Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 8/18

I, Sarah Helen Linton, Coroner, having investigated the death of ***Baby A*** *with an inquest held at the* ***Broome Court House, Hamersley Street, Broome*** *on* ***5 and 6 February 2018*** *find that the identity of the deceased person was* ***Baby A*** *and that death occurred on* ***24 January 2015*** *at* ***Derby Hospital*** *as a result of* ***Mechanical Asphyxiation as a Consequence of Overlaying*** *in the following circumstances:*

Counsel Appearing:

Ms F Allen assisting the Coroner.
Ms A Barter (ALS) appearing for Ms Alexis Rogers, mother of the deceased.
Mr J Winton (State Solicitor's Office) appearing on behalf of the West Australian Country Health Service.

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SUPPRESSION ORDER IN PLACE

There is a suppression order in place in relation to the deceased's name for the purposes of publication. The deceased is generally referred to as Baby A or the baby throughout the finding.

INTRODUCTION

1. Baby A was born prematurely on 2 December 2014 at the Wangkatajunka Aboriginal Community. Following his birth he was taken by ambulance to Fitzroy Crossing Hospital and a paediatric team flew in from Broome to care for him. It was established that Baby A would require longer term medical care, so he was eventually transferred to Darwin Hospital by the Royal Flying Doctor Service and his parents followed.

2. During his admission at Darwin Hospital Baby A was treated for a number of medical problems common to premature babies, including hyaline membrane disease, jaundice, low sodium levels and feeding issues.

3. Once Baby A's condition improved arrangements were made to transfer Baby A to Derby Hospital so that he and his parents would be closer to home. It was intended that he would remain at Derby Hospital for further monitoring of his weight and to provide support for his mother until he was considered of sufficient weight to be safe to go home.

4. On 23 January 2015 Baby A was discharged from Darwin Hospital. He flew with his parents to Broome, where he was reviewed by a paediatrician at Broome Hospital, before he took a bus with his parents to Derby Hospital. The family arrived at Derby Hospital that evening after a long day of travelling.

5. On arrival Baby A was examined by a midwife and noted to be a healthy baby who was breastfed with bottle top ups. He was approximately 7 weeks' old at this time. Baby A's initial observations were all within normal range. He was admitted to a ward at 9.30 pm that evening with his mother.

6. During the night Baby A was found co-sleeping with his mother a number of times, contrary to the advice of the midwife. He was moved back to his cot by the midwife on each occasion.

7. The following morning another midwife entered the room and found that Baby A was again asleep with his mother in the hospital bed. She did not wake them and left the room. When the midwife returned a few hours later Baby A was breastfeeding. Baby A was also seen around this time by a

doctor. The doctor noted the baby appeared to be active and feeding normally.

8. A different midwife entered the room about an hour later and found Baby A co-sleeping with his mother in the bed. She approached him and found he showed no signs of life. Vigorous resuscitation attempts were made but Baby A could not be revived.

9. On 29 January 2015 a Forensic Pathologist conducted a post mortem examination and could not identify a cause of death. However, given the known circumstances of the death, overlaying was raised as a possible contributing factor.

10. I approved an inquest on 17 March 2017 to explore the cause of death further and the circumstances in which the hospital midwife saw a baby co-sleeping and did not intervene.

11. I held an inquest at the Broome Courthouse on 5 and 6 February 2018. The inquest focused primarily on the events that occurred at Derby Hospital overnight on 23 to 24 January 2015 and the issues surrounding co-sleeping. For the purposes of this finding I am using the term 'co-sleeping' to describe the practice of a parent/carer and baby both sleeping at the same time on the same bed surface.

BACKGROUND

12. Baby A's mother was a young Aboriginal woman. She usually lived in the Wangkatajunka Community near Fitzroy Crossing in the Kimberley region of Western Australia. Her pregnancy with Baby A was her second pregnancy. Her first baby had been diagnosed with abnormalities in the second trimester and she went into premature labour and her baby died.[1]

13. The second pregnancy appears to have been uncomplicated (although no antenatal care is recorded) until Baby A's mother went into spontaneous early labour on 1 December 2014 at only 28 weeks' gestation. There was a suggestion that Baby A's mother may have been seriously assaulted while pregnant, but this could not be confirmed. Baby A's father admitted punching Baby A's mother once in the stomach before he knew she was pregnant but maintained that it was not a hard punch and she did not appear injured.[2]

14. Despite the premature labour Baby A's mother did not seek medical help until nearly 24 hours later, at about 8.00 pm on the evening of 2 December 2014. Baby A was born a short time later at 9.10 pm by vaginal delivery. The ambulance arrived with a doctor on board at 9.12 pm. The baby was flat at birth and required stimulation and intermittent bag and mask ventilation during the journey to Fitzroy Crossing Hospital.

[1] Exhibit 2, Tab 1 and Tab 2 and Tab 13.
[2] Exhibit 1, Tab 2 and Tab 7 [18] – [24]; Exhibit 2, Tab 1.

He arrived at the hospital at 12.45 am on 3 December 2015. A paediatric team flew in from Broome shortly after as there was no specialist paediatric team in Fitzroy Crossing. Baby A was intubated, ventilated, given antibiotics and transferred to Royal Darwin Hospital by the Royal Flying Doctors Service.[3]

15. On arrival at Darwin Hospital Baby A was noted to be extremely premature with a very low birth weight and requiring respiratory support. He was diagnosed with possible sepsis and continued on antibiotics, although the blood cultures were later found to be negative. During his admission he was treated for a range of medical problems including: hyaline membrane disease, which was managed with CPAP, surfactant and caffeine; a left intraventricular haemorrhage; jaundice, which required phototherapy treatment; low sodium levels and feeding issues. He also received various immunisations.[4]

16. In the Darwin Hospital medical records there is reference to Baby A's parents watching a 'SIDS' DVD on 6 December 2014 while Baby A was still in the nursery.

17. There was some concern expressed about difficulty breastfeeding and maternal reluctance during the Darwin Hospital stay. Education and support were provided.[5] An Indigenous Liaison Officer apparently later advised the nursing staff that the plan was for Baby A's grandmother to take care of Baby A once he was discharged from hospital.[6]

18. As noted above, Baby A was discharged from Darwin Hospital on 23 January 2015 with the plan that he would be admitted to Derby Regional Hospital, which was closer to home, for further monitoring of his weight and to provide support for his mother in breastfeeding. His discharge weight was 2.375 kg and once he reached 2.5 kg in weight he would be fit for discharge.

19. Baby A flew with his parents to Broome and Baby A was reviewed by a paediatrician at Broome Hospital before he boarded a bus with his parents bound for Derby Hospital. They arrived at Derby Hospital that evening.

