QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of James Daniel TABUAI**
TITLE OF COURT:	Coroners Court Queensland
JURISDICTION:	NORTHERN (Cairns)
FILE NO(s):	2013/425
DELIVERED ON:	30 June 2022
DELIVERED AT:	CAIRNS
HEARING DATE(s):	24 April 2022, 6 – 8 June 2022
FINDINGS OF:	Nerida Wilson, Northern Coroner
CATCHWORDS:	Coroners inquest: head trauma; skull fracture; non-accidental; 7 month old child; in family home.

REPRESENTATION:

Counsel Assisting:	Ms M. Mahlouzarides
Counsel for QPS Union and Detective Sgt G. Wallwork	Mr S. Hollands
Legal Representatives for Ms Synoa Tabuai	Ms A. Taylor, ATSILS
Counsel for Commissioner of Queensland Police	Mr M. Fenlon

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Publication

Section 45 of the *Coroners Act 2003* ('the Act') provides that when an inquest is held, the coroner's written findings must be given to the family of the person in relation to whom the inquest has been held, each of the persons or organisations granted leave to appear at the inquest, and to officials with responsibility over any areas the subject of recommendations. These are my 37 page findings in relation to James Daniel Tabuai. They will be distributed in accordance with the requirements of the Act and published on the website of the Coroners Court of Queensland.

Relevant Legislation

Pursuant to s.45 of the *Coroners Act* 2003 I must, if possible, make findings as to:

a) Who the deceased person is;

b) How the person died;

c) When the person died;

d) Where the person died; and

e) What caused the person to die

I must not include within those findings any statement that a person is, or may be:

a) Guilty of an offence; or

b) Civilly liable for something.

Standard of Proof

The particulars a Coroner must, if possible, find under section 45 (Coroners Act), need only be made to the civil standard but on the sliding Briginshaw scale. That may well result in different standards being necessary for the various matters a coroner is required to find. For example, the exact time and place of death may have little significance and could be made on the balance of probabilities. However, the gravity of a finding that the death was caused by the actions of a nominated person would mean that a standard approaching the criminal standard should be applied because even though no criminal charge or sanction necessarily flows from such a finding, the seriousness of it and the potential harm to the reputation of that person requires a greater degree of satisfaction before it can be safely made.

The paragraph above was specifically contemplated by the Court of Appeal with apparent approval. The Court went on to state:

> *"Two things must be kept in mind here. First, as Lord Lane CJ said in R v South London Coroner; ex parte Thompson, in a passage referred to with evident*

approval by Toohey J in Annetts v McCann: …an inquest is a fact finding exercise and not a method of apportioning guilt … In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defendant, the judge holding the balance or the ring, whichever metaphor one chooses to use. Secondly, the application of the sliding scale of satisfaction test explained in Briginshaw v Briginshaw does not require a tribunal of fact to treat hypotheses that are reasonably available on the evidence as precluding it from reaching the conclusion that a particular fact is more probable than not."

Issues at Inquest

a. The findings required by s 45(2) of the Coroners Act 2003, namely,

when, where and how James Daniel Tabuai died, and what caused his death;

b. Whether any person contributed to his death; and

c. The adequacy of the police investigation into James Daniel Tabuai's death.

Non-publication order

1. The number and street name of the residence where the relevant events occurred is not to be identified or particularised other than as the Edmonton address;
2. The addresses and contact details of all witnesses are not to be published.

Material relied on at Inquest

A coronial brief of evidence was tendered (A1 to H7.2 inclusive). I refer to and have regard to the evidence and material contained therein, and to the oral evidence of the witnesses listed below.

Witnesses required to give evidence

The following persons were called to give oral evidence at inquest:

i Detective Sergeant Glenn Wallwork (investigation officer in person)

ii Germaine Lenoy (maternal grandmother via video link)

iii Nyrah Tabuai (maternal aunt via video link)

iv Renee Tabuai (maternal aunt in person)

v Danielle Tabuai (maternal aunt via video link)

vi Ehammed Anderson (husband of Danielle in person)

vii Synoa Tabuai (child's mother in person)

viii Dr Deanna True (Forensic Paediatrician via video link)

ix Dr Paul Botterill (Forensic Pathologist in person)

Section 39 Application

The legal representative on behalf of Synoa Tabuai, the deceased child's mother, advised the Inquest prior to the commencement of her evidence that she would refuse to give oral evidence because the evidence would tend to incriminate her.

I required **Synoa Tabuai** to give evidence that would tend to incriminate her pursuant to s. 39 *Coroners Act* 2003 because I was satisfied it was in the public interest to do so.

Her evidence is not admissible against the witness in any other proceeding (other than a proceeding for perjury).

Introduction and Background

1. James Daniel Tabuai, the first born child of Synoa Tabuai was born on 5 July 2012 at Cairns. Synoa and James enjoyed the love and support of their large family and affectionately referred to him as 'bubba James'. Synoa and her family identify as Indigenous. James was named after her much loved now deceased father James Snr.

2. James was almost 7 months old when he died at the Cairns Hospital on 1 February 2013. Synoa and her family identify as Indigenous.

3. On the night of 1 February 2013, Synoa and James were staying with her mother Germaine Lenoy, at Ms Lenoy's Edmonton home. There were other family members present, including those who lived at the household: Germaine's daughters Sheyenne (16) and Nyrah Tabuai (11); son Peter Baira Jr. (4) and niece Bianca Lenoy (17).

4. Synoa's sister Danielle Tabuai (23), her partner Ehammed Anderson (34), and their daughter Aaliyah (2) were also there, visiting from Malanda. The family enjoyed being together and Germaine's house was the hub for family coming together. There were enough rooms with extra mattresses for everyone to sleepover.

5. Nyrah was sharing her bedroom with visiting family members, and a number of mattresses were laid out for them in that room (room 1).

6. At about 10.30 p.m., Ehammed Anderson says that he woke to discover that James was no longer breathing. He alerted those in the house and carried the child out to the dining room table, where he commenced CPR while Germaine Lenoy called the emergency Triple0 number.

7. The Queensland Ambulance Service (QAS) received a call for service at 10.49 p.m. QAS Paramedics arrived at 10.52 p.m. They saw Ehammed performing effective CPR and observed that James was unresponsive with no pulse and no obvious signs of trauma. He was transported to the Cairns Hospital and arrived in the Emergency Department at 11.26 p.m. where CPR continued. Tragically despite all efforts James displayed no signs of life and by 11.59 p.m., resuscitation measures ceased and James was formally pronounced deceased.

8. On 5 February 2013, Professor David Williams (ret.) a Forensic Pathologist then based at the Townsville Hospital conducted an autopsy. The autopsy was temporarily suspended upon the Forensic Pathologist discovering of skull fractures, so that police investigators could attend. The autopsy resumed the following day on 6 February 2013, during which several traumatic injuries were identified including a skull fracture consistent with severe and forcible blunt impact; and haemorrhaging on the brain and behind the eyes.

9. Professor Williams determined that James' death was caused by head injury. He indicated the different mechanisms (direct trauma and shaking) and different ages of the injuries tended against a finding of accidental infliction.

10. Dr A Tannenberg was engaged to examine James' brain and to undertake neuropathology of the brain.

11. Professor Williams concurred with Dr Tannenberg's conclusions and findings that there were multiple traumatic episodes estimated to have occurred from weeks to days to moments before James' death, including a shaking incident several days prior to death and impact to the head several weeks beforehand.

