



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003564

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Therese McCarthy
Deceased:	Baby M
Date of birth:	April 2023
Date of death:	July 2023
Cause of death:	1a: Complications of coronavirus and adenovirus respiratory tract infection in the setting of an unsafe sleeping environment
Place of death:	Berwick, Victoria
Keywords:	Infant death, respiratory tract infection, safe sleeping practices

INTRODUCTION

1. On July 2023, Baby M was two months old when she died in the home in Berwick where she lived with her mother, Ms L, and other members of her extended family.
2. Baby M was born at 1.26am on April 2023 at Dandenong Hospital.¹
3. Baby M was Ms L's first child, and Ms L was the sole parent responsible for Baby M. Her father was not involved in her life or her care.
4. Baby M lived with Ms L and extended members of her supportive Samoan family in a house in Berwick. The family were observed to be a large and a "*very close, integrated and loving family*".² At the time of Baby M's death there were eight adults and nine children living in the house.³ Family remarked that while Ms L was Baby M's main carer the family would "*chip in to help look after her*".⁴ Ms L and Baby M shared their own bedroom where Baby M had a cot to sleep in.⁵

THE CORONIAL INVESTIGATION

5. Baby M's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008 (the Act)*. Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.
6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

¹ Monash Health medical records of Baby M.

² Coronial Brief (CB), Summary of Circumstances prepared by Coronial Investigator Detective Sergeant Warren Hill [77].

³ CB, Statement of Ms L dated 2 July 2023, [4]; CB, Statement of Ms L's cousin dated 2 July 2023, [8] – [10].

⁴ CB, Statement of Ms L's sister dated 2 July 2023, [14]; CB, Statement of Ms L's cousin dated 2 July 2023 [12].

⁵ CB, Statement of Ms L dated 2 July 2023, [5].

8. The investigation into Baby M's death was commenced by Coroner John Olle and I assumed carriage of the matter in August 2025 upon his retirement, to conclude the investigation and make findings.
9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Baby M's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, and investigating officers – and submitted a coronial brief of evidence. I also sought medical records from Baby M's treating clinicians and maternal healthcare records. I viewed body worn camera footage taken by police members on the day Baby M died.
10. This finding draws on the totality of the coronial investigation into Baby M's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.⁶

BACKGROUND

11. Baby M was born at full term and was described as a healthy baby at birth.
12. Ms L engaged with the Maternal and Child Healthcare Service (**MCHS**) following Baby M's Birth.⁷ Ms L was additionally supported by the Enhanced Maternal and Child Health Service (**EMCHS**) which provides an extension of the MCHS to families that require additional targeted support.
 - a) The MCHS and EMCHS conducted regular in person visits and telephone consultations with Ms L and Baby M. They also conducted key age and stage development checks.⁸ As part of the consultations with Ms L and Baby M, clinicians conducted regular safe sleeping checklists and discussed safe sleep practices with Ms L.
 - b) On 9 May 2023, the EMCHS observed an electric blanket on the cot mattress. Ms L was educated about the dangers of using an electric blanket in a cot with such a young baby.⁹

⁶ Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

⁷ City of Baby M Maternal and Child Healthcare Service Records of Baby M (MCHS Records).

⁸ Ibid, pp. 6-7.

⁹ Ibid p. 55.

At future visits it was observed that the electric blanket had been removed from the cot and continued education was provided regarding the dangers of using electric blankets.¹⁰

- c) On 26 May 2023, the EMCHS noted that Ms L had been co-sleeping with Baby M on a double bed. The EMCHS educated Ms L on the dangers of co-sleeping and told Ms L that a cot needed to be set up. It was noted at this visit that Baby M was feeding well, gaining weight and meeting developmental milestones.¹¹
 - d) On 2 June 2023 the MCHS conducted an eight week check on Baby M and was observed to have had a cot set up for Baby M to sleep in. Notes taken from a later visit by clinicians on 16 June 2023 state that “*the cot and sleep space...was in line with safe sleeping guidelines*”¹²
 - e) On 16 June 2023, Ms L noted with MCHS clinicians that Baby M did not like to be put down to sleep in the cot, instead she preferred to sleep on Ms L. MCHS notes reflect that the clinician educated Ms L on ways to appropriately swaddle Baby M to assist in settling her in the cot.¹³
 - f) Clinicians noted that there was a “*lovely connection and strong attachment between Ms L and Baby M*” and observed Ms L talking and singing to Baby M on multiple occasions.¹⁴
 - g) The EMCHS ceased involvement with Ms L and Baby M the day prior to her death with case file notes reflecting that Ms L was “*happy with Baby M and had no concerns*”. The EMCHS indicated that the MCHS would still be involved and that should Ms L require any further additional support she could reach out to the service for assistance.
13. Ms L reflected that the MCHS along with a nurse at the Dandenong Hospital educated her on SIDS. Ms L noted that she was told “*to make sure her feet were near the end of the cot and to swaddle her*” and to not have anything in the cot along with advice not to use “*heavy*” and “*fluffy blankets*” or put “*too many clothing layers*” on Baby M.¹⁵ MCHS notes reflect that Ms L had asked if “*Baby M could go on her tummy*” and the MCHS clinician educated her on the