ADMISSION TO DERBY HOSPITAL

20. Baby A was triaged at Derby Hospital at 8.48 pm on 23 January 2015. His arrival had been expected. He was noted to be a healthy premature baby who was breastfed with bottle top ups. His initial observations were all within normal range. He was assessed as alert and healthy at that time.[7]

[3] Exhibit 2, Tab 1 and Tab 2.
[4] Exhibit 2, Tab 2.
[5] Exhibit 1, Tab 14, Royal Darwin Hospital Discharge Summary and Royal Darwin Hospital Inpatient Clinical Progress Notes Entry 19.1.2015.
[6] Royal Darwin Hospital Inpatient Clinical Progress Notes Entry 19.1.2015.
[7] Exhibit 1, Tab 14.

His 'Corrected Gestational Age' at that time was 36 weeks and 2 days, so still less than a term baby.[8]

21. Nurse and Midwife Vicki Mdala was working the night shift in the maternity ward of Derby Hospital on 23 January 2015. She commenced her shift at 9.00 pm and was present when Baby A was admitted to the ward at 9.30 pm that evening.[9]

22. Ms Mdala was aware that Baby A was a premature baby with a corrected age of 36 weeks who had been transferred from Darwin Hospital so that he could be monitored and assisted to gain weight.[10] At the time of admission the baby was well, had no abnormalities and was feeding very well.[11]

23. Ms Mdala showed Baby A's parents to their room. The room had a hospital bed for Bay A's mother and a cot for Baby A.[12] Ms Mdala also provided Baby A's father with a folding bed.

24. Ms Mdala said that she then explained the hospital's policy regarding safe sleeping, which includes the baby sleeping in a safe cot in the parent's room and not co-sleeping.[13] Ms Mdala gave evidence that she emphasised the safe sleeping message because she was aware that Indigenous patients often co-sleep with their babies and in this case there were significant risks as: the baby was born prematurely, was small, and they had all travelled a long way so Baby A and his parents would likely be tired.[14] All of these are noted to be SUDI (Sudden Unexpected Death in Infancy) risk factors.[15]

25. Ms Mdala recalled that Baby A's parents said that they had already been told about safe sleeping while in Darwin Hospital (consistent with having watched the DVD) but Ms Mdala nevertheless reiterated the policy to them as it was the policy at Derby Hospital to convey the safe sleeping information.[16] Ms Mdala's impression was that Baby A's father was not happy at the time about being told the information as he felt they were being told what they already knew and they were tired and wanted to go to bed.[17]

26. Baby A's parents did not say that they intended to co-sleep, contrary to the hospital's safe sleeping policy. Ms Mdala understood that they were '[f]ully aware that they shouldn't do it"[18] and Ms Mdala thought that they would comply with the hospital's safe sleeping policy.[19]

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[8] Exhibit 1, Tab 13.
[9] Exhibit 1, Tab 15.
[10] Exhibit 1, Tab 15.
[11] T 86.
[12] Exhibit 1, Tab 2, Questionnaire Scene information - Map of room.
[13] T 86; Exhibit 1, Tab 15 [15], Exhibit 2, Attachment 4.
[14] T 86 – 87, 90 - 91
[15] Exhibit 2, Attachment 4.
[16] T 87; Exhibit 1, Tab 15 [16].
[17] T 87.
[18] T 87.
[19] T 87.

27. After Baby A and his parents had been settled into their room Ms Mdala returned to her other duties. Ms Mdala did not make a note of her conversation with Baby A's parents in the medical records and no care plan was signed.[20]

28. Throughout the night Ms Mdala checked regularly on Baby A. She could not recall the exact times but it was her usual practice to check on patients every half an hour to an hour. On a number of these occasions Ms Mdala found that Baby A was co-sleeping with his mother.[21] Ms Mdala could not remember how many times this occurred but on each occasion she removed the baby and put him back in the cot. This often necessitated waking Baby A's mother as she usually had her hand on him.[22]

29. Removing the baby was consistent with Ms Mdala's usual practice when she found a baby co-sleeping with a parent in the hospital.[23]

30. If Baby A's mother was awake and Baby A was feeding while in the bed, Ms Mdala would tell Baby A's mother to sit up while breastfeeding so that she would not fall asleep.[24]

31. Nurse Mdala made only two entries in Baby A's integrated Progress Notes. The first was at the time of admission to the ward on 23 January 2015 (incorrectly recorded as 22 January 2015), where it was noted that Baby A was alert and appeared healthy and was fully breastfeeding on demand. His various weights and observations were also recorded and some other relevant information. As mentioned above, she did not document her discussion with Baby A's parents about safe sleeping.[25]

32. The second entry was made at 7.00 am on 24 January 2015. The brief note indicated that the baby had been asleep with his mother in bed.[26] This note was made at the time of handover to the next nursing shift.

EVENTS ON THE MORNING ON 24 JANUARY 2015

33. Registered Nurse and Midwife Amanda Hogan commenced duty on the morning shift at Derby Hospital at 7.00 am. She had been working at Derby Hospital for four to five months at that time and it was her first full-time placement as a midwife. Ms Hogan had, however, worked in the Kimberley as a registered nurse for a few years prior.[27]

34. On starting her morning shift on 24 January 2015 Ms Hogan received a handover from Ms Mdala, who was finishing the night shift. The two midwives could not recall exactly what was discussed during the handover

[20] T 87.
[21] Exhibit 1, Tab 15 [19] – [21].
[22] T 88 - 89.
[23] Exhibit 1, Tab 15 [21] – [234.
[24] T 88.
[25] Exhibit 1, Tab 14, Derby Hospital Integrated Progress Notes.
[26] Exhibit 1, Tab 14, Derby Hospital Integrated Progress Notes.
[27] T 18, 30.

but Ms Hogan did recall that Ms Mdala told her that she had taken Baby A out and put him in the cot at least once overnight and possibly a couple of times.[28]

35. Ms Mdala said she passed that information on as part of the handover so that the next midwife would know that there was a possibility that it could happen again. However, given it was the start of the day shift, Ms Mdala thought it was less likely as usually the mother would not be sleeping much during the day.[29]

36. Ms Mdala gave evidence that when she passed on the information she expected the next midwife would adopt the same practice as herself of removing the baby from the bed if she found him co-sleeping with his mother. Her understanding was that all of the midwives at Derby Hospital adopted that practice.[30]

37. Ms Hogan said that the first time she saw the family they were all asleep so she did not speak to them.[31] At that time Baby A was co-sleeping with his mother in the hospital bed. He was lying beside his mother with her arm around him. Ms Hogan described the baby's head as being in a straight position and his face was not covered.[32] Baby A's father was sleeping in a cot bed next to them.