12. The neuropathological diagnosis provided by Dr Tannenberg reported:

i. INFANT BRAIN
- development consistent with staged age of 7 months.

ii. Fractured skull
-evidence of forcible impact injury

iii. SUBDURAL HAEMORRHAGE
-evidence of organisation (duration of a few weeks)
-

iv. EVIDENCE OF "SHAKEN BABY"
-microscopic cervical spinal cord axonal injury.
- early microglial reaction consistent with duration of several days

v. SUBACUTE NECROSIS OF LEFT OCCIPITAL CORTEX
-duration of 3 to 5 weeks
-topography consistent with ischaemia rather than contusion

vi. CEREBELLAR PURKINJE CELL NECROSIS
-boundary zone distribution.
-duration of a few days

vii. BRAIN SWELLING AND RAISED INTRACRANIAL PRESSURE
-brain weigh 759 gms (expected 691-714 gms)
-compression of ventricles.
-"marker lesions' in both parahippocampal gyri
-"acute" consistent with terminal episode.
-agonal periventricular petechial haemorrhages in hypothalamus

Neuropathology Comment (Dr Tannenberg)

Neuropathological examination discloses multiple episodes of trauma from weeks to days to acute agonal.

Grouping suggests:

(a) shaking several days prior to death (spinal cord injury, cerebellar ischaemia).

(b) Impact several weeks prior to death (organising subdural, left occipital cortical necrosis).

(c) Terminal brain swelling probably related to severe impact with fracture of skull.

13. I include the full results of autopsy; neuropathology and paediatric radiography further below in these findings.

14. Further investigation by a biomechanical engineer, Dr Zachariah Couper, engaged by the Queensland Police, concurred that there were two separate incident clusters. He opined that the skull fracture and accompanying injuries were consistent with either a fall from a significant height (greater than two metres) onto a flat, hard surface or a direct blow with a large, heavy object.

15. It was ultimately concluded that the fracture could not have been caused by a fall from a bed, or rough child-handling. For the reasons herein I accept those conclusions.

16. In addition to forensic investigation the Queensland Police undertook a significant and thorough investigation of the circumstances surrounding James' death. The Crime and Misconduct Commission convened coercive hearings in relation to a number of relevant witnesses. At the conclusion of all investigations, further reviews were undertaken by a forensic paediatrician and a forensic pathologist.

17. There are no criminal charges arising from the Queensland Police Investigation.

18. The most recent opinions of specialist paediatrician Dr Deanne True, and Senior Staff Specialist Forensic Pathologist Dr Paull Botterill, (obtained after the CCC hearings) concluded that James died within minutes or hours of James being discovered unconscious.

19. The lack of knowledge claimed by adult carers within the home as to how the injuries were caused on the evening the child died remained implausible and necessitated an inquest.

20. The adult carers of the child present in the household at the time the injury was inflicted were:

    i the child's mother Synoa Tabuai;

    ii the last to see the child Ehammed Anderson,

    iii the child's grandmother Germaine Lenoy and

    iv Synoa's sister Danielle.

21. Ultimately the opinions of Dr True and Dr Botterill were further narrowed at inquest to the extent that a sudden external physical injury inflicted upon James caused him to become immediately unconscious and succumb to those fatal injuries. This opinion discounted the likelihood that the fatal injury occurred in the hours prior.

22. I find it is more probable than not that the fatal injury occurred proximate to the first indication the child was unconscious somewhere between 9.30PM and 10.00PM. I also take into consideration the fact that the child may have remained in that unconscious state for a period of time, perhaps one hour, before the household took action. His breathing, the best indicia of his state, was described to be unusual (like a stuck hiccup) sometime between 9.30PM and 10.00PM by then 11 year old Nyrah and was told by Ehammed "that's how babies breathe". Nyrah says she then fell asleep and woke to the emergency at 10.30PM.

23. Dr True concluded that James' death was caused by an acute fatal traumatic head injury caused by one or more impacts to the back of the head.

Relevant Chronology

Pregnancy and birth

24. Synoa gave oral evidence in person at the inquest. Synoa was close to her father James, and it seems she lost her way for a period of time after his death. She candidly described having a problem with alcohol when younger. My impression was that she was wayward, and her mother Germaine was concerned about

Synoa's capacity as a young mother based on her behaviours and conduct to that point.

25. Synoa, fell pregnant with James when she was 21 years. She was not in a relationship with the child's father Theodore Davis. Synoa was happy and excited for motherhood during her pregnancy. Whilst pregnant, Synoa says she reduced her cigarette intake and abstained from drinking alcohol altogether. She also stopped taking antidepressants previously prescribed to her. Synoa expressed with candour that her previous lifestyle of meeting friends and drinking alcohol was not compatible with pregnancy and motherhood.

26. The pregnancy itself seemingly had few complications except for a "black spot" observed on the foetus' heart during one of the scans, and that the baby was in breach position during the last trimester. Neither of those issues were exceptional, nor cause for any concern.

27. James Tabuai was a healthy baby born at the Cairns Hospital on 5 July 2012. Synoa was primarily responsible for his care, though she received substantial support from her mother Germaine Lenoy, sister Renee Tabuai (25), and other friends and relatives. Germaine would often ask Renee to look out for Synoa and the baby and assist them where possible.

28. Synoa's mother and sisters gave oral evidence (some in person and some via video link) at the inquest, and I was left with a sense that everyone was doing the best they could, given the responsibilities they each had for their own families and household and at the same time supporting Synoa as a first time mother on her own.

29. Witness accounts of Synoa's parenting were mixed. Friends and extended family described her as a "good" mother, who was patient and affectionate toward her son. Her immediate family members gave more nuanced insight:

    a. Germaine observed that Synoa had bonded well with James but quickly grew bored with the loss of her social life.

    b. Her sister Renee described Synoa as a "good mum" who was "gentle" with James but sometimes lost her temper at him. In the first few months of James' life, she knew Synoa to drink on a weekly basis to the point of intoxication. There was one occasion in approximately November 2012

when James had been left in Renee's care while Synoa disappeared to continue drinking. Renee generally concluded that, "I didn't think, like, she's capable of hurting him [James] or anything. It's just her drinking and, like, neglecting him … like, who knows who she's bringing in the house or – you're not able to look after a baby when you're intoxicated".

c. Her sister Danielle believed that Synoa was a "lazy parent", passing on the duties of feeding and changing James to the younger girls (Sheyenne, Nyrah and Bianca). She characterised Synoa's relationship with James as "all over the place … happy with him one minute and then angry with him the next minute", and that sometimes she would simply "zone out" when James was in her care. Danielle testified that she had secretly babysat James fortnightly in approximately October/November 2012 while Synoa went out and got drunk.

d. Danielle's husband Ehammed Anderson recalled that Synoa was "angry" and "frustrated" after James' birth, and there were times when she "got wild" with the baby. He added, on a later occasion, that she was always "going off at him saying that she's sick of him [James]", and that "she would shove him off to her sisters and cousins".

July to November 2012 (Satellite City Hotel)

30. Over James' short life, family and friends played a role in James' care. Her mother Germaine and sister Renee assisted in the days and weeks immediately following their discharge from hospital. Her close friend Tahnee also helped with feeding and changing James in those first few weeks.

31. From approximately July to November 2012, Synoa and baby James lived at two different units within the Satellite City Hotel complex on the Bruce Highway, Edmonton.