¹⁰ Ibid pp. 38, 43, 50.

¹¹ Ibid p. 45.

¹² Ibid p. 30.

¹³ Ibid.

¹⁴ Ibid p. 28, 49.

¹⁵ CB, Statement of Ms L dated 2 July 2023, [28]; CB, Exhibit 14, [115].

importance of tummy time but that “*Baby M was not to be put to sleep on her tummy or left unsupervised on her tummy*”.¹⁶

14. Ms L reported to the MCHS she had concerns that Baby M had an ongoing cough and running nose with the MCHS. Ms L also discussed issues relating to Baby M’s feeding. Ms L reflected that the MCHS did not raise any concerns with her about Baby M or her care.¹⁷
15. On 18 June 2023, Ms L took Baby M to the Dandenong Hospital as she continued to be concerned about her ongoing cough and running nose. Ms L told the court that Baby M was also experiencing reduced feeding. Ms L reported that treating clinicians were of the opinion that Baby M most likely had a virus. Baby M was diagnosed with mild bronchiolitis and was discharged with instructions for Ms L to treat Baby M with saline nasal drops, paracetamol and a vaporiser.¹⁸
16. On 21 June 2023, Ms L visited a general practitioner (GP) with Baby M. It was the first time Baby M had been seen by a GP. The GP notes reflect that Baby M was fully vaccinated and had a haemangioma on her cheek. The GP referred Baby M to a dermatologist for further treatment for the haemangioma. Ms L also discussed Baby M’s cough with the GP. The GP notes reflect that Baby M had an “*improving upper respiratory tract infection*” and that this was discussed with Ms L.¹⁹
17. Ms L noted that Baby M’s symptoms began to improve and that she had been feeding well in the week prior to her death.²⁰

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

18. On July 2023 at approximately 8.00am, Ms L fed Baby M a bottle of formula. Baby M fell asleep on Ms L’s stomach and after approximately 20 minutes Ms L transferred Baby M to her cot on her stomach in the bedroom to sleep.²¹
19. Ms L placed Baby M just below the middle of the cot, with her head on a pillow which was draped with a baby’s sleeping suit over the top as a pillowcase. Baby M’s head was facing to

¹⁶ MCHS Records, p. 30.

¹⁷ CB, Statement of Ms L dated 2 July 2023, [6]–[7]; MCHS Records p. 29.

¹⁸ Monash Health discharge record dated 18 June 2023; CB, Statement of Ms L dated 2 July 2023, [9].

¹⁹ Woodleigh Waters Medical Clinic, consultation notes for Baby M dated 21 June 2023.

²⁰ CB, Statement of Ms L dated 2 July 2023, [10].

²¹ CB, Statement of Ms L dated 2 July 2023, [15].

the side. Ms L placed a blanket over her to cover her from the shoulders down. Ms L reflected that while Baby M would often fall asleep whilst lying on Ms L's stomach, this was Baby M's usual sleeping position within the cot.²²

20. Once Baby M was settled, Ms L also fell asleep in the same bedroom alongside Baby M's cot.²³
21. Throughout the day, members of the family entered and exited the bedroom and observed both Ms L and Baby M sleeping.²⁴
22. At some time between 4.00pm and 5.00pm, Ms L's young niece entered the bedroom looking to see if Baby M was awake. She observed that the blanket was covering Baby M's head and she removed it and left the bedroom. She went and watched some television and then again entered the bedroom to check if Baby M was awake and saw that Baby M appeared to be purple in colour. Concerned about Baby M, Ms L's niece woke her to alert her that there was something wrong with Baby M.²⁵
23. Ms L removed Baby M from the cot and went to the living room where she alerted family members there that there was something wrong with Baby M.²⁶ Baby M was taken to a bedroom in the front of the house and placed on the floor and was given cardiopulmonary resuscitation (CPR).²⁷
24. Ms L called emergency services. The emergency call taker guided the family through providing CPR to Baby M.
25. At approximately 5.45pm, paramedics from Ambulance Victoria arrived and the family met them out the front of the property with Baby M in their arms.²⁸
26. Baby M was placed into the rear of the ambulance where paramedics commenced treatment. Baby M was observed to be unresponsive, not breathing and without a palpable pulse.