38. Ms Hogan said that she made sure Baby A was breathing normally and was comfortable before leaving the room.[33] Ms Hogan did not consider removing Baby A from the bed at that time or waking up the mother. Ms Hogan said in her statement that, "[s]eeing that all was correct, I continued on with the rounds and saw the other patients."[34] Ms Hogan explained at the inquest that what she meant by everything being 'correct', was that "they were asleep and breathing and that they were comfortable."[35]

39. Ms Hogan's evidence was that she did not have any concerns about the fact that mother and baby were co-sleeping, as it was "kind of part of the norm"[36] at the hospital. In her experience over the few months she had been there, a lot of people were co-sleeping with their babies in their beds at Derby Hospital, so Ms Hogan said she "just went with it."[37] While working at Derby Hospital it had become Ms Hogan's practice to leave the mother and baby co-sleeping provided the baby was uncovered. Ms Hogan could not recall exactly why this was so, in the sense of remembering seeing another midwife do so or being told it was acceptable, but she had just become accustomed to doing so over time having seen it occur.[38]

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[28] T 20, 22; Exhibit 1, Tab 15 [27].
[29] T 89.
[30] T 90.
[31] Exhibit 1, Tab 11 [5].
[32] T 20; Exhibit 1, Tab 11 [6].
[33] T 20.
[3434] Exhibit 1, Tab 11 [12].
[35] T 24.
[36] T 21.
[37] T 22.
[38] T 38 – 39.

40. In an interview for an in-hospital review after Baby A's death Ms Hogan also mentioned she thought she would leave them undisturbed "as they looked tired,"[39] although this was not her evidence at the inquest.

41. I asked Ms Hogan whether the fact that Ms Mdala had told her she had removed the baby from the bed overnight indicated to her that there was another option. She replied that it didn't at the time, but also accepted that in hindsight it should have.[40]

42. Ms Hogan noted in her statement that she understood on admission "the family was spoken to about co-sleeping."[41] Ms Hogan explained at the inquest that this information may have been handed over to her by Ms Mdala, although she could not at that time specifically recall, and she also recalled there was a safe sleeping pamphlet on the bedside table in Baby A's room.[42]

43. Ms Hogan understood the risks of co-sleeping herself, including that it raises the risk of Sudden Infant Death Syndrome (SIDS) and smothering.[43] However, she also understood that it is a cultural preference for Aboriginal mothers in the Kimberley region.[44]

44. Ms Hogan did not make any entry in the Integrated Progress Notes about seeing Baby A co-sleeping in bed with his mother. She did not make any note in the medical notes until later in the day. Her only note was made in retrospect at 12.15 pm, after Baby A's death.

45. Ms Hogan returned to Baby A's room at 9.00 am, at which time Baby A's mother was awake and breastfeeding Baby A. Ms Hogan had a discussion with Baby A's mother about breastfeeding and attachment during feeding and noted that Baby A's mother's "breastfeeding was perfect and she was mothercrafting nicely."[45] She spoke with the family for about 15 minutes but did not recall whether she spoke to them about safe sleeping practices, although it appears to me from her other answers that it was likely she did not.[46]

46. Before she left the room Ms Hogan asked Baby A's mother to press the call button when she had finished breastfeeding so Ms Hogan could return and complete the baby's observations.[47]

47. At 10.00 am the doctor on duty in the obstetrics and paediatrics section of the hospital, Dr Warren Young, came to review Baby A so the baby could be formally admitted into the hospital.[48]

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[39] Exhibit 2, Tab 9, p. 1.
[40] T 22.
[41] Exhibit 1, Tab 11 [8].
[42] T 23, 34.
[43] Exhibit 1, Tab 11 [9].
[44] Exhibit 1, Tab 11 [10] – [11].
[45] T 24.
[46] T 24.
[47] Exhibit 1, Tab 11 [13] – [16].
[48] T 73; Exhibit 1, Tab 8 [10] – [16].

48. Dr Young entered the hospital room and saw Baby A was breastfeeding. He was lying on his left side, feeding from his mother's right breast. He appeared to be active and feeding normally. Dr Young did not fully examine the baby because he was breastfeeding but there was nothing obviously concerning about his appearance.[49]

49. Dr Young spoke to Baby A's parents and they seemed to be communicating appropriately. They did not raise any concerns. Baby A's mother appeared very well and in Dr Young's opinion she did not appear to be tired, although he did recall that she said that they were all tired from their trip.[50] After speaking to the parents Dr Young left the room and made an entry in the medical notes. He intended to come back later to review Baby A.[51]

50. After Dr Young left the room Ms Hogan popped her head in and saw that both Baby A and his mother were awake. Baby A's mother was resting on her left side and holding her mobile telephone in her right hand, which she was holding up above her head. Her left breast was exposed and the deceased was lying on his back. His head was turned towards the breast, but he was not attached to the breast. Baby A appeared settled. She saw nothing that concerned her, so Ms Hogan went about her other duties.[52] Ms Hogan's retrospective note records that at 10.15 am she "visualised mother and baby co-sleeping"[53] but it appears this is what she was referring to in that note.

51. Baby A's father recalled that after Dr Young left Baby A's mother continued to breastfeed her baby, cradling him in her left arm. He says he could see that Baby A's mother was very tired and he told her to put Baby A down for a sleep. This was consistent with an account of a midwife, who recalled Baby A's father later remonstrating with his partner that he had told her to put the baby back into the cot.[54]

52. Baby A's father recalled that Baby A's mother put Baby A down to sleep in the cot at that time but he then cried so she picked him back up and again cradled him in her left arm.[55] Not long after Baby A's father fell asleep in his bed next to the one containing Baby A's mother and Baby A.

53. Baby A's mother later told police that Baby A did not seem sick and seemed a happy little boy while they were at Derby Hospital. He had kept her up all night feeding and was up early again in the morning. Baby A's mother recalled that on the morning of 24 January 2015 she and her partner were awake and ate breakfast together and she then breastfed Baby A, changed his nappy and put him to sleep in her left arm, cradling him. He was still sucking on her breast when he fell asleep. Baby A's

[49] T 73; Exhibit 1, Tab 8 [10] – [16].
[50] T 79.
[51] Exhibit 1, Tab 8 [20] – [22].
[52] Exhibit 1, Tab 11 [19] – [20].
[53] Exhibit 1, Tab 14, Integrated Progress Notes, 24.1.2015, 12.15 pm.
[54] T 15.
[55] Exhibit 1, Tab 7 [7] – [10].

mother wanted him to go to sleep as she was tired from being up with the baby all night.[56]

54. Baby A's mother waited for Baby A to fall asleep before she then fell asleep on her back in the hospital bed with the bed lying flat. She was cradling Baby A in her left arm as she slept.[57] The next thing she recalled was being woken by the midwife who took Baby A into the resuscitation room. It is perhaps not surprising that she did not recall all of the events of the morning, given the traumatic experience of her baby's death.

DISCOVERY OF BABY A NOT BREATHING

55. Clinical Nurse/Midwife Leanne Bowman commenced her shift at Derby Hospital that morning at about 9.30 am. Ms Bowman had been a midwife for eight years at that time but usually worked in Queensland. This was her first day at Derby Hospital and her first day in the Western Australian Country Health System (WACHS).

