IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 5125

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	CORONER DARREN J BRACKEN
Deceased:	JORDAN MALCOLM COLIN WHITE
Date of birth:	5 JULY 2018
Date of death:	19 SEPTEMBER 2019
Cause of death:	1(a) HYPOXIC ISCHAEMIC ENCEPHALOPATHY 1(b) NECK COMPRESSION
Place of death:	42 CARMEL STREET, YALLOURN NORTH VICTORIA 3825

INTRODUCTION

1. Jordan Malcolm Colin White (**Baby Jordan**) was fourteen months old when he died, on 19 September 2019, of hypoxic ischaemic encephalopathy in the setting of neck compression. At the time of his death Baby Jordan lived with his mother Markita Sturk, father Eathon White, half-sister Azaleigh White-Curtis (7) and sister Mekenzie (3) at 5 Howard Avenue, Churchill.

2. Baby Jordan had been born by emergency caesarean section at 37 weeks gestation. Apart from some recent viral symptoms, he had been well. Two days before his death he had been diagnosed with mild bronchiolitis.

3. For approximately two months prior to Baby Jordan's death, Ms Sturk, her partner and the children, established a routine of regular visits to Mr White's father, Alan White, and step-mother Fiona White (**Mrs White**) at 42 Carmel Street, Yallourn North to enable Mr Eathon White to help his father with home renovations. The family would go home to Churchill after dinner on Friday and return to Yallourn North around mid-morning on Saturday.

4. Ms Sturk provided a statement to the coroner's investigator (**CI**) in which she explained that Baby Jordan had an established sleep routine including taking daytime naps.

5. Mrs White, who also provided a statement to the CI, explained that, approximately four years earlier, she and Mr Alan White had obtained a portacot previously used by Mr Eathon White's brother, Dale, for his children. She said that the portacot:

> *"went back and forwards between Dale's house and our house over the years, but for the last couple of years it was predominantly at our house".*

6. The portacot had been set up for a few weeks in the master bedroom for use by Jordan for his daytime naps during these visits. Mrs White went on to describe how:

> *"Whilst it was set up here, the bottom rail of the porta cot would no longer lock into place. This was the bottom end of the cot. So, although it was fully set up, this rail would not lock into position, so the rail was in a V shape rather than a horizontal bar, as it would be if it could lock in place".*

THE CORONIAL INVESTIGATION

7. Baby Jordan'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.

8. 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.

9. 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.

10. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Baby Jordan's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of Baby Jordan Malcolm Colin White, 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. [1]

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

Identity of the deceased

12. On 19 September 2019, Eathon White identified the deceased as his son Jordan Malcolm Colin White, born on 5 July 2018.

[1] 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.

13. Identity is not in dispute and requires no further investigation.

Medical cause of death

14. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination of Baby Jordan's body and drew a written report of her findings dated 15 October 2019.

15. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any common drugs or poisons.

16. The examination of the Baby Jordan's body and the post-mortem CT scan did not reveal evidence of any injury of a type likely to have caused or contributed to death.

17. Dr Archer provided an opinion that the medical cause of death was *'1(a) Hypoxic Ischaemic Encephalopathy; 1(b) Neck Compression.*

18. I accept Dr Archer's opinion.

Circumstances in which the death occurred

19. On the evening of Friday 13 September 2019, Ms Sturk, her partner and the children visited Mr Alan White and Mrs White as usual. Ms Sturk said that Baby Jordan had a short nap in the portacot that night and the family went home at approximately 8.15pm.

20. The following day they returned to Mr Alan White's home before lunchtime. Sometime between 3.30pm and 4.00pm Ms Sturk took Baby Jordan into the master bedroom to feed him and put him down for his afternoon nap.

21. Ms Sturk explained that, following a feed, she placed Baby Jordan, in a sleeping bag/suit with his arms free, on his back in the portacot with his feet towards the unstable end. He immediately turned on his side which was his favoured sleeping position. She observed that as she left the room, Baby Jordan was crying as he normally did when first put down to sleep in his cot but the crying stopped a short time later.

22. Ms Sturk made coffee and sat outside with Mrs White and some visitors. Her daughter, Mekenzie told her she needed her shoes which were in the master bedroom. Ms Sturk asked her older daughter, Azaleigh to go quietly into the bedroom to retrieve the shoes. When Azaleigh returned with the shoes she told her mother that Baby Jordan was "*sleeping sitting up*" causing Ms Sturk and Mrs White to go to the bedroom to investigate.

