MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the names of the parties by direction of the Coroner)

I, Rod Chandler, Coroner, having investigated the death of Baby I

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

a) The identity of the deceased is Baby I;
b) Baby I was born in Launceston and was aged 3 months;
c) Baby I died in May 2017 in northern Tasmania; and
d) The cause of Baby I's death was probable suffocation due to overlaying whilst sleeping with an adult.

Background

Baby I was the son of Ms L and Mr N. He was born without complication following a full term pregnancy. During his short life he undertook all standard infant nursing and medical assessments and no medical or social issues were identified save for constipation. His last medical attendance was in May 2017 when he received his four month immunisations. Ms L says *"Baby I was in perfect health since his birth, he was such a happy little baby and never cried. He was never sick."*

Circumstances Surrounding the Death

In the evening of Baby I's death Mr N and Ms L hosted three friends for dinner held in a shed located adjacent to their residence. At around 7.00pm Ms L breastfed Baby I and then took him into the residence. He was put to bed in his bassinet which was in the master bedroom. In the hours following Baby I was checked by either of his parents at around 30 minute intervals.

At about 10.00pm the dinner guests left and Mr N and Ms L set about cleaning up. At around 11.00pm Ms L fell asleep in an armchair in the shed. At about the same time Mr N says that he was also tired and decided to go to bed. During the evening he had been drinking beer and estimates that he *"had about 10 beers by the time I went to bed."*

In the bedroom Mr N found that *"Baby I was awake, looking around and having a little bit of a cry."* He picked him up from the bassinet and laid him on his back in the bed.

Mr N then lay himself on the bed and went to sleep. He was lying on his left side and facing Baby I. At about 5.00am Ms L awoke and went into the residence. When she entered the bedroom she observed Mr N lying on his right side. Baby I was also lying on his right side and was pressed against his father's back. She picked Baby I up and noticed that he was cold to touch and stiff. She immediately woke Mr N. They phoned for an ambulance and Mr N carried out CPR whilst waiting for it to arrive. Paramedics determined that Baby I was deceased.

Officers from Tasmania Police attended and began an investigation as required by the *Coroners Act 1995.* Both Mr N and Ms L have been interviewed. In his affidavit Mr N states:

> *"I think I rolled on Baby I during the night. I didn't feel Baby I in my back, but Ms L told me Baby I's face was against my back. I think Baby I had died sometime during the night, I must have gone to sleep and I think I rolled on him, I may have smothered him. I am a very heavy sleeper…"*

The premises were closely examined and photographed. A number of items were taken for forensic examination.

I am advised by Tasmania Police that its investigation has not revealed any suspicious circumstances attaching to the death. I accept this advice.

Post-Mortem Examination

This was carried out by forensic pathologist, Dr Donald Ritchey. In his report Dr Ritchey says:

> *"The autopsy revealed a normally developed and nourished but small for age infant Caucasian boy with marked petechial haemorrhages of the surfaces of the lungs and prominent oedema and congestion of the lungs. Although these findings are non-specific in the context of sleeping adjacent to an adult, the findings strongly suggest accidental overlay of the child by the adult causing suffocation."*

In Dr Ritchey's opinion the cause of Baby I's death was probable suffocation due to overlaying whilst sleeping with an adult. I accept this opinion.

Comments and Recommendations

Tragically, deaths of infants caused by overlaying are continuing to occur in this State and nationally. This is so despite the warnings against the practice made by organisations such as Red Nose and also by coroners. In this State both Coroners McTaggart and Cooper have in recent years highlighted the dangers of co-sleeping and warned against the practice. Sadly, Baby I's death is a stark illustration that the warnings are not being heeded. It leaves me to add to the chorus of those warnings and to make my own **recommendation** that persons responsible for the care of infants under the age of 12 months ensure that such infants do not sleep in the same bed as any other person.

I have decided not to hold a public inquest into this death because my investigation has been sufficient to disclose the identity of the deceased, the date, place, cause of death, relevant circumstances concerning how his death occurred and the particulars needed to register his death under the *Births, Deaths and Marriages Registration Act 1999*. I do not consider that the holding of a public inquest would elicit any significant information further to that disclosed by the investigation conducted by me.

I convey my sincere condolences to Baby I's family and loved ones.

Dated: 12 November 2018 at Hobart in the State of Tasmania.

Rod Chandler
Coroner