IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 6395

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Sarah Gebert, Coroner
Deceased:	Baby M
Date of birth:	September 2018
Date of death:	December 2018
Cause of death:	Sudden Infant Death Syndrome (SIDS Category II)
Place of death:	Victoria
Keywords	*Baby, infant, co-sleeping, SIDS, SUDI*

CORONIAL INVESTIGATIONS

Coroners investigate reportable deaths under the authority of the *Coroners Act 2008* (Vic) (**the Act**). A reportable death includes a death that appears to be unnatural or violent, or to have resulted, directly or indirectly, from an accident or injury.

The Act sets out the matters about which a coroner must make findings. They are:

a. the identity of the deceased person;

b. the cause of death; and

c. the circumstances in which the death occurred.[1]

Coroners can report to the Attorney-General on a death they have investigated; to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and to make recommendations to any Minister, public statutory or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[2]

This is generally referred to as the prevention role of the coroner.

Coroner's Investigator

Coroners are assisted by members of Victoria Police to gather evidence on their behalf. In this case, Detective Senior Constable Jo Macdonald (**DSC Macdonald**) from the Casey Crime Investigation Unit, was assigned by Victoria Police to be the Coroner's Investigator.

DSC Macdonald compiled a comprehensive coronial brief of evidence which comprised of witness statements as well as other relevant documentation.

Whilst I have reviewed all the available evidence, this finding includes only those matters which are directly relevant to the investigation and, allow the findings and comments to be understood.

Prevention

This investigation highlights the potential danger of co-sleeping with infants and the risk of Sudden Infant Death Syndrome (**SIDS**) or Sudden Unexpected Death in Infancy (**SUDI**).

[1] Section 67(1) of the Act
[2] Sections 72(1), 72(2) and 67(3) of the Act regarding reports, recommendations and comments respectively.

BABY PEITA'S CORONIAL INVESTIGATION

1. This investigation involves the death of a baby named Baby M who was born in September 2018. She is the daughter of Ms A and Mr D with two older brothers and one older sister.

2. Baby M was only 3 months of age when she was found unresponsive by her mother one morning in December 2018.

Background

3. Baby M was born by *normal* delivery at the Monash Medical Centre. She weighed 3280g and was 38 cm in length. Her mother described the birth as *awesome* and that she was the *easiest baby.*

4. Baby M was under the care of a paediatric surgeon for a manubrial dermal sinus for which surgery was to be performed when she was older.

5. At Baby M's four week check she was *smiling/cooing*, at her six week check scheduled vaccinations were administered and, *Nothing untoward was noticed* and, at her 8 week check, she was *alert & active.*

6. As Baby M's mother hadn't realised she was pregnant until confirmed at around 6 months gestation, she performed a lot of heavy lifting at work and also smoked tobacco and some cannabis.

7. Baby M was breast fed for the first month of her life and formula fed thereafter.

8. When Baby M was two months old her mother returned to full time work and Baby M and two of her siblings attended a child care centre in Berwick. Her mother said that Baby M *was doing well, she was taking her bottle and sleeping well* and that *child care always said that she was an easy baby.*

9. On 27 November 2018, Dr Peter Ferguson, Paediatric Surgeon, Monash Children's Hospital, met Baby M at the outpatient clinic and apart from her sinus, he *observed that she was healthy and well as there were no obvious general health issues evident on presentation.*

10. At the time of Baby M's death there was an active intervention order between Baby M's parents, with the father as the protected person.

11. Child Protection were involved with the family, and a statement was provided by Shelley Mullens, Deputy Area Operations Manager, Department Health and Human Services (**DHHS**). Relevant to this investigation she said,

Unsafe sleeping practices were evident for [Baby M] *from the initial Child Protection visit on 19 September 2018 where* [Baby M] *was observed sleeping on* [the mother's] *bed with the window open, the heater on and blankets covering her. Child protection purchased a cot and bedding, assisted* [the parents] *assemble the cot and provided clear instructions about how to position* [Baby M] *in the cot. SIDS information and review of* [Baby M's] *sleep environment was provided to both parents at every home visit. Information was shared with Maternal Child and Health Nurse (MCHNS) about concerns for* [Baby M's] *sleep environment and consideration for an Enhanced MCHN was raised with MCHN to reinforce safe sleeping practice.*[3]

12. Baby M's mother said that during a home visit by DHHS they noticed a bong and advised her that as she was on her own with the children she should not be substance affected. She said that she only consumed cannabis at certain times, *just a bit of down time to relax.* DHHS provided support through a psychologist regarding her substance use and she undertook several drug screenings.

13. According to Ms Mullens, Baby M's mother '*informed Child Protection on 25 September 2018 that she had declined family services involvement as she does not need anyone telling her how to sleep her children'.* And that during, *'a home visit by Child Protection on 1 October 2018* [Baby M's mother] *again reiterated that she had enough support and was happy with her existing routine with the children, however did meet with Uniting Connection on two occasions, then cancelled support.'*

14. DHHS closed their case on 1 November 2018.[4]

15. A week prior to Baby M's death she developed conjunctivitis and was treated with eye drops and baby Panadol. The condition subsided after 2 days.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

16. On _ December 2018, the family attended a social function with friends. Baby M's mother drank six alcoholic drinks and smoked cannabis and her father drank beer and also smoked cannabis. Baby M, who had been asleep on the couch, woke at about 9.30pm, after which time the family returned home.