²² CB, Statement of Ms L dated 2 July 2023, [16] – [17].

²³ CB, Statement of Ms L dated 2 July 2023, [15].

²⁴ CB, Statement of Ms L's sister dated 2 July 2023, [3].

²⁵ CB, VARE statement of SY dated 2 July 2023, [24] – [28]; CB, Statement of Ms L dated 2 July 2023, [20].

²⁶ CB, Statement of Ms L dated 2 July 2023, [21].

²⁷ CB, Statement of Ms L's cousin dated 2 July 2023, [45]; CB, Statement of girlfriend of Ms L's cousin dated 2 July 2023.

²⁸ CB, Statement of CB of Ambulance Victoria dated 9 January 2024, [5].

Baby M's airway was assessed and ventilation was commenced. Paramedics conducted CPR until Mobile Intensive Care Ambulance (MICA) paramedics arrived.²⁹

27. Upon a more thorough assessment by MICA Paramedics and despite the best efforts of all, Baby M was tragically declared deceased at 5.57pm.³⁰
28. Victoria Police arrived at the scene and commenced an investigation into Baby M's death.

Identity of the deceased

29. On July 2023, Baby M, born April 2023, was visually identified by her mother.
30. Identity is not in dispute and requires no further investigation.

Medical cause of death

31. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine conducted an autopsy on 2 July 2023. Dr Young provided a written report of his findings dated 20 December 2023.
32. The autopsy and post-mortem CT scan showed evidence of an acute viral upper respiratory tract infection with marked inflammation in the airways and lungs, pus in the middle ears, facial sinus and middle ear opacification, and non-aerated mastoid air cells.
33. Multiple specimens were sampled at autopsy for microbiology testing. Seasonal Coronavirus was detected in both lungs and a nasopharyngeal aspirate, and adenovirus was also detected in the aspirate and bowel contents. COVID-19/SARS-CoV-2 was not detected in the nasopharyngeal aspirate, and normal respiratory flora were cultured from the lungs and left middle ear.
34. Dr Young commented that the microbiology results from the blood and urinary bladder were non-contributory and that the vitreous humour biochemistry was non-contributory noting that Serum procalcitonin (a marker of inflammation) was not elevated, at < 0.06 ug/l.
35. Dr Young commented that the autopsy findings were consistent with the clinical history suggestive of an ongoing viral infection. In this case, death would most likely have been due to respiratory arrest. Given that Baby M was placed face down in her cot, the possibility of an

²⁹ CB, Statement of CB of Ambulance Victoria dated 9 January 2024, [6]–[8].

³⁰ CB, Statement of CB of Ambulance Victoria dated 9 January 2024, [8]

impairment to respiration (i.e. an asphyxia component) could not be excluded as having contributed.

36. Toxicological analysis of post-mortem samples showed no ethanol (alcohol), carboxyhaemoglobin, common drugs, or poisons.
37. Methylamphetamine was detected in hair. Dr Young commented that given the methylamphetamine was not detected in blood, its presence in the hair may be due to ingestion, vertical transmission or environmental contamination. Dr Young opined that its presence in the hair has not caused or contributed to Baby M's death.
38. Dr Young noted a thin subdural membrane seen over the brain, which is a likely consequence of birth trauma, rather than a more recent inflicted injury and found no evidence of any injuries which may have caused or contributed to death.
39. Dr Young provided an opinion that the medical cause of death was '*1(a) Complications of coronavirus and adenovirus respiratory tract infection in the setting of an unsafe sleeping environment*'.
40. I accept Dr Young's opinion.