32. In late September or early October 2012, James' biological father Theodore (Theo) Davis travelled from Mareeba to stay with Synoa for about a week. Theo met James for the first time about one week prior at local shops. Theo on this occasion shared feeding and changing James. Synoa had, at first, been secretive about the identity of James' father. They had met online via a social networking website the year previous and shared a casual intimate encounter. Theo then learned of the

pregnancy through his girlfriend Nikisha, whilst he was incarcerated at a Correctional Centre. Theo ultimately breached his parole due to the length of his visit at Satellite City and was returned to prison on or about 24 October 2012, until December.

33. In October 2012, Synoa's cousins Marlee and Olive (and Olive's two young children) lived with Synoa over separate period for a few weeks each. Both women helped to look after James; neither reported any incidents or concerns.

34. Synoa later disclosed during the course of the police investigation for the first time that James had fallen off a fold-out couch, from a height of approximately one metre, while Marlee was living with her. She heard James crying but could not see him in the dark, and it was Marlee who picked him up off the tiles. They did not observe any injuries to him. Synoa said that she did not mention this at the time because she was scared of getting in trouble from her mother and had omitted it from her statements because she was grieving and not thinking clearly.

November to December 2012 (Prior Street unit)

35. In November 2012, Synoa took over her sister Danielle's lease at an address in Prior Street Edmonton when Danielle's family moved to Malanda. Synoa agreed to reimburse the bond money to Danielle (and her husband Ehammed) directly but this never occurred and remained a source of some tension between them, including I will find on the night of James death.

36. The Prior Street address was a two-storey townhouse. The internal staircase was 2.5 metres high, with a gap of approximately 15 centimetres between each step. There was no baby safety gate at either the top or bottom of the stairs. Synoa later told police that, "I know he [James] didn't fall down the stairs". She admitted that there was a time when she was watching television and James crawled underneath the staircase and accepted that there may have been other occasions when she was distracted and he crawled away. Germaine had also seen James crawl underneath the stairs on one occasion.

37. From approximately 22 to 26 December 2012, Theo stayed with Synoa and James at Prior Street for Christmas. Theo was sometimes left alone with James, but no injuries were observed at that time. It was also around this same time that Germaine expressed to other family members that she wished to assume care

of James, primarily due to concerns surrounding Synoa's attitude and behaviour. She ultimately decided that she did not have the means to do so.

38. Germaine pinpointed the date of 27 December 2012 as the last time that she saw her grandson James in "really good health". She had developed this view by the time of her fourth statement to police. She is alone in this observation.

Doctor visits on 1 & 3 January 2013

39. On 1 January 2013, at a family barbeque to celebrate the New Year, several of James' family members recalled him vomiting that afternoon and advised Synoa to take him to the doctor.

40. Synoa took James to the Cairns 24 Hour Medical Centre later that evening, where he was examined by Dr Rasheed. The history provided included a fever, reduced appetite, mild cough, and a single instance of vomiting. Symptoms included an inflamed throat and left ear. He was diagnosed with an upper respiratory tract infection and prescribed antibiotics.

41. When James' condition did not improve, Synoa returned to the surgery days later. On 3 January 2013, Dr Sivasambu examined James at the Cairns 24 Hour Medical Centre. His history again included vomiting. The examination was normal. The advice was to cease antibiotics and administer Panadol.

Doctor visit on 15 January 2013

42. On 14 January 2013, Germaine and her youngest children visited Synoa's unit for dinner. There, Germaine noticed that James *"looked tired, he was not playful, not smiling"*, with his head leaning off to the left. She saw him vomit clear fluid and urged Synoa to take him to the doctor. Synoa agreed to go the next day.

43. On 15 January 2013, Synoa took James to the Edmonton Family Medical Centre for scheduled immunisations. His reported history included three episodes of vomiting over the past few days. General Practitioner Dr Vishnoi and a clinic nurse observed that James was unusually subdued for a child of his age; he did not cry or respond to a finger prick test, nor did he react or move about during the examination generally. There was a routine check of James' head, which did not reveal any sensitivity or irregularity to the area.

44. Dr Vishnoi completed a referral for James to attend the Emergency Department at the Cairns Hospital and instructed Synoa to take him there immediately. That is supported by the referral letter and progress notes within the medical records. However, there was no attendance by Synoa and James at the hospital that day.

45. Synoa's versions developed over time. She first claimed that she had been told to use the referral only in the event that James did not improve; so when he started to look better, she decided not to go to the hospital. She later told police that she had simply forgotten to go to the hospital as directed. At a later date Synoa did not recall receiving the advice or referral letter at all, stating that the doctor either did not tell her to go to the hospital or she did not hear it. At inquest Synoa told the court the reason for not presenting James to the hospital was that she "was selfish in those days".

46. Danielle recalled speaking with Synoa immediately after the consult at the Edmonton surgery. Synoa had told her that she had been advised to take James to the hospital and planned to do that after she had gone to pay her rent. Danielle and Ehammed offered to do that for her, but she refused. Danielle spoke of that occasion again during her evidence at the coercive hearings. At that time, Danielle said that they had offered to drive Synoa to the hospital but she turned them down because she was planning to catch a bus and meet up with Theo.

Stay with father on 16 January 2013

47. James stayed with his father Theo overnight at an address in Mooroobool from 16 to 17 January 2013 (Synoa had agreed for Theo to take James on this occasion at his request without her being present). Members of Theo's extended family and his partner Nikisha were present. Nikisha described James as *"happy"* but *"tired"*, and the only mark that she saw to his body was a red fingernail scratch near his bum. That was the last time that Theo saw James.

48. After that sleepover, Synoa's impression was that James seemed sick or tired. She later elaborated that he had puffy cheeks and there was "black" under each of his eyes. Synoa's impression was that "James didn't look right". Like Nikisha, she also noticed a fingernail mark on his thigh at that time, but only disclosed it to her mother Germaine <u>after</u> James' death. On 8 February 2013, she told Germaine that James

had sustained the mark from another child there and admitted, *"I hid it from you Mum … I kept putting long shorts on him."*

49. That final visit with Theo generated conflict with Synoa. She was angered to learn that his girlfriend Nikisha had been involving in caring for their son. She sent Theo abusive messages via Facebook and denied him further access to James.

50. In the days following on either 17 or 18 January 2013, Germaine recalled that James was less active, reacting slowly, and was not focusing or making eye contact like he usually would.

The week prior to death

51. On Monday, 28 January 2013, the Australia Day public holiday, a large family group attended the Little Mulgrave River, a popular local swimming hole. Renee observed that James was quiet and less interactive that day, with "lines" or "bags" under his eyes. Germaine also heard him let out a squeal of "discomfort" as he was secured in the car. When Synoa bathed James that night, she noticed that the centre of the back of his head was sensitive to touch and he would let out a cry when she tried to dry the area.

52. On Tuesday, 29 January 2013, Tahnee caught up with Synoa and James at the Mount Sheridan shopping centre, and then returned to the Prior Street unit with them to play video games. James appeared "happy", "playful", and "talkative" on that occasion.

53. On the morning of Wednesday, 30 January 2013, Synoa thought that James looked sick. After a bath, she again noticed that he cried when she tried to touch his head. She gave James some liquid Panadol but was unsure how much. Synoa took photographs during the bath, which indicated a lump or swelling on the back of the child's head although she says she did not see the lump in the picture until after James' death. She does not know what caused it.