23. Mrs White entered the bedroom first and found Baby Jordan sitting at the bottom end of the portacot with his neck in the 'cup' of the inverted apex created by the partial collapse of the top cross bar of one end of the portacot. Baby Jordan was leaning slightly forward with his arms inside the portacot. He was unresponsive, his face was grey and he was not breathing. Mrs White immediately lifted him out of the portacot while Ms Sturk rang emergency services. Mrs White commenced CPR in accordance with the instructions of the emergency services call-taker until the arrival of ambulance paramedics.

24. Ambulance and MICA paramedics continued resuscitation efforts. Following approximately 30-45 minutes of chest compressions there was a return of spontaneous circulation. Baby Jordan was intubated and transported to the Royal Children's Hospital by air ambulance.

25. Paediatric intensive care consultant, Dr Thomas Rozen provided a statement to the CI in which he noted that:

> *"Early signs were concerning for potentially poor recovery after out-of-hospital arrest, including significant seizure activity in the early period on the Intensive care Unit and early findings on MRI brain (15/9/19). For completeness a thorough neuro-prognostication process was completed over subsequent days, including repeated physical examination by both myself and a consultant neurology specialist Professor Monique Ryan, assessment of electrical brain activity with EEG testing (16/89/19) and delayed imaging with repeat MRI (18/8/19) which concludes " these appearances are in keeping with evolving changes of profound hypoxic ischaemic brain injury in the current context." Combined these findings indicated a devastating neurological injury as a result of Jordan's cardiac arrest".*

26. Dr Rozen and Professor Ryan met with Baby Jordan's family on 18 September 2019 to discuss their findings and a decision was reached *"to redirect care towards palliation, prioritising comfort and dignity".*

27. On 19 September 2019, Baby Jordan was extubated and died peacefully in his parents' arms.

COMMENTS PUSUANT TO SECTION 67(3) OF THE ACT

28. The available evidence makes clear that this not a case involving malfunction or an inherent fault in the design of the portacot. The investigation revealed that the portacot in question was a Bugatti brand portable cot which had been in the family for several years and was known to be 'faulty'. In her statement Mrs White described the portacot as being:

"...fairly temperamental over recent times and had been difficult to lock into position...whilst it was set up here, the bottom rail of the porta cot would no longer lock into place. This was the bottom end of the cot. So although it was fully set up, this rail would not lock into position, so the rail end was in a V shape rather than a horizontal bar, as it would be if it could lock into place.".

29. The portacot, in the state described by Mrs White may not have posed a danger to a younger and less independently mobile baby. It cannot now be determined exactly how Baby Jordan came to be stuck in the collapsed "V" section of the horizontal crossbar of the portacot. However, according to Ms Sturk, Baby Jordan was capable of getting around and had progressed to "*guerrilla crawling*" (rather than crawling on all fours) and it is at least possible that he moved to the end of the portacot and perhaps sought to pull himself up by the end and there-by found himself resting his neck in the inverted apex of the cross-bar.

30. Kidsafe Victoria publishes warnings on its website about the dangers associated with the use of damaged or faulty equipment such as portacots and I propose to make the recommendations below to the Victorian Department of Health and Human Services and Kidsafe Victoria that they together consider the circumstances of Baby Jordan's death and develop a strategy aimed at reducing, if not eradicating such deaths by increasing public awareness of the dangers associated with the use of faulty and or damaged equipment such as portacots. This Finding including the recommendation will be published on the Coroners' Court website.

31. Having considered all of the available evidence, I am satisfied, and find, that Baby Jordan's death was an appallingly tragic accident and that no further investigation is required.

RECOMMENDATIONS

32. Pursuant to section 72(2) of the Act, I recommend that:

1. The Victorian Department of Health and Human Services and Kidsafe Victoria, together develop and implement a strategy to increase public awareness of the potentially fatal dangers of parents using faulty or damaged 'baby care equipment' such as portacots with a view to reducing, if not eradicating accidental deaths such as that of Baby Jordan caused by such use.
2. Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

FINDINGS AND CONCLUSION

33. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    (a) the identity of the deceased was Jordan Malcolm Colin White, born on 5 July 2018;

    (b) the death occurred on 19 September 2019 at 5, Carmel Street, Yallourn North; and

    (c) the death occurred in the circumstances described above.

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

    (a) Ms Markita Sturk and Mr Eathon White; senior next of kin;

    (b) Ms Melanie Courtney, CEO, Kidsafe Victoria;

    (c) Mr Martin Foley, Victorian Minister for Health;

    (d) Ms Annabelle Mann, Royal Children's Hospital, Melbourne; and

    (e) Detective Leading Senior Constable Andrew Barter, Coroner's Investigator, Victoria Police.

Signature:

DARREN J BRACKEN

CORONER

Date: 24 February 2021

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.