56. On arrival Ms Bowman engaged in a short orientation with Ms Hogan, who showed her the general layout of the ward and hospital and where the emergency equipment was located. After the brief orientation they started doing clinical 'hands on' work.[58] Ms Bowman began to do her rounds and check on patients. At around 11.25 am Ms Bowman entered Baby A's room intending to do Baby A's observations. She had not seen him before.[59] Ms Hogan followed her into the room to see if she needed any assistance.[60]

57. Upon entering the room Ms Bowman observed both parents sleeping and Baby A was co-sleeping with his mother on the main bed. Ms Bowman was aware the baby had been breastfeeding earlier and it appeared to her that he and his mother had fallen asleep while he was feeding.[61]

58. Ms Bowman's evidence was that her practice if she found a baby co-sleeping with a parent was to "personally always speak to them about co-sleeping"[62] and try and educate them about SIDS. Her practice was also to take the baby out of the bed and place them into the cot beside the bed.[63]

59. Ms Bowman approached the bed and she could not see any part of Baby A's face as "his face was actually up against the breast."[64] Ms Bowman lifted Baby A's arm. She noticed his arm was floppy and had no tone and she realised Baby A was not breathing. Ms Bowman immediately pushed

[56] Exhibit 1, Tab 6 [9] – [16].
[57] Exhibit 1, Tab 6 [17] – [18].
[58] T 6.
[59] T 5 - 6; Exhibit 1, Tab 10.
[60] T 25.
[61] T 7; Exhibit 1, Tab 10.
[62] T 7.
[63] T 7.
[64] T 7.

the emergency button and, with Ms Hogan, took Baby A to the neonatal resuscitation room.[65]

60. Baby A's mother recalled being woken up by a nurse trying to wake her baby and that he wasn't moving. The nurse took Baby A out of the room and Baby A's mother woke her partner and they waited in the hallway while attempts were made to resuscitate Baby A.[66]

61. Another doctor, Doctor Hohaia, was working in the hospital and he was first to arrive in the resuscitation room after he heard the emergency button sound. Dr Hohaia saw that Baby A was very floppy with pale blue, mottled looking skin. He had no cardiac output, was cool to the touch and not breathing. Dr Hohaia commenced resuscitation with some midwives assisting.[67]

62. At 11.30 am Dr Young received a phone call reporting the emergency. He immediately went to the neonatal resuscitation room and saw Dr Hohaia and nursing staff performing CPR on Baby A. Both doctors made unsuccessful attempts to intubate Baby A and he was bag and masked and given doses of adrenaline but he could not be resuscitated. A later internal review concluded that the resuscitation attempts were timely and effective and if Baby A had been in a state where a resuscitative effort could have revived him, the baby would have been revived by the efforts made.[68]

63. Dr Young certified Baby A life extinct at 11.50 am. His parents were advised that their baby had passed away. They were allowed to spend some time with him before he was taken away.[69]

CAUSE AND MANNER OF DEATH

64. A post mortem examination was performed on Baby A by Forensic Pathologist Dr G Cadden on 29 January 2015. Dr Cadden found no gross pathology, congenital disease or injury such as would explain the death.[70]

65. Virology and microbiology testing showed rotavirus RNA detection in respect to the small/large bowel and there was also mixed coagulase negative staphylococci in blood cultures; however, the significance of these, if any, was not known. I understand the rotavirus detected in the bowel was felt likely to have been as a result of recent immunisation against rotavirus.

[65] Exhibit 1, Tab 10.
[66] Exhibit 1, Tab 6 [19] – [29].
[67] Exhibit 1, Tab 9.
[68] Exhibit 2, Attachment 9.
[69] Exhibit 1, Tab 8.
[70] Exhibit 1, Tab 5.1.

66. Toxicology showed nothing of significance.[71]

67. Neuropathology showed a normal brain with a small organising haematoma in the left cerebral haemorrhage such as occurs in premature infants. No other abnormalities were detected.[72]

68. At the conclusion of all investigations Dr Cadden formed the opinion that the cause of death was unascertained. However, Dr Cadden did note the possibility of overlaying was a consideration, given the circumstances in which Baby A was found not breathing.[73]

69. Dr Cadden explained that overlaying is a type of asphyxia to which young children are especially prone due to their small size/developmental level. Overlaying occurs when a larger individual is sleeping with an infant and accidental suffocation of the infant results. It is said to represent a complex form of asphyxia that includes airway obstruction, thoracic and abdominal compression and impairment of neck circulation. In most cases, autopsy findings will be minimal. As the autopsy findings are usually negative, it is difficult to separate overlaying from other forms of suffocation. The history and the scene are therefore critical. Dr Cadden noted that cases have been reported in the past where infants have died when their breastfeeding mother has fallen asleep.[74]

70. Dr Cadden referred to the author Professor Roger Byard, who has published extensively on this topic. In one article Professor Byard referred to two recent studies "which support the hypothesis that infants who die in a shared sleeping situation are different from those who die alone," although the two studies do not help pathologists to make a particular diagnosis in a specific case as there are no specific autopsy findings identified.[75]

71. Therefore, while Dr Cadden's post mortem investigations can exclude obvious causes of death, the autopsy findings cannot identify overlaying as the cause of death. It must be inferred from the factual circumstances of an unsafe sleeping environment in company with any other known facts about the general health of the infant and the like.

72. In this case, the evidence before me was that Baby A had been under close medical supervision for a number of weeks in Darwin Hospital and had been reviewed the day before his death by a paediatrician in Broome Hospital. He had also been examined by an experienced midwife, Ms Mdala, the evening before and seen by another midwife and Dr Young in the morning. All of the evidence supported the conclusion that Baby A was active and well until shortly before he was found in a lifeless state. The evidence of Ms Bowman, was that when she found Baby A "his face

[71] Exhibit 1, Tab 5.4.
[72] Exhibit 1, Tab 5.1 and Tab 5.3.
[73] Exhibit 1, Tab 5.1.
[74] Exhibit 1, Tab 5.5.
[75] "Overlaying, co-sleeping, suffocation, and sudden infant death syndrome: the elephant in the room," Roger W Byard, Forensic Sci Med Pathol (2015) 11:273-274.

was actually up against the breast."[76] It is a similar account to other coronial cases where a baby has asphyxiated while co-sleeping after the mother has fallen asleep during breastfeeding. It is also consistent with some of the case examples given in the Safe Sleeping 'e-learning' education package delivery by the Department of Health.[77]

73. Taking into account the lack of any post mortem finding to explain the death, noting that in cases of overlay the autopsy findings are usually negative, and the evidence that until shortly before he was found in an overlay situation Baby A had appeared healthy and active, I am satisfied that the cause of death was mechanical asphyxiation as a consequence of overlaying. In the circumstances, I find that death occurred by accident.