54. On Thursday, 31 January 2013, Synoa tried to put a bucket hat on James' head before going for a swim but he would become upset and pull it back off. Later that day, Synoa and Renee were watching movies together when James rolled off the bed, from a height of approximately 30 centimetres, and landed on the carpeted floor, which was reported by them to be covered with pillows and clothes. James was unsettled but did not seem hurt; neither Synoa or Renee observed any marks or bumps to his head.

55. That night, Synoa and James stayed at Germaine's Edmonton home. Danielle and Ehammed were there, as were the younger family members including Nyrah. James was placed on one of the beds in Nyrah's bedroom, where she watched over him for a while. She heard Danielle and Ehammed arguing about money nearby. When Nyrah left to get a drink, she heard *"a loud, big cry"* and returned to see James on the opposite side of the bed from where she had left him. Ehammed was also in the room, laying on another mattress, playing on his phone. Nyrah picked up James and comforted him.

1 February 2013

56. On the morning of 1 February 2013, James was crying more than usual. Germaine heard that Synoa was "verbally cranky" towards James. Similarly, Ehammed recalled Synoa yelling at James, growing louder and more frustrated.

57. That morning, Ehammed recalled seeing Synoa push James' walker with her foot "a bit hard", causing his head to move backwards though it did not hit anything. and James' head move back. Years later, Renee disclosed a similar incident, though she placed it a week or two before Australia Day. She recalled James following Synoa in his walker and, out of irritation, Synoa kicking him back a distance of about a metre. He was not upset, but his head rocked backwards. Synoa and Danielle described only a small nudge of the walker, but neither particularised an occasion.

58. That evening, sometime after 5.30 p.m., Germaine observed that James looked like he had "bags" or "grey lines" underneath his eyes. When she asked Synoa about those, she became defensive and said that he was tired.

59. Sometime after 7 p.m., James was put to bed in Nyrah's room. The younger girls, Sheyenne and Bianca, fed him and played peekaboo. Later that night, James remained in the room with Ehammed, his daughter Aaliyah, and Nyrah. At some point, Sheyenne and Bianca returned to the room to see James sleeping down on the mattress next to Ehammed.

60. Later that night, between 9.30 and 10 p.m., Nyrah went to bed and lay down next to James, as Ehammed watched a movie in the room on a separate mattress. Nyrah raised concerns with Ehammed that James was "breathing funny", making a deep gasping noise (she described this noise during oral evidence at inquest as like a '**stuck hiccup'**).

61. The description Nyrah gave of James' laboured breathing is in my view similar to a description of agonal breathing – where a person gasps for air because the brain is not getting enough oxygen. Dr True is of the opinion that the event that caused the fracture to the James' skull would have caused an almost simultaneous lapse into unconsciousness, (of which the laboured breathing would have been indicative).

62. Ehammed and Danielle also observed James' breathing; it was sufficiently irregular for Danielle to bring it to Synoa's attention, though she was not concerned. Synoa did not recall anybody raising such concerns. Nyrah and Ehammed give versions that they fell asleep as the movie continued to play.

63. At approximately 10.30 p.m. Ehammed Anderson says he woke to discover that James was no longer breathing. He did not react to Ehammed's touch; his limbs were limp and his lips were blue. Ehammed went outside to the driveway to alert Synoa. She began to scream and ran to the room to pick up James. Ehammed followed and took James from her arms so that he could commence CPR.

64. There are various witness accounts of Synoa's apparent rough handling of James at that point. She has little memory of those events, but explained that she was in shock and recalled collapsing to the extent where his foot may have touched the ground. Similarly, Danielle and Ehammed described Synoa momentarily losing her grip on the child though she did not drop him. The couple later both added that Synoa had shaken James with significant force when she first picked him up. With reference to the expert opinion of Dr True and Dr Botterill I discount that any of these incidents of so called rough handling is the source of the fatal injuries. I find any injuries that might be characterised as a result of rough handling occurred prior to the events of 1 February.

65. Germaine was woken by Synoa's screams and called Triple0 at 10.49 p.m. as Ehammed continued CPR on the kitchen table. The Ambulance arrived on the scene at 10.52 p.m. and observed that James was unresponsive.

66. James was taken by ambulance to the Emergency Department at Cairns Hospital, and all resuscitative attempts were unsuccessful. Danielle accompanied James and rode in the back of the Ambulance to hospital with him.

67. Synoa remained at her mother's Edmonton home. Ehammed and Danielle later returned from the hospital to collect her and take her to the hospital.

68. At 11.59 p.m., a decision was made to terminate treatment and James was declared deceased.

69. Hospital staff observed that Synoa did not attend the hospital for a long period of time after James' transport, and did not wish to hold him after he had died. A registered nurse commented that this was unusual in her experience, but later acknowledged that people grieve in different ways.

Statements made to Police after James died

70. On the afternoon of 2 February 2013, Synoa and her sister Danielle visited their aunt Renee Lenoy. Synoa told her that James had died because *"he choked on his* own *vomit"*.

71. On 2 February 2013, Danielle allegedly told Sheyenne Tabuai that James should never have been born. Danielle referred to her miscarriage from years earlier; the baby was also expected to be a boy who she planned to name after their father. Sheyenne did not report this to police until weeks later because she was afraid of Danielle hitting her. Both Danielle and Ehammed have denied, including at inquest, that James' name had caused any frictions within the family.

72. On 7 February 2013, Synoa called her mother Germaine and disclosed that she had tried to kill herself. Germaine later observed cuts to her wrists. Synoa told Germaine that she thought James had a headache during his bath on the Wednesday night before (30 January 2013), so must have given him too much Panadol, saying, *"It's my fault"*. Synoa later denied this and told police that she had tried to take her life because she was a *"bad parent"*. The following month, she told police that the injuries on her arm were self-inflicted because she felt alone and missed being a mother.

73. On 8 February 2013, Synoa disclosed the fingernail mark on James' thigh to Germaine for the first time, telling her that a child at Theo's house had caused it. Synoa admitted to hiding the injury from Germaine.

74. James' funeral was held on 14 February 2013. By that time, Theo had moved to South Australia and did not attend. At the funeral, Synoa was overheard whispering to James: *"I'm sorry"*. Years later, she accepted that she had apologised and explained that she had done so *"because I failed him as a parent. I should've been there to protect him."*

75. On 25 February 2013, Aunt Renee Lenoy saw Synoa at Stockland Shopping Centre. Synoa told Renee further information about the injuries inflicted to James: *"They found a mark from a ring on his leg. It had to be Danielle's ring. Nobody else has a ring like that to leave a mark on his body."* There is no such mark described in the autopsy report.

76. On 5 March 2013, Synoa Tabuai took part in a second record of interview with police. During that interview, police discussed the informal findings from medical experts and suggested to Synoa that somebody may have been frustrated and done something to James' head *"and the person who did it might not even realise they've done it"*. Synoa responded, *"Yeah, no, I think it was me but I can't, can't remember.* She said that she could not remember how she handled James on 1 February 2013 and could not remember being frustrated with him, but that it *"would have been me if I was frustrated and that, I don't know. I can't remember."* She added that Danielle had also often been frustrated with James.

Autopsy (and medical experts)

77. Professor David Williams conducted an autopsy on 6 February 2013 (an external and full internal examination of the body). The cause of death was concluded to be "head injury".

78. The external examination identified the presence of "poorly defined" bruising (5cm x 3cm) adjacent to and behind the child's right ear. James' measurements all fell within the appropriate parameters for his age.

