right side of his face.

When questioned about the bruising on Vaughan's chin, Ms Link recalled that she had noticed this bruising approximately one-two weeks before the death. She said that she had asked Mr Murray about the cause of the bruising, and he had replied that he had accidentally flicked Vaughan on the chin. She had asked a local chemist what to do about the bruising, and she was advised to put some Betadine on it.

When questioned about the rib fractures detected at autopsy, Ms Link did not know how they were inflicted. She denied ever squeezing Vaughan around the chest area. She described how on a number of occasions she saw Mr Murray throw him up in the air, and then catch him around the chest area. She never saw Mr Murray squeezing him around the chest area. She never saw Mr Murray be violent towards Vaughan.

Ms Link denied any suggestion that she caused, or was otherwise involved in Vaughan's death. She also denied having any knowledge of what caused the death.

### *Mr Murray*

Mr Murray was 20 years of age when Vaughan was born. He already had a child from a previous relationship, making Vaughan his second child.

Mr Murray spoke to police at the IGH on the evening of the death. It was also a brief interview, during which he said that he, Ms Link and Vaughan had been out all day and arrived home around dusk. He said that he had shared a joint with Ms Link on the way home.

When they arrived home Vaughan began crying. He prepared a bottle of milk as normal and took Vaughan into the bedroom for feeding. He placed the bottle in Vaughan's mouth and laid him down on the bed; the bottle was beside Vaughan on a pillow but still in his mouth.

Ms Link called out to him so he left Vaughan on the bed. He started to play video games on the computer, whilst Ms Link was watching a movie in the lounge room. He forgot about Vaughan until the end of the movie, at which time he went to check on him. He observed that Vaughan was not moving and thought he was asleep. A closer inspection revealed that Vaughan was not breathing. He tried to rouse him by calling his name but this was unsuccessful.

Mr Murray declined all further opportunities to be interviewed by police during the course of the investigation.

At the inquest Mr Murray gave evidence that, in addition to marijuana, he and Ms Link had also used heroin on the day of the death, however this was denied by Ms Link during her evidence. He maintained his initial version provided to police, despite Ms Link's evidence that she had been the one to place Vaughan on the bed, feed him, and then proceed to check on him up to three times during the course of the evening.

Mr Murray provided fresh evidence to the inquest about what occurred in the bedroom with Vaughan when he was being fed. He said that, in the process of picking up Vaughan to feed him, he dropped him. He fell onto the bedroom floor, landing on his face. He had fallen approximately from the height of the bed. Mr Murray picked him up and said that Vaughan was crying as a result of the fall. He didn't notice any marks to the face or any other injuries.

He said it was at this point that Ms Link called out to him. He placed Vaughan down, on his right side, on a pillow which was situated on top of the bed. He placed the

bottle on the pillow in front of Vaughan's face. The bottle was pointing into Vaughan's mouth so that he could feed from it. He then left the bedroom and started to play video games. He forgot about Vaughan for some time.

It would seem that during this period when the movie was on and both parents were not in the bedroom, they were in the lounge room and both smoking marijuana.

After the movie finished, Mr Murray remembered Vaughan in the bedroom. Mr Murray went into the bedroom to check on him. He thought he was asleep. The bottle was still positioned in his mouth, but the right side of his face was now covered by the pillow, to the extent that both nostrils were covered. He tried to rouse Vaughan by nudging him, but there was no response. He picked up Vaughan and took him out to the lounge room where Ms Link was. The ambulance was then called.

When questioned about the bruising on Vaughan's chin, Mr Murray could not recall any bruising in the lead up to the death. He could not recall a conversation with Ms Link where he had said he had accidentally flicked Vaughan on the chin. The only facial injury which he could recall was to Vaughan's upper lip but he did not know how this was caused. He could recall asking Ms Link how the lip injury was caused, but could not recall any other detail.

When questioned about the rib fractures detected at autopsy, Mr Murray did not know how they were inflicted. He denied ever squeezing Vaughan around the chest area. The evidence of Ms Link was put to him about how, on a number of occasions, he was seen to throw Vaughan up in the air, and then catch him around the chest area. He denied ever doing this with Vaughan.

Mr Murray denied any suggestion that he caused or otherwise contributed to Vaughan's death. He also denied that the fresh evidence provided by him at the inquest was all lies.

I close this inquest. I express my condolences to Vaughan's family.

John Hutton
Brisbane Coroner
17 June 2014