IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 006592

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Baby B
Date of birth:	15 October 2020
Date of death:	05 December 2020
Cause of death:	1(a) SIDS Category 2
Place of death:	Morwell, Victoria
Keywords:	SIDS; co-sleeping; infant death; Child Protection

Aboriginal and Torres Strait Islander readers are advised that this content contains the name of a deceased Aboriginal person. Readers are warned that there may be words and descriptions that may be culturally distressing.

INTRODUCTION

1. On 05 December 2020, Baby B was seven weeks old when he passed away in the bed of his mother and stepfather. At the time of his passing, Baby B lived in Morwell with his mother, stepfather, and sibling. Baby B had another sibling who resides in out of home care.

2. Baby B's mother is a Wemba Wemba woman; the traditional owners of North Western Victoria and South-Western New South Wales, including the Mallee and Riverina regions.

3. Baby B was born via vaginal delivery with no complications and thrived post-birth. He was both breast and bottle fed. His only medical issues were colic and reflux. His mother consulted with a Maternal Child Health Nurse and Pharmacist and was recommended to commence him on Gaviscon Infant and Infant Friends.

THE CORONIAL INVESTIGATION

4. Baby B'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.

5. 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.

6. 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.

7. This finding draws on the totality of the coronial investigation into the death of Baby B. 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]

[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

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

Circumstances in which the death occurred

8. Three days prior to Baby B's passing, his mother introduced thickened formula into his diet, as suggested by his Maternal Child Health Nurse. He seemed well and happy; there were no obvious symptoms of him being ill.

9. Between 3am and 4am on 5 December 2020, Baby B's mother bottle fed him. At around 5am he stirred in his cot, so she took him from the cot and breast fed him in bed before placing him between herself and his stepfather.[2]

10. At 7:18am, Baby B's mother woke and found him unresponsive. At 7:20am, emergency services were called.

11. Paramedics arrived shortly thereafter and commenced cardiopulmonary resuscitation and administered adrenaline, with nil response. Tragically, Baby B was declared to have passed at 7:59am.[3]

12. According to Baby B's mother, the Royal Women's Hospital 'had encouraged her to co-sleep and she believed this to be culturally appropriate and not a SIDS risk.[4]

Identity of the deceased

13. On 5 December 2020, Baby B, born 15 October 2020, was visually identified by his mother, who provided a Statement of Identification.

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

Medical cause of death

15. Forensic Pathologist Dr Yeliena Fay Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Baby B on 11 December 2020 and provided a written report of her findings dated 22 July 2021. Dr Baber had available to her the following materials:

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evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] Court File (CF), Statement of Dr Karen Sutherland, dated 23 November 2021.

[3] CF, Ambulance Victoria Verification of Death form.

[4] CF, Statement of Dr Karen Sutherland, dated 23 November 2021.

a) Victoria Police Report of Death (Form 83);

b) Post mortem computed tomography (**CT**) scan;

c) Victoria Police Sudden Unexpected Death of Infant Checklist;

d) Child protection information;

e) Toxicology report of Dr Dimitri Gerostamoulos;

f) Vitreous electrolytes and glucose report;

g) Microbiology report;

h) Metabolic studies; and

i) Radiology report.

16. The post-mortem examination revealed lung petechiae and thymus petechiae. Dr Baber commented that these findings were non-specific and non-diagnostic but may be seen in cases of SIDS or overlay.

17. No natural disease, congenital abnormality or injury was identified.

18. Toxicological analysis of post mortem hair samples identified the presence of the following:[5]

a) 6-Monoacetylmorphine[6] ~ 0.09 ng/mg

b) Morphine ~ 0.2 ng/mg

c) Codeine ~ 0.9 ng/mg

d) Methadone ~ 0.3 ng/mg

e) Oxycodone ~ 0.1 ng/mg

f) Tramadol ~ 1.4 ng/mg

g) Methylamphetamine ~ 3.3 ng/mg and its metabolite amphetamine

[5] CF, Toxicology Report of Dr Dimitri Gerostamoulos, Chief Toxicologist.
[6] 6-Monoacetylmorphine and morphine are metabolites of heroin.

h) Delta-9-tetrahydrocannabinol ~ 0.3 ng/mg

i) Diazepam ~ 0.02 ng/mg and its metabolite oxazepam

19. Dr Baber commented that the presence of oxycodone, tramadol, diazepam and oxazepam, methadone, methylamphetamine, amphetamine and delta-9-tetrahydrocannabinol may be due to previous ingestion or environmental contamination.

20. The presence of heroin metabolites (6-monoacetylmorphine, morphine and codeine) is suggestive of previous ingestion either through placental transfer, or ingestion via breast milk or formula feed.