79. The internal examination revealed the following injuries:

    a. Extensive complex skull fractures on both sides of the head, with the main fracture centred on the occipital area (back) of the skull and extending forward through the left and right parietal areas;

    b. Large subgaleal haemorrhage (14 x 4.5cm) at the right side of the head;

    c. Small amounts of subdural haemorrhage over the brain;

    d. Well-defined area of redness overlying the skull at the left side of the head;

    e. Bruising (up to 9.2cm) at the back of the skull under the scalp; and

f. Haemorrhages associated with the back of each eye (the retina of the left eye and around the optic nerve for the right eye).

80. Professor Williams referred to the findings of Dr Anthony Tannenberg, who provided an expert neuropathological opinion to the following effect:

a. Small amounts of subarachnoid blood on both sides of the vertex (bleeding in the space surrounding the brain, at the highest point of the head), said to be associated with the skull fractures;

b. There was evidence of organisation within the subdural haemorrhage that indicated a duration of a few weeks;

c. Subacute necrosis of left occipital cortex (death of brain tissue in lobe responsible for visual processing) of an estimated duration of 3 – 5 weeks, which was consistent with ischaemia as opposed to contusions (a lack of blood supply rather than a direct blow);

d. Within the cerebellum: minor subarachnoid haemorrhage and petechial haemorrhage, as well as scattered Purkinje cell necrosis (death of cells responsible for regulating and coordinating motor movements), indicating a duration of a few days; and

e. Cervical spinal cord axonal injury and early microglial reaction said to be evidence of shaking and consistent with a duration of several days.

81. Dr Tannenberg formed the view that the results of the examination were consistent with multiple episodes of trauma. The grouping of the injuries, in his opinion, suggested:

a. The child was shaken several days prior to death;

b. The child experienced a severe head impact several weeks prior to death; and;

c. The terminal brain swelling was probably related to that severe impact.

82. Professor Williams echoed those findings with respect to there being multiple traumatic incidents. He opined that the different mechanisms and different ages of the injuries tended to exclude their accidental infliction.

83. Dr Anthony Lamont PSM a paediatric radiologist opined that the skull fractures could not be aged with any degree of certainty but must have required substantial force. The bilateral nature of the injuries indicated that either the child was crushed between two hard surfaces or received two separate blows to each side of the head. There was considerable swelling of the brain, sufficient to cause the fracture lines to widen (up to 3.5mm) and separate. The swelling was indicative of an injury as recent as a day or two before death. Dr Lamont could not comment on whether the injuries were non-accidental or not.

84. Dr Lamont provided an addendum report on 14 July 2020, which provided further comment on the age of the skull fractures. He remarked that they were "not new" based on the quality of the fracture margins, and that the right side fractures were older than the left but could not say by how long. Having been provided with further medical material, it was his opinion that the brain injury was present at the time of James' medical examination on 15 January 2013 based on the doctor's observations at that time and the evidence of some healing of the bones.

85. The findings of Dr Zachariah Couper, a biomechanical engineer opined that the skull fractures were consistent with a fall from a height greater than two metres onto a flat, hard surface or a direct blow with a large, heavy object. The fatal injuries could not have been caused by a fall from a bed or rough child-handling.

86. Specialist paediatrician Dr Deanna True from the Queensland Children's Hospital concluded that baby James suffered an acute fatal traumatic head injury on 1 February 2013 caused by one or more impacts to the back of the head, either on the day or days prior to the death. The recency of the impact was supported by a number of the clinical observations. Having further considered the observations of family members and photographs depicting the infant as being well on the day of his death, Dr True opined that the acute injury event occurred within minutes or hours prior to the alteration in his breathing leading to death. Dr True stated that it was not likely that the brain injury was caused by a fall off the bed, nor was there any witnessed event or accidental mechanism that could plausibly explain such extensive and severe injuries.

87. Dr True also accepted that there was possibly one or more other impacts days to weeks earlier, but it was "extremely unlikely" that an older head injury contributed to the death. In her words, an older injury of that nature would not "suddenly trigger" brain swelling and death after those acute symptoms had resolved. The older injury may have been present at the time of the appointment on 15 January 2013,

given the reduced responsiveness of the infant at that time, although those symptoms were non-specific and indicative of only a mild to moderate head injury from which James seemed to have recovered (and therefore not from the fatal injuries). At that appointment, James' head was measured within the normal circumference, so it is unlikely that there was any swelling or haemorrhage at that time.

88. Dr True opined that some of the injuries, including the retinal haemorrhages and subdural haemorrhage, could have been caused by either angular acceleration and deceleration forces (shaking) or direct impact. However, her opinions as to the mechanism of the injuries were somewhat constrained by her view that there was a lack of detail in the original autopsy report. For example, she says there was limited description of the nature of the retinal haemorrhages insofar as the number of layers or extent of damage, and no description of the extent, location, or age of the subdural haemorrhage over the brain. (Further, both Dr True and Dr Lamont indicated that they would have been assisted in assessing the injuries by a CT or MRI being conducted at the post-mortem.)

Summary of medical evidence

89. James sustained several significant injuries, one of which caused his death. I have sufficient evidence before me to conclude that several weeks before his death he sustained a head injury which left him with a bleed on his brain. This injury was severe, but not fatal. Several days before his death he was shaken hard enough that his spinal cord and brainstem were damaged.

90. Almost immediately prior to his death James sustained one or more severe blows to the head which fractured his skull, caused his brain to swell, and was accompanied by an almost immediate lapse into unconsciousness. That injury caused his death. I place the incident that caused the fatal injury within one one (1)hour prior to 10.30PM when the alarm was raised in the household, (between 9.30PM and 10.00PM) at around the time Nyrah says she first noticed the child breathing funny).

91. I place weight on Nyrah's evidence noting she was the subject of some five (5) 93A police interviews post James' death, she was continuously with James that night and was generally looking out for him (James apparently was very close to Nyrah and looked for her when she came home from school of an afternoon), and the veracity of her oral evidence at inquest.

92. The fatal injuries were caused to the child by either of the following means (1) hit by an object or objects with significant force, or (2) impacting a surface (such as a floor or wall) with considerable force or (3) falling from a considerable height (more than 2 metres).

93. I discount a fall from height and find that of the two remaining hypotheses, impacting a surface with considerable force is more probable in these circumstances, than James being hit by an object such that it would cause those injuries (there was no evidence of such a weapon or implement).

94. I find that James impacted a wall or floor with considerable force, to be more precise he was slammed or thrown against a wall or floor by one of the persons present in the household and within an hour or less of the emergency being raised at 10.30PM. It is possible that James was left in a state of unconsciousness for a period of time before the alarm was raised. Although he fell into unconsciousness almost simultaneously with the force that caused his fatal injury, I believe he was left for a time without being immediately attended to.

95. At the relevant time Synoa and Danielle posit themselves on the front driveway of the Edmonton house (talking and hanging out); Germaine places herself in a bedroom with her youngest son Peter bedding down for the night and oblivious she says to the rest of the household. Ehammed places himself in 'bedroom 1' watching television and then sleeping in proximity to James and Nyrah. Nyrah says she was in 'bedroom 1' with James and Ehammed also sleeping.

96. The time between the family evening meal and the clean up, the movement of each person in the home thereafter to different rooms and locations; detail as to who was checking on children; who was sleeping and where they were sleeping, is extremely vague and ill defined up to and including the moment that Ehammed raised the alarm at or about 10.30PM that evening. That lack of detail has in my view been deliberately cultivated to cover the true nature of events inside the home.