COMMENTS ON SAFE SLEEPING – POLICY & PRACTICE

74. Under s 25(2) of the *Coroners Act 1996* a coroner may comment on any matter connected with the death including public health or safety. In this case, there was an issue as to whether Baby A's parents were appropriately educated about safe sleeping practices. There was also evidence generally about the difficulty reconciling the hospital policy in that regard and the cultural practice of co-sleeping by Aboriginal women.

WACHS policies on co-sleeping

75. In 2010 Deputy State Coroner Vicker released a finding in relation to the death of Nathaniel West, a newborn baby who died in April 2006 after co-sleeping (bed sharing) with his mother at Kalgoorlie Regional Hospital. The circumstances of Baby West's death had similarities to this case, as it also involved a teenage Aboriginal mother who had been seen co-sleeping with her baby by a midwife after falling asleep breastfeeding and the mother and baby had been left undisturbed. The baby was later found unresponsive in bed under his mother's breast and eventually died due to the hypoxic brain injury he sustained.[78]

76. In 2006 Kalgoorlie Regional Hospital did not have a specific policy in place with respect to the issue of co-sleeping in the hospital maternity ward and there was evidence in the West inquest that co-sleeping was not discouraged by hospital staff and staff had received minimal, if any, education on the topic.[79]

77. Her Honour observed the logical place for education and communication to occur about safe sleeping practices is in the maternity units of hospitals. It was recommended that this would involve the discouragement of co-sleeping and the active removal of sleeping babies from sleeping mothers into a position in proximity to, but separated from,

[76] T 7.
[77] Exhibit 2, Tab 5.
[78] Inquest into the death of Nathaniel West (384/06), Deputy State Coroner Vicker.
[79] Inquest into the death of Nathaniel West (384/06), Deputy State Coroner Vicker.

the sleeping mother's bed surface."[80] Her Honour also indicated that it needed "to be understood co-sleeping policies are not designed to diminish safe physical contact between mother and baby, but to minimise the known risks of accidental deaths."[81]

78. Following the death of baby West the WA Health Department introduced comprehensive policies and clinical guidelines that were devised to help reduce the incidence, and raise awareness of, sudden unexpected deaths in infancy in WA. The current policy has six key messages to reinforce safe infant sleeping:

- Sleep baby on back;
- Keep baby's head and face uncovered;
- Keep baby smoke free before and after birth;
- Safe sleeping environment night and day;
- Sleep baby in a safe cot in parent's room; and
- Breastfeed baby.[82]

All WA Health staff are required to adhere to the policy, which as noted above includes a safe sleeping message in conjunction with encouraging and supporting breastfeeding.[83]

79. The same type of information also appears in the child health book "All About Me" given to each child born in a hospital in Western Australia. It includes a picture of safe sleeping.[84]

80. The guidelines and policies acknowledge certain situations as 'high risk'. One such situation is co-sleeping with babies under 11 weeks of age. Babies in maternity wards are usually under 11 weeks of age, so it follows that co-sleeping should be actively discouraged in these wards.

81. In Baby A's case, he had a number of identified high risk factors, including being a baby under 11 weeks of age. He was also preterm, had a low birth weight and his mother potentially had extreme tiredness to the point where she would find it difficult to respond to the baby.[85] It was particularly necessary to educate Baby A's parents about safe sleeping given these risks.

Education of Baby A's parents regarding 'safe sleeping'

82. Baby A's mother provided a statement indicating that in Wangkatajunka Community "babies normally sleep with Mum on the mattress. There aren't any cots for the babies." She maintained that babies co-sleeping with their mother's was "how we all do it in the community."[86]

[80] Ibid, pp.31 - 32.
[81] Ibid, p. 30.
[82] WA Health Safe Infant Sleeping Policy and Framework 2013.
[83] Baby Friendly Health Initiative 2014.
[84] Exhibit 2, Attachment 10.
[85] Exhibit 1, Tab 9.
[86] Exhibit 1, Tab 6.1 [8] – [9].

83. She maintained that no one gave her any lessons or taught her about how to look after a baby at either Darwin Hospital or Derby Hospital.[87] Baby A's mother acknowledged that Derby Hospital gave her a cot to use for Baby A but claimed that they didn't teach her "about sleeping with babies or using cots."[88] Baby A's mother also recalled that in her room there were no posters or any signs on the walls about safe sleeping or caring for babies.[89]

84. In her statement given to police in June 2016, Baby A's mother stated, "[i]f someone had told me about using the cot, I would have done what they told me to do."[90] Baby A's instructions to her counsel at the inquest were to the same effect.[91] Baby A's mother was not able to attend court to give evidence in person at the inquest due to flooding in the Kimberley, which made the roads impassable, so unfortunately her evidence could not be tested further.

85. Weighing against Baby A's mother's recollection is the evidence contained in the Darwin Hospital medical record of the viewing of the Safe Sleeping DVD, Ms Mdala's account of Baby A's parents' reference to watching that DVD as well as her own counselling against co-sleeping and Ms Mdala's evidence that she removed Baby A from his mother's bed more than once overnight. This was consistent with the hospital policy. There were some difficulties with hearing Ms Mdala's evidence due to some technological difficulties in the courtroom, but I was nevertheless impressed by Ms Mdala as a credible and reliable witness who gave sound reasons for why she acted as she did.

86. I also note Baby A's father indicated in his statement that he told his partner to put the baby in his cot when she was falling asleep, and there was a reference to him saying something of that kind in front of Ms Bowman after Baby A's death, although this was not able to be tested further.

87. I put to Ms Barter that the weight of the evidence was against Baby A's mother note being counselled against co-sleeping. However, I accepted the submission that other hospital staff gave evidence that it was not uncommon to see mothers with babies in bed at the hospital and possibly what she saw around her may have coloured her recollection. In addition, given her fatigue and the stress of having a premature young child, coupled with the tragic event of his death following on the death of another baby, her ability to process information and recall events accurately and without some tendency to wish things had been different would be very difficult and entirely understandable.

[87] Exhibit 1, Tab 6.1 [6].
[88] Exhibit 1, Tab 6.1 [7].
[89] Exhibit 1, Tab 6.1 [10].
[90] Exhibit 1, Tab 6 [11].
[91] T 31.

88. Therefore, while I am satisfied that Baby A's parents were provided with information about safe sleeping practices, and counselled against co-sleeping with Baby A, I acknowledge that they may not have processed that information fully and found it difficult to comprehend when weighed against their knowledge of their own cultural practices. Baby A's mother and father were both only 18 years old at the time of his birth and this was Baby A's mother's first child, so they had little to base their practices on apart from what they had seen modelled for them at home.[92]

89. While Ms Mdala continued to take Baby A out of the bed and place him into the cot at night, Baby A's mother may not have fully registered what was occurring as she had been sleeping and there was no clear evidence that Ms Hogan spoke to her about co-sleeping in the morning, to reiterate why Ms Mdala had acted as she had, and her behaviour was to the contrary.