21. Dr Baber stated that despite autopsy and multiple ancillary investigations, the cause of death remained undetermined. As such, it was appropriate to invoke the acronym of SIDS, being sudden unexpected death of an infant less than 1 year of age with the onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation, including performance of a complete autopsy and review of the circumstances of death and the clinical history.

22. Category 2 SIDS is used in cases where according to the circumstances mechanical asphyxia or suffocation cannot be determined or excluded with certainty. Dr Baber noted that Baby B was asleep in his parents' bed, and while overlay was not confirmed or refuted by autopsy, the sleeping position was potentially hazardous.

23. Dr Baber provided an opinion that the medical cause of death was 1 (a) SIDS CATEGORY 2.

CHILD PROTECTION INVOLVEMENT[7]

24. Baby B and his siblings were the subject of several Child Protection reports and consultations.

25. On 9 June 2020, a consultation occurred with Community Based Child Protection (**CBCP**)[8] following reported allegations of his mother using and scoring drugs, and family violence perpetrated by his stepfather. Baby B's mother was approximately 20 weeks pregnant with

[7] CF, Statement of Dr Karen Sutherland, dated 23 November 2021.

[8] Section 38 of the *Children, Youth and Families Act 2005* (Vic) enables a registered community and family service to consult and seek advice from the Department of Families, Fairness and Housing's Community Based Child Protection Practitioners to undertake risk assessments and inform decision making. This is to allow for opportunities to offer effective earlier intervention and prevention services before there is a need for child protection intervention.

him at the time. CBCP assessed there was insufficient information to indicate unborn Baby B was at significant risk of harm.

26. On 29 July 2020, Child Protection received an unborn child report in relation to Baby B. The concerns related to Baby B's sibling who was reported to have had multiple showers with their stepfather. Services had discussed with Baby B's mother the inappropriateness of this, but she indicated she did not have concerns. The concerns related to Baby B insofar as they related to his mother's capacity to make appropriate parenting decisions relating to potential harms to her children.

27. On 14 October 2020, another CBCP consultation occurred regarding a lack of supervision for Baby B's sibling while his mother was at the Royal Women's Hospital for Baby B's birth. The CBCP practitioner requested that the hospital place an unborn alert[9] on their system in relation to Baby B.

28. On 8 November 2020, Child Protection received a report that Baby B's mother had verbally threatened his sibling while at Woolworths and may have been drug affected.

29. A secondary report was received on 11 November 2020 in relation to Baby B's stepfather who fell from an electricity pole while alcohol affected. Whilst in hospital, he disclosed methamphetamine use and significant drinking. It was reported that he and Baby B's mother were extremely abusive to hospital staff and Baby B's mother had difficulty prioritising her children's needs and was often heard screaming and swearing at them. It was also reported that Baby B had been seen with a black eye, that his mother said his sibling had caused accidentally.

30. Child Protection undertook an extensive risk assessment and in consultation with Lakidjeka[10], assessed that the children were not at significant risk in their mother's care, subject to her aggressing to enter into a protective agreement plan. The plan included, *inter alia,* the children having no contact with their stepfather pending a full assessment, and the children not being exposed to family violence or substance misuse.

[9] An unborn alert involves Child Protection requesting that the hospital record an alert on the pregnant mother's patient record to indicate there is current Child Protection involvement, and potential risks and/or harms for the unborn and newborn child and requesting Child Protection be contacted upon the child's birth.

[10] The Victorian Aboriginal Child Care Agency (VACCA) is known as Lakidjeka.

31. On 20 November 2020, a report was made to Child Protection alleging the children were being neglected, their mother lacked basic parenting skills and the home environment was messy and chaotic.

32. Baby B's siblings were the subject of numerous reports to Child Protection, with his older sibling subject to a Long-Term Care Order. The protective concerns related to exposure to family violence, parental substance abuse, lack of supervision and concerns relating to parenting capacity.

33. At the time of Baby B's passing, Child Protection was at the beginning of an investigation with the family.

Cultural considerations

34. It is a requirement under the *Children, Youth and Families Act 2005* (Vic) that in making a decision or taking action in relation to an Aboriginal child, that Child Protection seek advice from the Aboriginal Child Specialist Advice Support Service (ACSASS), who provide expert advice about culturally appropriate interventions

35. In Baby B's case the ACSASS service was delivered by 'Lakidjeka', the Victorian Aboriginal Child Care Agency. Lakidjeka assists in identifying members of the child's kinship or community network who may be suitable to provide a placement, and culturally appropriate referrals to services. Lakidjeka was involved in all aspects of interventions and decision making about Baby B and family.