97. In the intervening nine (9) years between James' death and this inquest, not one person present, Synoa, Danielle, Ehammed, Germaine (or Nyrah now aged 21 years) has indicated any knowledge nor proffered any explanation as to how James sustained his fatal injury. Despite the tensions and fallings out between family members since, not one person claims to know what went on in the Edmonton home that night. It is absolutely implausible given the non-accidental force that was required to cleave James' skull such that it caused a bilateral fracture – and a massive haematoma and brain swelling that no one knows or remembers anything.

98. All those present deny striking James, witnessing an assault upon him, or having the circumstances of the event later disclosed to them. That implausible silence infers that not only does one person know, I am satisfied that all of the primary care giving adults know what occurred either from their own knowledge of events that night, or have come to learn since and not disclosed.

99. The subsequent police investigation did not give rise to any criminal charges.

100. For those reasons an inquest was necessary to examine

(a) Whether the actions of any person contributed to James' death;
(b) The adequacy of the police investigation into James' death.

Issue Three (3)
The adequacy of the Queensland Police Investigation

101. The lead investigator Detective Sergeant Glenn Wallwork was stationed within the Child Protection Investigation Unit Cairns. At the time he was assigned as the lead investigator he had approximately 7 years experience in the specialist CPIU Unit. By the time of inquest that experience in the area had more than doubled.

102. Detective Sergeant Wallwork authored a Supplementary Report to Coroner on 7 November 2018 from which a meaningful timeline can be derived (I refer to the chronology throughout my narrative below).

103. The criminal investigation into James' death commenced upon the discovery of skull fractures at autopsy on 5 February 2013, under the name 'Operation Lima Halifax'.

104. From 5 February to 18 March 2013, officers obtained multiple statements from family members and friends, received informal advice from medical experts, and undertook the examination of Synoa and Germaine's homes for fall points and other forensic evidence.

105. Police received the formal medical reports in August 2013. In the ensuing months, they then engaged Dr Couper to provide a biomechanical opinion, which was received the following year in December 2014.

106. At that stage, police considered that normal investigative strategies had been exhausted. In September 2015, investigators successfully applied to the CCC for

coercive hearings, which consequently unfolded over two separate periods: (1) medical staff on 13 September 2016; and (2) family members from 10 to 13 September 2018.

107. At the outset of the investigation, police solely focused on Synoa as a suspect, though she denied responsibility for James' death. By mid-2013, police had also purportedly identified Ehammed Anderson as a person of interest. They formed the view that Theo's (James's father with whom he last had contact in January) involvement with James was outside of the possible timeframe of the injuries.

108. Ultimately, there was no evidence gathered that uncovered the circumstances of James' death or identified the person responsible, nor was there any prospect of a successful prosecution against any person for the death. The conclusion of the 'Final CPIU Report' was that the investigation would be filed as unsolved pending new information becoming available.

109. During a review of the matter by the Office of Northern Coroner in April 2020, it was identified that the experts did not have the benefit of James' medical material from prior to his death, particularly in relation to his medical examination on 15 January 2013. This material was provided to radiologist, Professor Anthony Lamont, who provided an addendum report on 20 July 2020, which altered the initial timeline of the injuries considered by the police.

110. Subsequently at the request of the Office of Northern Coroner the QPS obtained the statement of Dr Deanne True was dated 26 May 2021.

111. Detective Sergeant Wallwork gave oral evidence in person at inquest and in evidence deposed that, as this was the sudden, unexpected death of a child, and the autopsy had found traumatic injuries to James' body, officers from the CPIU, the Homicide Unit (Brisbane), and the Child Trauma Unit (Brisbane) all played a part in the joint investigation.

112. From 5 February to 18 March 2013, officers obtained multiple statements from family members and friends, received informal advice from medical experts, and undertook the examination of Synoa and Germaine's homes for fall points and other forensic evidence. Covert strategies were employed but these did not lead to any evidence of value.

113. Police received the formal medical reports from the pathologist and the neurologist in August 2013, and a radiologist's report in January 2013. Detective Sergeant

Wallwork gave evidence that these showed that James had sustained two sets of injuries to his head, one up to several weeks before his death, and one up to days before his death. In the ensuing months, the investigating team conducted a high-level review of the evidence and determined that QPS would seek a biomechanical opinion as to how the injuries had been caused. Officers were aware that this would cause a delay in the investigation, but it was considered a necessary step in an investigation which had otherwise stalled. The report by Dr Zachariah Couper was provided to QPS the following year in December 2014. Detective Sergeant Wallwork told the inquest that this report identified the substantial force which would have been necessary to cause James' injuries but was unable to provide any firm evidence as to who may have been involved in causing those injuries.

114. Police considered that normal investigative strategies had been exhausted and Detective Sergeant Wallwork gave evidence that as he was in the process of preparing a report for the coroner investigators successfully applied to the CCC in September 2015 for coercive hearings to be carried out in this case, which unfolded over two separate periods, medical staff on 13 September 2016; and family members from 10 to 13 September 2018.

115. Covert strategies were again used in relation to the CCC hearings and the hearings targeted those family members who it was believed were most likely to have information about what might have happened to James.

116. Detective Sergeant Wallwork evidence is that, at the outset of the investigation, police primarily focused on Synoa as a suspect as she was James' primary carer. By mid-2013, police had also identified Synoa's brother-in-law, Ehammed Anderson, as a person of interest as he had been the last person with James, and he had also advised police that he had concerns that he may have banged James' head while trying to revive him, and this concern was raised before the autopsy showed there were head injuries.

117. QPS did not further investigate James' biological father, Theo Davis', as his involvement with James was after the GP visit on 15 January 2013, which had been identified as a critical time by which the earlier set of injuries were likely to have occurred. Ultimately, there was no evidence gathered that uncovered the circumstances of James' death or identified the person responsible, nor was there any prospect of a successful prosecution against any person for the death.

118. The conclusion of the 'Final CPIU Report', submitted to the coroner on 13 November 2018, was that the investigation would be filed as unsolved pending new information becoming available.

119. During a review of the matter by the Coroners Court in April 2020, it was identified that the medical experts did not have the benefit of James' medical material from prior to his death, particularly in relation to his GP examination on 15 January 2013. This material was provided to the radiologist, Professor Anthony Lamont, who provided an addendum report on 20 July 2020, which altered the initial timeline of the injuries considered by the police.

120. After consultation with the Coroners Office Cairns, CPIU completed a submission for a forensic paediatric review into the death as at 7 January 2021.

121. The statement of Dr Deanna True was provided on 4 August 2021. Dr True was able to 'tighten up the time frames' (in the words of Detective Sergeant Wallwork) as to when the fatal injury occurred, which could have been as little as minutes before he was found unresponsive. She also identified that the earlier head injuries would not have been fatal.

122. Detective Sergeant Wallwork noted, in his evidence, that Dr Botterill's subsequent expert medical review also identified that the injuries were unlikely to have been caused by accident.

123. Despite these medical findings, no person has been charged with any criminal offences relating to the death. Although Synoa is considered the most likely to have caused the injuries because she had most opportunity and was most often alone with James, Detective Sergeant Wallwork could not identify any action by Synoa, or any other member of the family, which could be proved to the criminal standard, as having been the cause of James' death.

124. I accept the investigating officers evidence that Operation Lima Halifax used every investigative tool at their disposal and every resource they could to attempt to discover who may have been involved in James death but were simply unable to find definitive evidence which could support a criminal prosecution.