90. What the evidence of Baby A's mother does reinforce is that even if the message is being delivered by Derby hospital staff, it is not necessarily being received in a way that is understood and accepted. That is why consistent modelling of the recommended behaviour by hospital midwives and nurses is so important.

91. I accept Ms Hogan's evidence that mothers co-sleeping with their babies on the maternity ward at Derby Hospital was not uncommon. Her evidence was supported by Dr Young and the other midwives. However, the difference between Ms Hogan's evidence and the other midwives' evidence is that she did not take any action, either to wake the mother or move the baby when she saw Baby A co-sleeping on the morning of his death. The other midwives made it clear that they would at least attempt to take some action, even if ultimately the mother declined to allow them to move the baby. If the mother insisted on continuing to co-sleep, the evidence was that the midwives would then document that decision.[93]

92. Ms Mdala had demonstrated this practice by removing Baby A throughout the night. Ms Bowman acknowledged that there is a cultural component to co-sleeping and stated it is "one of the strongest cultural things that I've seen with Indigenous women." She acknowledged that ultimately "it's the mother's choice to be able to co-sleep," but it is also the midwife's role to educate mothers in regards to SIDS and co-sleeping so that they understand that they run a risk.[94] If they continue to co-sleep, her practice is to document in the notes that the mother is aware of SIDS and risks of co-sleeping and still chooses to co-sleep.[95]

93. Nevertheless, Ms Bowman reiterated that her practice is always that "if the baby is asleep and mother is asleep and he is not attached at the breast I will always put him into the cot."[96] Ms Bowman was asked whether there

[92] Exhibit 1, Tab 2.
[93] T 7.
[94] T 8 – 9, 11.
[95] T 9.
[96] T 10.

were any circumstances in which she would vary that practice and leave that baby in the bed. Ms Bowman indicated that it would only be after she had personally had a conversation with that mother first about SIDS and the risks of co-sleeping and then she would be absolutely sure to document that conversation and the mother's choice to continue to co-sleep.[97] Ms Bowman attempts to complete contemporaneous documentation as much as possible and would make an effort to do so in a case such as this, but she also indicated that she would expect such an important decision to be documented in the care plan.[98]

94. Dr Young's evidence was also that he understood when he saw mother's co-sleeping with their babies in the hospital that this was after their decision to co-sleep, following appropriate education about safe sleeping, had been properly documented.

95. My impression of Ms Hogan's evidence was not that she understood that Baby A's parents had been counselled appropriately against co-sleeping and had made a conscious and firm choice to do so nevertheless. Further, she could not have thought such a choice by the parents was documented, as there was nothing in the progress notes to that effect.

96. In my view, what Ms Hogan ought to have done when she first saw Baby A co-sleeping with his mother at 7.00 am, was to wake her and ask her if she wanted the baby to go into his cot and, if she declined, document that conversation and choice. Alternatively, she could have tried to move the baby to his cot without waking his mother, as other midwives gave evidence was their practice. What was not appropriate was to leave Baby A co-sleeping with his mother in circumstances where it was not clear that Baby A's parents had made that choice fully understanding the risks it carried.

97. That is particularly so in the case of Baby A, who was a small, premature baby it was apparent that all the parties were likely to be fatigued from their journey the night before. Ms Mdala gave evidence that she understood from what was known about Baby A and his parents that he presented a high risk of SUDI in the circumstances, and Ms Hogan (albeit a less experienced midwife) should have been alert to the same concerns.

98. Ms Hogan was obviously distressed during her evidence at the inquest and she acknowledged that in hindsight she could have done things differently and now wished that she had done so. I do not wish to add to her distress by my comments in this finding. I accept that she was faced with a difficult situation that midwives in regional Australia face every day.

99. Ultimately, it is a parent's choice as to whether they co-sleep with their child. However, my concern in this case is that the lack of documentation and Ms Hogan's decision not to wake Baby A's parents and have her own conversation with them, leaves us in the situation now where Baby A's

[97] T 14, 16.
[98] T 14, 17.

mother says she did not receive that information and would have behaved differently if she had, and I must rely upon the oral evidence of witnesses weighed against that, rather than a contemporaneous note clearly documenting education of the parents and their decision to run the risk. The same can be said of Ms Mdala, in the sense of the lack of documentation of the education, but in her case she was vigilant in removing the baby when she saw them acting contrary to her advice.

100. Like so many inquests, effective communication and good documentation are highlighted in this case and most health practitioners will accept in hindsight that it could, and should, have been done better.

101. Following her experience in this matter Ms Hogan gave evidence that she has now changed her practice in terms of co-sleeping and is now active in educating mothers about the dangers of co-sleeping. When presented with a similar situation, which she says she faces almost daily, she removes the baby without waking the mother and places the baby in the cot. She also discusses with the parents the risks of co-sleeping, in particular suffocation, and documents that conversation in the notes.[99]

102. Midwife Hogan gave evidence that in her experience gained since these events, a few parents will say that they want to co-sleep despite having been educated about safe sleeping practices. However, others will say nothing and then continue to co-sleep.[100]

103. I accept that where the parents have verbally made clear their intentions to continue to co-sleep after they have been educated, and that education and decision has been properly documented, then it is difficult for midwives to intervene unless they can see that the infant is in imminent jeopardy from the position of the infant vis-à-vis the adult. It is ultimately the parent's choice to do so, however unwise it might be given the known risks, and there is a risk that continuous intervention by a midwife may jeopardise the relationship between the health professionals and the parents.

104. However, for the parents who have not made that decision express, I can see no reason why midwives should not continue their practice of removing the baby cautiously and putting them in a cot.

105. A similarl practice can be followed where mothers are breastfeeding and fall asleep. It is very important for midwives and nurses to encourage breastfeeding and skin-to-skin contact, but not at the expense of safe sleeping practices. The evidence of the midwives was that where a mother falls asleep while her baby is breastfeeding, they will endeavour to remove the baby without waking the mother and place the baby in the cot. This appears to me to be a sensible and proper way to deal with the issue.

[99] T 26 – 28.
[100] T 35.

106. Nevertheless, given the evidence indicated there is an entrenched practice of co-sleeping in Aboriginal communities in Australia, it raises the question whether there needs to be a greater focus on changing the cultural practice in these communities rather than educating individual mothers? Alternatively, there is the option of trying to find a practical way for 'relatively safe' co-sleeping to occur? I explore this further below.