FINDINGS AND CONCLUSION

41. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Baby M, born April 2023;
 - b) the death occurred on July 2023 at Berwick, Victoria, from complications of coronavirus and adenovirus respiratory tract infection in the setting of an unsafe sleeping environment; and
 - c) the death occurred in the circumstances described above.
42. I am satisfied that Baby M's death was as a result of a combination of factors and that her death was accidental and a tragic loss for her family, particularly Ms L. I am satisfied that there were no suspicious circumstances or third-party involvement in Baby M's death and that no adverse comments can be made about the conduct of any person involved.
43. Baby M was found to have suffered from both coronavirus and adenovirus respiratory tract infections, each of which were contributory to her death. The available evidence shows that

Ms L loved her daughter, engaged with her and was focussed on her care. I find that she took reasonable, appropriate and extensive steps to have Baby M's infections treated by seeking external clinical support at first from the MCHS, and subsequently at the Dandenong Hospital and via her GP.

44. Baby M's death also occurred in the context of her sleeping on her stomach with her head to one side. This is considered to contribute to an unsafe sleeping environment. Ms L was a new mother who was educated on safe sleeping both at the hospital at the time of Baby M's birth and via the MCHS and EMCHS. The evidence shows that despite Baby M being placed in an unsafe sleeping environment on the day of her death, that Ms L had previously taken appropriate steps to address safe sleeping when she was provided with targeted education to assist her in doing so. For example, Ms L ceased her previous co-sleeping arrangement, provided Baby M with a cot and removed an electric blanket within the cot upon direction. Further, the evidence suggests that Ms L's means of settling Baby M was to have Baby M fall asleep on her chest and then transfer her to her cot and that on this fatal occasion, this occurred when Baby M was very ill with respiratory virus.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

45. To assist the investigation, Coroner John Olle requested the Coroners Prevention Unit³¹ (CPU) compile information about the incidence of infant deaths where unsafe sleeping is considered to be a factor and provide further information about the current initiatives in promoting infant safe sleeping.
46. Several initiatives and educational materials have stemmed from coronial recommendations regarding safe infant sleeping. Of particular significance, in July 2021 Safer Care Victoria published their Infant Safe Sleeping: Clinical Guidance,³² aimed at assisting maternal and neonatal health care providers to provide consistent advice to parents and caregivers and to model safe sleeping practices within their health service.

³¹ The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

³² See <https://www.safercare.vic.gov.au/best-practice-improvement/clinical-guidance/neonatal/infant-safe-sleeping#goto-guidelinesfor-health-professionals>

47. This guidance advises that there should be an educational approach with parents and caregivers about the need for infants to sleep on their backs from birth and that the safest place for an infant to sleep is on their own sleep surface in the same room as the carers.
48. Red Nose is the leading Australian non-government organisation that is involved in safe sleeping research, education and advocacy. They advised that placing a baby on their back to sleep helps keep their airway clear and ensures their protective reflexes work. Back sleeping reduces the risk of suffocation, overheating and choking.
49. Red Nose continues to research infant deaths. This vital research forms the basis of future mass public health campaigns and consumer-led education packages to reduce the rates of infant deaths in Australia.
50. Available data shows that as with all forms of psychoeducation, there may be a gap between delivery of education and parents' adherence to the safe sleeping practices. It concludes that behaviour change is best advocated through education. This is not a criticism of any organisation or person, but a reminder that new parents are often overtired, struggle with new information about multiple subjects related to how they care for a highly dependent little human being.
51. It is also acknowledged that there is sometimes conflicting information provided to parents by other organisations and people in their social networks which goes against the advice from Safe Care Victoria and Red Nose. Some of this shared wisdom is derived from cultural sources. This can be confusing to parents to understand what is safest for their baby.
52. It should also be acknowledged that Ms L's extended family lived with Ms L and Baby M. This means that there were many others around this new mother, many who have their own children, opinions and ideas. The language and culture of this supportive and extended Samoan family was evident in the body worn camera footage viewed by the court. Notably, Ms L's statement did not contain information about the advice Ms L received from her family as to Baby M's care and what was important culturally regarding her parenting and the involvement of MCHS. There is no information available to the coroner about the cultural practices adopted in settling a baby in Baby M's Samoan family.
53. This supports a need for ongoing safe sleeping measures to be informed and communicated in a way which considers the cultural and linguistic circumstances of new mothers and is reinforced consistently by all relevant health services involved in the care of infants. There is

significant evidence that the MCHS were sensitive to Ms L's environment and supportive of her learning about parenting an infant and that Ms L responded to this support.

I convey my sincere condolences to Baby M's family for their loss.

I direct that a copy of this finding be provided to the following:

Ms L, Senior Next of Kin

Commission for Children and Young People

KidSafe Victoria

Red Nose Australia

Safer Care Victoria

Sergeant Samuel Dunstall, Coronial Investigator

Signature:



Coroner Therese McCarthy

Date: 02 October 2026

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