125. An issue in respect of the lack of testing relevant persons for alcohol at the time (Synoa indicated she may have partaken of a modest amount of spirits, Danielle says she had a 'sip') was explained as due to James' death being considered a SUD (sudden unexplained death) death until 5 February when the autopsy results

showed traumatic injuries to his head, and it would not have been normal procedure for all adults in the household to have been breath-tested.

126. Whilst in retrospect that may be considered an investigative oversight, I accept the submissions of Counsel Assisting the inquest Ms Mahlouzarides that it is, in fact an aspect of the difficult path police have to negotiate with families who have suffered sudden infant deaths – a balance between intruding on the family's grief, and obtaining the best evidence possible in the case of suspected criminal matters.

127. I am satisfied that the police investigation and particularly the efforts of Detective Sergeant Wallwork were of the highest standard and that from that perspective all that could be done, was done, by the Queensland Police in this case.

Inquest Issue Two (2)
Whether the actions of any person contributed to James' death

128. There has been detailed enquiry into the possible cause of the injuries to James' skull by a number of medical experts over the course of the police and coronial investigations.

129. The medical evidence reveals that the cause of James' death was one or more non-accidental blows to his head, at one or more impact points on the back of his skull, each impact involving sufficient force to fracture his skull and cause swelling and bleeding to his brain, ultimately resulting in his death.

130. Specialist paediatrician Dr Deanna True concluded that baby James suffered an acute fatal traumatic head injury caused by one or more impacts to the back of the head, either on the day or days prior to the death.

131. Dr True gave evidence that the recency of the impact was supported by the histology findings in the autopsy report. She went on to say that, considering the observations of family members and photographs depicting the infant as being well on the day of his death, her opinion was that the acute injury event occurred within minutes or hours prior to the alteration in his breathing leading to death.

132. Dr True deposed that it was not likely that the brain injury was caused by a fall off the bed, nor was there any witnessed event or accidental mechanism that could plausibly explain such extensive and severe injuries. Dr True's evidence was that the mechanism of the injuries would have been James' skull striking a flat surface

with significant force or being struck by a blunt object with significant force. Dr True was unable to exclude the possibility that James was also shaken violently at the time these injuries were sustained.

133. Dr True in her evidence noted that some of the injuries, including the retinal haemorrhages and subdural haemorrhage, could have been caused by either angular acceleration and deceleration forces (shaking) or direct impact. However, her opinions as to the mechanism of the injuries were further constrained by the lack of detail provided by the forensic pathologist at autopsy, Professor Williams. For example, there was limited description of the nature of the retinal haemorrhages insofar as the number of layers or extent of damage, and no description of the extent, location, or age of the subdural haemorrhage over the brain. She also noted that she would have been assisted in assessing the injuries by a CT or MRI being conducted at the post-mortem.

134. Dr True accepted that there was possibly one or more other impacts days to weeks earlier, but it was "extremely unlikely" that an older head injury contributed to the death. In her words, an older injury of the type shown in the scans would not "suddenly trigger" brain swelling and death after those acute symptoms had resolved. This older injury may have been present at the time of the appointment on 15 January 2013, given the reduced responsiveness of the infant at that time, although those symptoms were non-specific and indicative of only a mild to moderate head injury from which James seemed to have recovered. At that appointment, James' head was measured within the normal circumference, so it is unlikely that there was any swelling or haemorrhage at that time. Dr True's opinion was that this injury was one which James could have recovered from without further treatment.

135. Dr True gave evidence that James was described by family members as doing quite well on the day of his death. She explained that a child of James' age who had sustained the severe injuries that he had sustained could be expected struggle with breathing (as Nyrah indicated). Difficulty breathing is one of the key signs of a head injury as there is not enough oxygen getting to the brain. A child with these injuries might also be sleepy, not able to interact, or unconscious or unresponsive. Vomiting may also be in keeping with such an injury, but not determinative out of context of the child's other behaviours. It is unlikely that James would have been able to feed after an injury of this nature. Dr True advised that if the blow was hard enough James may not have made much noise – he may have been too injured to make a loud cry.

136. James was said to have eaten that night, including after he was placed in 'room 1' to sleep, sometime after 8.30PM, and therefore further marrows the time frame for the infliction of the fatal injury.

137. Given all of the evidence, Dr True's opinion was that James was likely to have sustained the fatal injuries shortly before his breathing was noted to be laboured. His injuries are consistent with his having been hit or thrown against a wall or a floor.

138. A recent review by a senior staff specialist forensic pathologist (not previously assigned to this this case) of all medical expert opinions and all of the available medical evidence supports the findings made by Dr True.

139. In his evidence and his written report, senior forensic pathologist Dr Paull Botterill opines that the lethal injuries were likely to have occurred within hours of James' presentation to hospital on 1 February 2013. Dr Botterill has said that, although the lethal injury could have occurred up to a number of days prior to James being found unconscious, this is unlikely given the family's reports of James' behaviour earlier in the day, and the photo which shows him looking well that morning.

140. Dr Botterill's conclusion is that the "severe impact with fracture of skull" which caused the "terminal brain swelling" was not a minor event, was non-accidental, and James would have had an obvious reaction to it – either he would have been very distressed or he would have had impaired consciousness.

141. On the basis of the medical evidence, I accept the submissions of Counsel Assisting (adopted by Counsel for the QPS Union and Detetective Sergeant Wallwork, and Counsel for the Commissioner of Police), that I can make a number of findings about James' injuries.

142. In respect of the older head injuries, it is likely that these had occurred by 14 January 2013. On that day, Germaine and her youngest children visited Synoa's unit for dinner. There, Germaine noticed that James "looked tired, he was not playful, not smiling", with his head leaning off to the left. She saw him vomit clear fluid and urged Synoa to take him to the doctor. Synoa agreed to go the next day. On 15 January 2013, Synoa took James to the Edmonton Family Medical Centre for scheduled immunisations. His reported history included three episodes of vomiting over the past few days. Dr Vishnoi and nurse Sylvia Kruger observed that James was unusually subdued for a child of his age; he did not cry or respond to a finger-prick test nor did he react or move about during the examination generally.

There was a routine check of James' head, which did not reveal any sensitivity or irregularity to the area.

143. Dr Vishnoi completed a referral for James to attend the Emergency Department at the Cairns Hospital and instructed Synoa to take him there immediately. That is supported by the referral letter and progress notes within the medical records. However, there was no attendance by Synoa and James at the hospital that day.

144. Synoa's version about these events has developed over time. She first claimed that she had been told to use the referral only in the event that James did not improve; so when he started to look better, she decided not to go to the hospital. She later told police that she had simply forgotten to go to the hospital as directed. By the time of the coercive hearings, Synoa did not recall receiving the advice or referral letter at all, stating that the doctor either did not tell her to go to the hospital or she did not hear it.

145. At inquest during oral evidence in person, Synoa first claimed to have no memory of the visit to the doctor at all, but then appeared to recall a different visit to the 24-hour clinic and accepted that she had been told to go to the hospital with James. She said that she did not go because she was too worn out from dealing with him and she was selfish in those days.

146. When it was suggested to Synoa at the coercive hearings that she knew of James' head injury but had not sought medical treatment to avoid intervention by Child Safety, she explicitly denied this. It seems clear on the evidence, however, that James's symptoms in mid-January were consistent with him having suffered the non-fatal head injuries around this time. I infer that if Synoa had inflicted these injuries, or knew that they had been inflicted by someone else, she would be reluctant to seek further medical treatment at a hospital where the full extent of the injuries would likely have been discovered.