Aboriginal women and the cultural practice of co-sleeping

107. Following the West inquest the Telethon Institute of Child Health Research undertook an evaluation of the Statewide Co-sleeping/Bed sharing policy Operational Directive. Ms Smith referred to the report in her evidence at this inquest and helpfully provided her copy to the court after the inquest concluded.[101]

108. The report, delivered in February 2012, made 14 recommendations, including the need for ongoing education and training of health professionals to provide consistent messages about co-sleeping/bed sharing; to improve access to education and resource material for parents; and development of culturally appropriate information. Recommendations 8 to 10 were directed at exploring how Aboriginal women and women from culturally and linguistically diverse backgrounds are provided with information about co-sleeping and to determine the cultural appropriateness of the information provided.[102]

109. I note that of the six Aboriginal mothers and grandmother consulted for the study, all co-slept and described co-sleeping as 'normal' and an integral part of their culture. These women also stated they disagreed with midwives or child health nurses who advised them not to co-sleep and did not comply with this advice. They viewed the current information about co-sleeping as inappropriate for their needs.[103] The Aboriginal mothers and grandmother also maintained that larger families, lack of appropriate housing and the socio-economic circumstances of many Aboriginal families meant that co-sleeping was inevitable and viewed this as even more likely in rural areas.[104]

110. Several women, including Aboriginal mothers, asserted that an official position and information on 'safe sleeper aids' could provide a useful compromise for women who wanted to co-sleep more safely.[105]

111. The researchers referred to key national health statistics that report that Aboriginal populations have an increased risk for SIDS; however, it is not clear whether this is due to a greater likelihood for genetic risks, environmental or cultural factors. Death from SIDS amongst Aboriginal

[101] T 68; Evaluation of the Department of Health Western Australia Operational Directive Statewide Co-sleeping/Bed-sharing Policy for WA Health Hospitals and Health Services, J Dodd, February 2012.
[102] Evaluation of the Department of Health Western Australia Operational Directive Statewide Co-sleeping/Bed-sharing Policy for WA Health Hospitals and Health Services, J Dodd, February 2012.
[103] Ibid, p. 10 – 11.
[104] Ibid, p. 11.
[105] Ibid, p. 81.

children is reported to be around four times as common as that in non-Aboriginal populations and the highest mortality rates from SIDS is reported for the age of 1–2 months for Aboriginal and non-Aboriginal infants (0.36 and 0.06 per 1,000 live births respectively). Aboriginal infants of this age died at almost six times the rate of non-Aboriginal infants.[106]

112. Considering these statistics in the context of the known cultural practice of co-sleeping amongst this population (which is likely to be one of the reasons for the greater mortality rates), it becomes apparent that considering all options of reducing the incidence of co-sleeping by Aboriginal mothers should be a priority.

113. The evidence heard in this inquest about this issue reinforces that position. The midwives and medical staff from Derby Hospital who gave evidence at the inquest indicated that in their experience indigenous mothers commonly exhibit a strong preference for co-sleeping with their babies. Ms Hogan gave evidence that Aboriginal mothers co-sleeping with their babies was the "norm" at Derby Hospital in the months that she was there.

114. Dr Young also gave evidence to that effect.[107] His evidence was that the fact it was accepted as being the norm was a problem.[108] Dr Young expressed the view that the midwives at the hospital are "vigilant about the problem of co-sleeping"[109] but once the mothers have signed the care plan the midwives are powerless to do much about it apart from keep a close eye on the baby and mother in the bed. In Dr Young's experience, which has predominantly been in country hospitals, it is mainly an issue with Aboriginal women patients and is seen as a cultural issue.[110]

115. Ms Bowman, who gave evidence that she had done a lot of cultural awareness training through her employment and had also completed additional cultural awareness training as part of her Masters for Indigenous Health, found it "one of the strongest cultural things"[111] she had seen with indigenous women.[112] Ms Bowman expressed the opinion that further education of mothers is unlikely to change that habit but did suggest that cots attached to the side of the bed, as she had seen overseas, would be a great improvement.[113] As to education, if it was to be effective, then Ms Bowman suggested it should be undertaken in the communities, although in her opinion there is extensive education materials already out in the community so it is difficult to see how that could be improved.[114]

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[106] Evaluation of the Department of Health Western Australia Operational Directive Statewide Co-sleeping/Bed-sharing Policy for WA Health Hospitals and Health Services, J Dodd, February 2012.
[107] T 74.
[108] T 75.
[109] T 75.
[110] T 76.
[111] Exhibit 3.
[112] T 12.
[113] T 9.
[114] T 9.

116. Dr Pauline Vunipola, a Senior Medical Officer at Wirraka Maya Health Service Aboriginal Corporation, provided a report during the coronial investigation. Dr Vunipola confirmed that "co-sleeping is the norm in Aboriginal parenting. The newborn sleeps with their mothers until they are old enough to sleep with their older siblings or if the mother weans them off from breastfeeding." This is despite the fact Aboriginal communities are educated about safe sleeping practices.[115]

117. The WACHS Sentinel Event Analysis report prepared following Baby A's death found the WACHS Kimberley staff comply with the WACHS Co-sleeping policy. Despite this, Aboriginal mothers in Kimberley hospitals continue to co-sleep with their babies. It was reported that,

> *[c]ontext is very relevant. In the Kimberley amongst the Aboriginal population it is wrong for mothers to separate themselves from their child and they would be seen as poor parents if they did this. Often the women are also young mothers; they have their children early. They are very unlikely to act in a way contrary to their cultural norm.*[116]

118. Following Baby A's death midwives and doctors in Kimberley hospitals were asked about their experience of the co-sleeping issue as part of the Sentinel Event Analysis. Staff in Derby Hospital and other hospitals in the region all stated that Aboriginal mothers dislike being apart from their babies and do not comply with the WACHS co-sleeping policy. The report concluded that staff cannot enforce a practice that is seen as "culturally intolerable."[117]

119. Ms Bec Smith, the current Regional Director of WACHS in the Kimberley, was the Operations Manager at Derby Hospital at the time of Baby A's death. Ms Smith gave evidence that at the relevant time it was mandatory that staff at Derby Hospital comply with the WA Health Safe Infant Sleeping Policy and Framework 2013 as part of the WA Health state-wide obstetric service.[118] The policy is promoted to staff locally through orientation at the maternity unit, compulsory completion of an e-learning package and as part of care planning and shift handover.[119]

120. Ms Smith advised that WACHS does not have a written procedure that directly instructs what a staff member should do if they find a mother co-sleeping with their baby in hospital, but the policy framework says that staff should model the behaviours of safe sleeping and continually try to educate about the risks of co-sleeping. How that should be done in practice varies depending upon the circumstances.[120]

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[115] Exhibit 3.
[116] Exhibit 2, Attachment 9, p. 4.
[117] Exhibit 2, Attachment 9.
[118] T 43 – 44.
[119] T 44 – 45.
[120] T 45 - 46.

121. In preparation for giving evidence at the inquest Ms Smith spoke to midwives across the Kimberley region and there were effectively two schools of thought that emerged as to how they approach a scenario where the mother is co-sleeping with a baby in a hospital bed. The first group indicated a preference to wake the mother and ask them if they would like the midwife to put the baby back in the cot. The other group indicated that, particularly if it is night time, they will simply remove the baby and put the baby back in the cot. None of them indicated a willingness to simply walk past without intervening.[121] Still, as noted earlier in this finding, these interactions can have a negative effect on the relationship between midwives and new parents.