CORONERS PREVENTION UNIT REVIEW

36. At my request, the Coroners Prevention Unit (**CPU**)[11] provided me with a summary of deaths involving co-sleeping between 2008 and 2023.[12] The CPU defined a co-sleeping death as *the non-intentional death of an infant which occurred while the infant was sharing a sleep surface (a bed, couch, mattress, blanket, armchair or so on) with another person or people and/or pets.*

[11] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[12] Coroners Prevention Unit issues brief: Deaths of Victorian infants in a co-sleeping context, updated 5 September 2023.

37. The CPU identified 163 Victorian co-sleeping deaths of infants between 2008 and 2023[13], with a great fluctuation in numbers from year to year. 77.8 percent (n=127) of the deaths occurred while the infant was sleeping with an adult or adults in an adult bed, and 33.7 percent (n=55) of deaths involved the caregiver using drugs and/or alcohol proximate to the infant's death. Most deaths occurred in infants between 31 and 60 days old, including that of Baby B (32.5%, n=53). There was an unusually high number of co-sleeping deaths among infants of Aboriginal and/or Torres Strait Islander descent in 2020 (n=4), and 2021 (n=5).

COMMENTS

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

1. I acknowledge that co-sleeping is common in many cultures and can have significant wellbeing benefits for both parents and baby. Co-sleeping is a personal choice and I do not intend to criticise that choice, however it would be remiss of me not to note with emphasis that sharing a sleeping surface with an infant carries inherent risks, including the risk of sudden unexpected death in infancy. These risks are exacerbated where the parent/s use alcohol and/or other drugs.

2. Victorian Coroners have investigated numerous co-sleeping deaths and made pertinent recommendations. Coroner Spanos, in her *Form 37 Finding into Death with Inquest*[14] in the matter of Baby Isabella Rose, stated:

   A number of coronial findings contain comments and recommendations aimed at reducing the number of preventable deaths of infants, and essentially reiterating safe sleeping practices and SIDS awareness for infants and young babies. An important finding in this area is that of my colleague Coroner John Olle in the matter of Baby J (2010 2580) which was a cluster investigation of four infant deaths.

   The known risk factors for SIDS noted in that finding, based on international research, relevantly include sleeping with an adult other than the mother, maternal exhaustion, alcohol or drug use (whether recreational or prescription) by the adult caregiver sharing the sleeping surface, thermal regulation and ventilatory control (such as a warm environment) and infection suffered by the infant.

[13] Between 1 January 2008 and 31 July 2023.
[14] https://www.coronerscourt.vic.gov.au/sites/default/files/2018-12/babyisabellarose_373113.pdf

3. It is reassuring to note that several initiatives and educational materials have stemmed from coronial recommendations regarding co-sleeping. For example, in July 2021, Safer Care Victoria released their infant safe sleeping clinical guidance[15], 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.[16]

4. I hope that Baby B's untimely passing serves as a reminder, albeit a tragic one, of the potential consequences of co-sleeping, and reinforces the importance of promoting the inherent risks of co-sleeping in order to prevent similar deaths from occurring in the future.

5. Finally, I wish to note that the circumstances of Baby B's passing are not the fault of his parents, who loved him very much. Baby B's tragic outcome is all too common; Baby B is one of many infants who have passed away in similar circumstance, while co-sleeping with adults.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Baby B, born 15 October 2020;

   b) the death occurred on 05 December 2020 at Morwell, Victoria;

   c) I accept and adopt the medical cause of death as ascribed by Dr Yeliena Fay Baber and I find that Baby B died from SIDS category 2.

2. AND, having reviewed the evidence before me, I find that the investigations and interventions by Child Protection were appropriate, and culturally appropriate, in the circumstances, and that Baby B's tragic outcome could not have been reasonably foreseen.

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

[15] https://www.safercare.vic.gov.au/sites/default/files/2021-06/Clinical%20guidance_Infant%20safe%20sleeping.pdf

[16] The clinical guidance states that the safest place for an infant to sleep is in their own cot, in the same room as the parent/adult caregiver until at least six months of age (preferably 12 months). It advises clinicians to advise parents of the risk of co-sleeping for all infants under three months of age, and to warn parents of the significantly increased of co-sleeping if the parents smoke, drink alcohol or take drugs.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

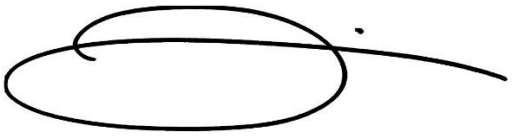
Senior Next of Kin

Child Protection, Department of Families, Fairness and Housing

Commission for Children and Young People

Senior Constable Kate Gardner, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 17 April 2024

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.