147. I accept the submission of Counsel Assisting the inquest that if Synoa had presented James to the hospital as she was advised to do by a General Practioner, action may have been taken by the hospital and Child Safety which could have prevented the second, fatal set of injuries being inflicted two weeks later.

148. In respect of the fatal injuries, I am satisfied that a person present in the Edmonton home that night inflicted James' fatal injuries.

149. I accept the submission of Counsel Assisting that it is open to me to find that the family has not been honest with this court, or the police, as to the extent of their knowledge about who and what caused James' fatal injuries, and I do so find, one or all possess information of relevance.

150. Sometime after 7pm, James was put to bed in bedroom 1, Nyrah's room. Sheyenne and Bianca fed him and played peekaboo.Later that night, James remained in the room with Ehammed, Aaliyah, and Nyrah on one of the various mattresses placed in the room. Sheyenne and Bianca saw James sleeping on the mattress next to Ehammed. (They later left the home to visit friends)

151. Later that night, between 9.30 and 10pm, Nyrah went to bed and lay down next to James, as Ehammed watched a movie. Nyrah raised concerns with Ehammed that James was "breathing funny", making a deep gasping noise. Ehammed and Danielle observed his breathing (Ehammed dismissing the noise to her as 'what babies do'); it was sufficiently irregular for Danielle to, at some time, bring it to Synoa's attention, though it was said Synoa herself not concerned. Synoa's evidence on this point contradicts Danielle and she says that no one raised such concerns with her. Nyrah and Ehammed apparently fell asleep as the movie on television continued to play.

152. Dr True noted the family accounts are vague around what was happening with James in the two hours after he was fed and when Nyrah first reported his breathing difficulties. It is in my view that period of time during which the fatal injuries were inflicted.

153. I dismiss any explanation of 'rough handling' by any person as causative of the fatal injuries.

154. Synoa, as the primary carer for James, and the person to whom the family deferred when it came to the care of James, and the person who has admitted to drinking alcohol that night (perhaps understating the consumption), is the person in that house who is most likely to have inflicted the fatal injuries on James.

155. Synoa conceded during inquest that she found her emotions hard to control at that time, and that she was stressed and angry about issues with James' father and child support on that day. Despite the denials amongst family witnesses I formed a view that the unpaid bond money owed by Synoa to Danielle and Ehammed were the source of an argument that night. Synoa was also dealing with the fact that Theo had made it clear to her that he wanted to be with Nikki and she was very

upset about that. Synoa told this court that she felt that Theo had misled her about wanting to be with her and possibly have another baby with her.

156. Ehammed was the last to see James and was in the room with the baby for some considerable period before alerting Synoa to his laboured breathing. He claims to know nothing about anything.

157. Germaine was the undoubted family matriarch at the time of James death. Along with Synoa, Danielle and Ehammed I formed a view that Germaine knows much more than what she has revealed.

Further considerations

158. The medical evidence reveals one or more blows to baby James' head involving sufficient force to impart a bilateral fracture his skull and cause swelling and bleeding to his brain, ultimately resulting in his death. Not one witness has ever proffered a plausible explanation for those injuries, despite several opportunities over the past nine years to do so. Some family members provided up to five witness statements within a month or so of his death.

159. When it was suggested to Synoa at the coercive hearings that she knew of James' head injury but had not sought medical treatment to avoid intervention by Child Safety, she explicitly denied this.

160. Some family members spoke of minor incidents involving James that could not possibly explain the fatal injuries, for example, rough handling or swinging of the child. Such incidents included the following:

    i. Danielle once saw Synoa give James a single outward shake, saying, *"Why are you whinging?"* She never saw this repeated, but it drew her attention.

    ii. Ehammed once saw Synoa throw James onto a bed from a height of about 10 centimetres. He seemed winded but not hurt.

161. Ehammed emerged as a person of interest at a later stage in the police investigation primarily due to: (1) his presence, alone with baby James, at the time of his demise; (2) an unsolicited call to police after James died and prior to autopsy,

advancing an unsolicited innocent explanation for any injuries to James' head and (3) a previous allegation that he physically harmed a child relative in the past.

162. Consideration of Ehammed's involvement arises from a medical finding that the fatal injuries were inflicted immediately proximate to the child's death and that he was with the child at the time and alerted the mother.

163. I find that James impacted a wall or floor with considerable force that is that he was slammed or thrown into or against a wall or floor by one of the persons present in the household and within an hour or less of the emergency being raised at 10.30PM. It is possible that James was unconscious for the period of time between 9.30PM and the time the alarm was raised. So, whilst he fell into unconsciousness almost simultaneously with the force that caused his fatal injury I can reasonably infer he was left for a time without being immediately attended to.

164. To this day, nine (9) years later, no person has disclosed an event that explains James' fatal injuries and no person has been charged in relation to his death.

Acknowledgements

165. I take this opportunity to thank Counsel Assisting the inquest Ms Mahlouzarides and co-Counsel Ms Lane for all assistance to me and to the inquest. I also thank Ms Taylor and ATSILS for accepting the brief to represent Synoa Tabuai and for doing so at short notice. To Mr Hollands, Mr Fenton and to all for the professionalism and courtesy displayed at all times.

166. I acknowledge the assistance of the Queensland Police and in particular Detective Sergeant Wallwork for the quality of his brief to the coroner and the extensive aide-memoirs in the form of a chronology and outline of evidence. I cannot imagine that he or his colleagues remain unaffected by the circumstances of this case.

Condolences

167. I extend my deepest condolences to all who love and cared for James in his short life. May he rest in peace.

Findings required by s. 45

Identity of the deceased – James Daniel Tabuai

How he died – On 1 February 2013 7 month old James Danial Tabuai was noted to be 'breathing funny' by a member of his family sometime on or between 9.30PM and 10.00PM. Alerts to his laboured breathing were dismissed until another family member realised he had stopped breathing altogether at around 10.30PM at which time the child's mother and the ambulance service were alerted. Emergency resuscitative efforts were futile. Post mortem examination including neuropathology and radiology confirmed a bilateral fracture to the child's skull and bleeding and swelling to the brain. The injuries are deemed to be non-accidental. Four adult care givers were present in the family home that night including the child's 21 year old mother, his maternal grandmother and maternal aunt and her partner. James's 11 year old aunt was also present. No one has then or since claimed any knowledge of the events of the night. A thorough police investigation did not give rise to criminal charges against any person. With regard to all of the evidence I find that James Daniel Tabuai died when he was slammed or thrown against a wall or into a floor by a person with such force as to cause the fatal injuries. I further find that the event that gave rise to the injuries occurred at or between 9.30PM and 100.00PM and that he immediately became unconscious, indicated by his irregular breathing and remained so until the household was alerted at 10.30PM that he had stopped breathing. The lack of detail as to the movements of family members in the two hours prior to 10.30PM is deliberate and has been cultivated to cover up the true nature of the events. I am satisfied that all members of the family present that night know what transpired.

Place of death – Cairns Base Hospital 165 The Esplanade CAIRNS QLD 4870 AUSTRALIA

Date of death– 01/02/2013

Cause of death – Acute traumatic head injury (non-accidental)

I close the inquest.

Nerida Wilson

Coroner
CAIRNS