122. Given the difficulties faced by staff in communicating the safe sleeping message to patients who have a strong cultural preference, Ms Smith gave evidence that Derby Hospital has been exploring more culturally appropriate ways of delivering the safe sleeping message to parents since Baby A's death.

123. In 2016 Ms Smith made contact with the CEO of the Kimberley Aboriginal Medical Service, Ms Vicki O'Donnell, to discuss whether or not the two services might be able to work together on a project around culturally safe sleeping messages. Ms O'Donnell advised that the service was looking at a Pepi-Pod program that was being trialled through the University of Sunshine Coast in Queensland.[122] A Pepi-Pod is essentially a safe sleeping box. It can sit in the bed, so that the baby can be in the bed with his or her parents without the risk that the parent will roll over onto the child or become caught in the bedding.[123]

124. Ms Smith said that she has discussed the Pepi-Pod project closely with Ms O'Donnell through the Kimberley Aboriginal Health Planning Forum, which has a maternal and child health working group. She reported that everyone is very engaged in the project and the concept but Derby Hospital was not able to simply go out and purchase Pepi-Pods as they are still undergoing a randomised control trial at the University of the Sunshine Coast and the product has not been registered as a therapeutic good in Australia yet.[124] Some concerns have been expressed that the pods might increase the risk of falls, as the pod is not fixed to the bed, so problems such as these are being explored.[125]

125. Further information was obtained after the inquest about the Queensland Pepi-Pod Program. The Pepi-Pod Program had originated in New Zealand, where it was used in populations considered at high risk of SUDI. The program was believed to be associated with a 36% reduction in post-perinatal infant mortality during the period 2009 – 2016. The New Zealand Program was adapted for an Australian context and delivered to consenting Aboriginal and Torres Strait Islander families with identified

[121] T 67 – 68.
[122] T 47.
[123] T 47.
[124] T 48.
[125] T 49.

SUDI risks. Data collection continues with more than 300 families recruited to date. Most families had intended to co-sleep even though safe sleeping awareness had been raised. It was found the Pepi-pod program was accepted and used appropriately by the parents and reduced the risk of SUDI in the context of co-sleeping with known risk factors.[126]

126. It is indicated that the program will continue in participating sites in Queensland during 2017 – 2019 with a focus on Aboriginal and Torres Strait Islander mothers ages 25 years or less.[127] The program is supported by a network of government and non-government agencies.

127. Ms Smith has advised the research project team that Derby Hospital is enthusiastic about participating in the trial.[128] While waiting to hear more from the USC project team, Ms Smith indicated that Derby Hospital has already started training for the Pepi-Pod program as that is part of the framework for implementation. The long-term plan is for the pods to be used not only in the hospital, but also as part of a loan arrangement so local families can use it in the home.[129]

128. Ms Smith advised that in the past WACHS has trialled a different cot, that attached to the side of the bed, but it was fraught with issues because it limited access to the mother if there was an emergency and its design tended to cause the infant to end up in the corner of the cot, which was an unsafe sleeping position. So at this stage, WACHS is focussing its attention on the Pepi-Pod option.[130]

129. In terms of other improvements to promoting and encouraging safe sleeping practices in a culturally appropriate way within Derby Hospital, Ms Smith indicated that the hospital had invited the Director of the WA Health Aboriginal Health Directorate up to the region at the start of the year to talk to hospital staff about institutionalised racism and Ms Smith also met with the Kimberley Interpreting Service to discuss implementing a better structure around interpreter use with a proposed model of sessional interpreters in the hospital for a minimum of four hours, five days a week. It is hoped this will improve communication between health practitioners and Aboriginal patients.[131]

130. This is in addition to the WACHS online cultural awareness training and other specific local cultural awareness training sessions conducted by local training providers in the region.[132] There are also Aboriginal Liaison Officers based at the hospital, which at Derby Hospital has recently been extended to include a weekend model.[133]

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[126] https://www.usc.edu.au/research-and-innovation/medical-and-health-science/nurture/research-projects/the-queensland-pep-pod-program.
[127] https://www.usc.edu.au/research-and-innovation/medical-and-health-science/nurture/research-projects/the-queensland-pep-pod-program.
[128] T 48.
[129] T 48 -49.
[130] T 52.
[131] T 53, 55.
[132] T 53 - 54.
[133] T 55.

131. Ms Smith also gave evidence that WA Health is trialling an Aboriginal health practitioner pilot in the region to try to facilitate Aboriginal health workers transitioning to become Aboriginal health practitioners and increase the number of Aboriginal staff.[134]

132. In addition, Ms Smith noted there is a focus on antenatal care and trying to engage with expecting parents and deliver strong messages throughout the antenatal period, rather than simply waiting until the point of contact within the hospital after the baby is delivered.[135] Ms Smith also mentioned that she had made contact with Darwin Hospital, who had agreed to provide a copy of the Safe Sleeping DVD that Baby A's parents had watched, as another tool in a multi-pronged focus on delivering the safe sleeping message.[136]

133. I was impressed by Ms Smith as a witness. She showed a genuine commitment to improving the services that Derby Hospital can provide to Indigenous parents and their babies in a way that is culturally sensitive and yet still prioritises the safety of the baby. Ms Smith's enthusiasm for the possibilities presented by the Pepi-Pod Program was apparent at the inquest and I share her enthusiasm. I encourage the WACHS as a whole to explore this practical and promising safe sleeping option, which based on the results in New Zealand and Queensland can potentially have a dramatic effect on infant mortality rates in vulnerable communities, many of which are based in regional Western Australia.

RECOMMENDATION

I recommend that the WACHS give active consideration to implementing a culturally appropriate safe sleeping space tool, such as the Pepi-Pod, in regional WA Hospitals, following the lead set by New Zealand and the Queensland Government.

CONCLUSION

134. Baby A survived a premature birth in a remote Aboriginal community and multiple medical complications only to die in the arms of his mother in Derby Hospital as a result of overlaying.

135. Allowing mother's to co-sleep with their babies is contrary to the Department of Health and WACHS policies, although it is acknowledged that ultimately the decision is made by the parents. I am satisfied that

[134] T 55 - 56.
[135] T 67.
[136] T 67.

Baby A's parents were given information regarding safe sleeping while in hospital after his birth. However, they did not follow this advice.

136. The evidence before me at this inquest emphasised the need for the WACHS to explore alternative safe sleeping options for Indigenous mothers in Western Australia in addition to continuing to ensure WACHS staff educate parents about, and model in practice, the safe sleeping message. I am satisfied that these options are being properly explored, in conjunction with appropriate health agencies such as the Kimberley Aboriginal Medical Service. The success of programs such as the Pepi-pod program provides hope that culturally appropriate safe sleeping options can be found that work to provide a safer environment for vulnerable babies.

S H Linton
Coroner
23 August 2018