



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Simon Cooper, Coroner, having investigated the death of Alby Fox Davis

Find, pursuant to Section 28(1) of the *Coroners Act 1995*, that

- a) The identity of the deceased is Alby Fox Davis;
- b) Alby died as a result of choking on a rubber ball at his family home;
- c) The cause of Alby's death was hypoxic brain injury; and
- d) Alby died on 26 February 2018 at the North West Regional Hospital, Burnie, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Alby's death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; relevant police and witness affidavits; medical records; forensic and photographic evidence; and a report of an investigation conducted by the office of Consumer Affairs and Fair Trading.

Alby died, aged 3 years, 11 months and 22 days, when on Monday 26 February 2018 he choked on a small rubber 'bouncy ball'. At the time he was at his family home in Wynyard. The ball had been bought 'on-line' as part of supplies for Alby's 4th birthday party, due to have taken place the following Saturday.

The ball arrived by post that morning. It was in a package, labelled in a way that complied with consumer law requirements in that the label warned that the ball was small, may present as a choking hazard and was unsuitable for children under the age of 3 years.

Out of his mother's sight for only a brief time Alby seems to have placed the ball in his mouth and swallowed it. The ball became lodged in his throat. His mother made frantic efforts to dislodge it, but could not. She called Ambulance Tasmania at 3.29pm and continued her efforts to dislodge the ball and perform CPR until the first paramedic arrived 14 minutes later. He took over attempts at resuscitating Alby. Two other

paramedics arrived within minutes. The three officers were able, eventually and with difficulty, to dislodge the ball from his throat and made attempts to stabilise Alby. Two more paramedics arrived and assisted with attempts at resuscitation and stabilisation. Alby was loaded into an ambulance at 4.16pm and arrived at the North West Regional Hospital at 4.28pm. Medical personnel made every effort to resuscitate Alby after he arrived at the hospital but those efforts were unsuccessful. At 4.48pm Alby was pronounced dead.

After formal identification, his body was transported by mortuary ambulance to the mortuary at the Royal Hobart Hospital. At the Royal Hobart Hospital an autopsy was carried out by experienced forensic pathologist Dr Donald McGillivray Ritchey. Dr Ritchey expressed the opinion, which I accept, that the cause of Alby's death was hypoxic brain injury as a result of asphyxia.

The circumstances of Alby's death were extensively investigated by Uniform, Criminal Investigation Branch, and Forensic Services officers of Tasmania Police. No circumstances giving rise to any suspicion were identified. I am quite satisfied Alby's death was nothing other than an unimaginable tragedy.

Comments and Recommendations

I extend my appreciation to investigating officer Constable Andrew Wood for his investigation and report.

The circumstances of Alby's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Alby Davis.

Dated 2 October 2018 at Hobart, Tasmania.

Simon Cooper
Coroner