17. Baby M was fed in her mother's bedroom and finished her bottle of approximately 150mls of formula at about midnight. Her previous feed had been at about 6.00pm.

[3] Statement dated 27 August 2019
[4] Not all matters under investigation by DHHS are noted in this finding.

18. Baby M was then placed in her mother's bed to sleep. The queen size bed was positioned against a wall and she was placed closet to the wall, with her mother in the middle between Baby M and her father. She was wearing a nappy and singlet and her lower half was covered with a portion of the blanket they shared.

19. Baby M would usually wake between 4 and 5.00am.

20. Sometime around 6.00am, her mother woke and noticed that the blanket was covering Baby M's face. She said,

    I was sleeping, and I just woke up in a fright, I just had this feeling. I had seen the sunlight, and usually she's up before the sunlight. I seen the blanket at the same time, I knew straight away something was wrong. I knew she was gone. I had a bad feeling waking up and seeing the sunlight and then the blanket.[5]

21. She said that she *freaked out* and tried *pumping her* legs and arms and then blowing breaths into her mouth. Baby M's parents described her colour at this time as either *purple* or *blue.*

22. Baby M was bundled into the car by her mother who drove off *at high speed*[6] in the direction of her mother's house. During the journey she called her mother who told her to call for emergency assistance.

23. At approximately 6.20am, Baby M's mother called Triple Zero who advised her to pull over and place Baby M on her back. She pulled over in Berwick as instructed and was assisted by an endorsed enrolled nurse, Grace Wilson, who was on her way to work. Ms Wilson commenced CPR and was on her third cycle when the ambulance paramedics arrived. She noted that the baby's airway was not obstructed but did not observe any signs of life.

24. MICA paramedic, Matthew Cerra, who arrived at 6.36am said,

    On examination of this patient, I found the patient to be non-responsive, non breathing and with no palpable pulses. The monitored heart rate and rhythm was of asystole. There was no obvious external injuries that I could identify at the time.[7]

25. Despite resuscitation attempts which continued for over 30 minutes, Baby M was pronounced deceased at 7.07am on _ December 2018. She was transported by ambulance to the Monash Medical Centre in accordance with SIDS guidelines.

[5] Statement dated _ December 2018.
[6] According to a neighbour.
[7] Statement of Matthew Cerra dated 15 August 2019.

Police Investigation

26. Police immediately commenced an investigation into the death. Originally Baby M's mother told police that Baby M had been asleep in her cot and the father was not present. She said that she was *overwhelmed with fear* because of the *safe sleeping plan* put in place by DHHS. She feared she might go to *jail for murder.*

27. She said that, *I was doing the safety plan and I really tried, she wouldn't settle in her own bed.* She said that she was frighten that DHHS would take her other children away. She was also mindful that Baby M's father was not permitted to be at the house because of the intervention order.

28. She did however quickly recant this version of events.

IDENTITY

29. On _ December 2018, Ms A visually identified her daughter, Baby M, born _ September 2018.

30. Identity is not in dispute and required no further investigation.

CAUSE OF DEATH

31. On 26 December 2018, Dr Joanna Glengarry, a specialist forensic pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy and provided a written report, dated 4 April 2019. In that report, Dr Glengarry concluded that the cause of Baby M's death was *Sudden Infant Death Syndrome (SIDS Category II).*

32. The post mortem showed a normally developed, well nourished infant. There was no structural abnormality that would account for her death. Ancillary testing including toxicology, procalcitonin, virology, bacteriology and metabolic examinations did not show lethal abnormalities.

33. There was no post mortem evidence of violence or injury contributing to death. No injuries were demonstrated either radiologically or by the autopsy examination.

34. On the basis of the information available, Dr Glengarry considered that the death was due to natural causes.

35. The death was classified as Sudden Infant Death Syndrome (SIDS, or 'cot death'), Category II. The Report noted that SIDS is defined as the sudden unexpected death of an infant, with the onset of the episode apparently occurring during sleep, that remains unexplained after a

thorough investigation, including the performance of a complete autopsy examination with ancillary testing, a review of the circumstances of the death, and the clinical history.

a. SIDS Category II includes infant deaths where the circumstances of death suggest that mechanical asphyxia caused by overlaying is not determined or excluded with certainty.

b. The history suggests a *potentially* unsafe sleep environment. The situation of adults and infants sharing a sleep environment is hazardous due to body size discrepancy and the lack of protective reflexes available to the infant. Adults move during sleep and this is normal. They may not notice accidently overlaying an infant. In saying this however, there *is no definite evidence* to suggest that overlaying has occurred in this case.

