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 name of the deceased, family, friends and others by direction of the Coroner)

I, Simon Cooper, Coroner, having investigated the death of Baby B

Find pursuant to section 28(1) of the *Coroners Act* 1995 that

a) The identity of the deceased is Baby B;
b) Baby B died in the circumstances set out below;
c) The cause of Baby B's death was unexpected death in infancy whilst co-sleeping with an adult and sibling; and
d) Baby B died in August 2016 in northern Tasmania.

Background

Baby B died, aged just over 2 months, in August 2016.

He was born in June 2016 at the Launceston General Hospital. The son of Ms S and Mr L, Baby B was the youngest of the couple's three children. Although his umbilical cord was wrapped around his neck during his birth and his heart rate dropped during labour, Baby B's birth was, relatively speaking, uneventful; he was delivered naturally and weighed 2380 gm.

After his discharge from hospital, Baby B lived in the family home, with his parents, sister and brother. Reportedly, Baby B was a normal, happy and healthy baby during his short life; both feeding and sleeping well. His medical records support this conclusion. The same records note a visit by a community nurse who reported nothing of concern.

Generally speaking Baby B's family seems to have been settled and cohesive. It is noted that on 15 June 2016, shortly after Baby B's birth, police attended a family violence incident at the home, recorded as a family argument. Attending police saw no signs of violence and witnessed nothing which gave rise to concern for Baby B's (or his siblings') welfare. I also note four other recorded family violence incidents involving Baby B's parents, all of which

occurred prior to his birth. The most serious of these incidents was one which occurred in February 2012 in which Baby B's father assaulted his mother. She suffered minor injuries and was admitted to the Launceston General Hospital for a mental health assessment in the aftermath of the assault.

Circumstances Surrounding the Death

The day prior to Baby B's death the family kept an appointment in Launceston, did some shopping at Kmart and returned home. During the course of the day Baby B reportedly fed and slept well.

Baby B's parents made a decision that the whole family would sleep in the lounge room on the night prior to his death as the bedrooms of the home were cold. Accordingly, his mother moved a double bed mattress from one of the bedrooms into the lounge room. Baby B, his mother and his then five-year-old sister slept on the double mattress.

Baby B's mother reported that at about 11.00pm that night she fed Baby B and whilst he was feeding he fell asleep. She then wrapped him in a blanket, put a pacifier in his mouth and lay him on the mattress. Baby B's mother then positioned herself between Baby B and her daughter.

At about 5.00am the next morning Baby B's mother awoke and noticed he was in the same position in which she had laid him down to sleep at about 11.00pm the previous evening. She was unable to wake Baby B. She noticed blood on his face and screamed out to her partner who in turn called 000 (dispatch records from Ambulance Tasmania indicate that the call was made at 4.58am and the ambulance arrived six minutes later). CPR was attempted by Baby B's mother before the arrival of the ambulance crew, who continued those attempts. Sadly, Baby B was unable to be resuscitated and he was pronounced dead at 5.10am.

Police officers were quickly on the scene where an investigation was commenced pursuant to the *Coroners Act* 1995. The investigation included, *inter alia*, the completion of the Sudden Unexpected Death in Infancy (SUDI) Checklist, a copy of which was provided to me. Both parents were interviewed. Detectives from the Launceston Criminal Investigation Branch attended the scene as did an officer from Forensic Services. The premises were carefully examined and photographed extensively. The photographs have been provided to me as part of the investigation.

A number of exhibits were taken by police for subsequent forensic analysis. Those exhibits included the pacifier, Baby B's bedding and his clothing.

Nothing was found at the scene indicating any suspicious circumstances surrounding Baby B's death. Subsequent forensic examination of the exhibits did not reveal anything which would help identify the cause of Baby B's death.

Baby B's body was taken to the Launceston General Hospital where formal identification took place and he was declared life extinct by a medical practitioner. His body was then transported by mortuary ambulance to Hobart where an autopsy was carried out by highly experienced forensic pathologist, Dr Donald McGillivray Ritchey. Dr Ritchey expressed the opinion, which I accept, that the cause of Baby B's death was unexpected death in infancy whilst co-sleeping with an adult and an older child. He said in his report that the autopsy "*revealed a normally developed, nourished and hydrated infant… boy [and that] no significant viruses were recovered in specialised testing of autopsy samples [and that] a natural cause of death was not identified at autopsy*".

As a cause of death, 'unexpected death in infancy whilst co-sleeping' in reality describes the circumstances of a death that occurs in an unsafe sleeping environment. Dr Ritchey said that the possibility of an asphyxial death caused by unintentional overlay either by Baby B's mother or sister could not be excluded. However, I cannot be satisfied to the requisite legal standard that asphyxial death caused by unintentional overlay was the cause of Baby B's death.

Dr Ritchey also said that the blood observed by Baby B's mother on his face was attributable to pulmonary oedema, something very commonly seen in deaths of infants. Dr Ritchey said, and I accept, that in this case the oedema seen is non-specific in the sense that it does not help to elucidate the cause of death. It is something that is observed in the death of infants from many different causes including sudden infant death syndrome and accidental overlays, as well as almost every other cause of death.

Samples taken from Baby B's body at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. The results of that analysis were unremarkable.

Comments and Recommendations

Whilst there has been a reduction over the years in sudden unexpected deaths in infancy in Tasmania (as well as nationally), these deaths comprise a high proportion of potentially preventable deaths of children under the age of 18 years. Tragically, they are still occurring on a frequent basis.

In Australia sudden unexpected death in infancy is the most common cause of death for children aged between one month and one year of age. Studies have shown that sharing a sleep surface with a baby increases the risk of sudden unexpected death in infancy. Additionally, adult sleeping environments may contain hazards that can be fatal for babies, including accidental overlaying of the baby by another person or suffocation from pillows, blankets or loose bedding.

The message promoted widely by organisations such as Red Nose is for adults and older siblings not to sleep on the same surface as an infant. Coronial findings in this state have consistently warned of the dangers of co-sleeping.

In findings published in 2008 and 2011 Coroner McTaggart made the point that it seemed that the advice not to sleep with an infant was not getting through to many people in the community. Tragically, that seems to be precisely the case in this death.

Coroner McTaggart also made a number of recommendations and comments dealing with the elimination of SUDI risk factors, and specifically highlighted the dangers of co-sleeping. In my view the warning against co-sleeping needs to be repeated.

Therefore, I again **recommend** that the parents or older siblings of infants under the age of 12 months are not to sleep in the same bed with their infants, but to always place them on their back in their own cot to sleep.

I also **comment** that it is extremely important that this simple but crucial message is disseminated repeatedly by involved government agencies, health professionals, and the media, whenever it is appropriate. It is quite clear that repeated reinforcement is necessary to be effective in preventing the tragic deaths of infants in our community. It seems quite clear in this tragic case that the message was not properly understood.

In concluding, I convey my sincere condolences to the family of Baby B.

Dated 2 April 2018 at Hobart in Tasmania.

Simon Cooper
Coroner