36. A Neuropathology Report was prepared by specialist forensic pathologist, Dr Linda Iles who identified no macroscopic neuropathological abnormality.

37. I accept Dr Glengarry's opinion as to the medical cause of Baby M's death.

COMMENTS

38. Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

Co-sleeping and the potential risk of infant death

39. The precise cause Baby M's death remains unexplained as noted by Dr Glengarry. Similarly, in most co-sleeping deaths a definitive cause of death has not been recorded following a complete autopsy, and so the causal link (on a forensic medical basis) has not been established between the co-sleeping and the death.

40. The Coroners Prevention Unit (**CPU**) noted that studies of co-sleeping deaths have repeatedly found that they mainly occur in the presence of known hazards and risk factors for SIDS deaths more generally. These include parents who smoke, parental use of alcohol and drugs, young (under three months old) infants, infants who were born prematurely, presence of soft bedding, and co-sleeping on a sofa.

41. However, studies attempting to ascertain whether there is an elevated risk of infant death in the absence of known hazards while co-sleeping, have produced inconclusive results.

42. On 11 December 2019, Deputy State Coroner Caitlin English highlighted the continued lack of a Victorian government overarching guideline to ensure consistent safe infant sleeping messages are delivered to new parents. [8] She recommended:

That within six months from the date of this Finding, the Department of Health and Human Services finalise and release the Victorian Safe Infant Sleeping Guideline.

43. Consistent with this recommendation, in February 2020 Safer Care Victoria published *Safe Infant Sleep,* Clinical Guidance for consultation.

44. The draft guideline noted that,

- research showed that following simple, safe sleeping practices significantly reduces the risk of SUDI,
- all parents/caregivers should be provided with advice about safe sleeping for their baby as part of routine ante-natal and post-natal care,
- parents are also significantly influenced by the practices of health care professionals observed in the hospital setting, so it is imperative that staff model recommended safe infant sleeping practices, as well as providing appropriate verbal and written information to parents, extended family and other caregivers, and
- it is essential that all families receive clear and consistent information about safe infant sleeping and how to reduce the risk of SUDI, with information provided documented in the relevant clinical notes.

45. This draft guideline included recommendations from the 'Clinical Practice Infant Safe Sleeping Guidelines' developed by the Ritchie Centre, Monash University and the Red Nose Scientific Advisory Group, May 2019. In relation to bed-sharing/co-sleeping or sharing a sleep surface the following was noted:

- The safest place for an infant to sleep is in their own cot, in the same room as an adult care giver.
- Infants should not share a sleep surface with a parent, caregiver or another child.
- Parents should be provided with information about the risks and benefits of co-sleeping so they can make an informed decision for their individual family circumstances.
- Bed sharing with an infant if the parents/caregivers smoke, drink alcohol or take drugs that may affect their consciousness is especially dangerous and parents should be

[8] Maddox Wheeler , COR 2018 318

warned of the significantly increased risk and have strategies in place to avoid bed sharing in these circumstances.

- Infants most at risk of SUDI when sharing a sleep surface are those under 3 months of age, and infants who were born prematurely or small for gestational age.
- Parents/caregivers should be advised that sleeping on a sofa with an infant significantly increases the risk of entrapment and other fatal sleeping accidents and, therefore, should be avoided

46. In addition, the draft guideline included harm minimisation strategies for bed-sharing, noting *consideration of the varied parenting preferences, cultural beliefs and living circumstances in Victoria, parents should be provided with information that includes benefits, risks and strategies to improve safety, should they decide to share a sleep surface with their infant.*

47. At the time of finalising this investigation and finding, consultation in relation to the draft guideline had closed but the guideline was still in its draft form.

Conclusion

48. The evidence suggests that Baby M's death occurred in the setting of co-sleeping with her parents, with some of the known risk factors for SIDS present including parental use of alcohol and drugs and the death involving a young infant.

49. However, following a thorough investigation, including the performance of a complete autopsy examination with ancillary testing, a review of the circumstances of her death, and her clinical history, Baby M's cause of death remains unexplained.

FINDINGS

50. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the Act that Baby M, born in September 2018, died in December 2018 in Victoria, from Sudden Infant Death Syndrome (SIDS Category II), in the circumstances described above.

51. I convey my sincere condolences to Baby M's mother, father, siblings and extended family for the tragic loss of their precious and much loved family member.

The trauma of seeing my baby on the bed and not alive, it was the worst thing I have ever had to deal with. Seeing her like that and having all those things in my head, all I could

think of was 'baby dead, in my care'. I loved my baby so much and now she is gone. I'm so sad she's gone.[9]

52. Pursuant to rule 64(3) of the Coroners Court Rules 2009, I order that a **redacted** version of the Finding be published on the internet.

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

Ms A, senior next of kin

Mr D, senior next of kin

Department of Health and Human Services

Commission for Children and Young People

Detective Senior Constable Jo Macdonald, Casey Crime Investigation, Coroner's Investigator

Signature:

SARAH GEBERT

CORONER

Date: 31 August 2020

[9] Statement from Baby M's mother