Coroners Act, 1996
[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 36/14

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***(Baby W)****, with an Inquest held at the Perth Coroners Court, CLC Building, 501 Hay Street, Perth on 7 October 2014 find the identity of the deceased baby was* ***(Baby W)*** *and that death occurred on or about 24 September 2011 at 11 Wenstead Place, Stratton, in the following circumstances:*

Counsel Appearing:

Ms I Burra-Robinson assisted the Deputy State Coroner

Ms J Hook (instructed by State Solicitors Office) appeared on behalf of the Department for Child Protection and Family Support

Table of Contents

INTRODUCTION

At about 7:30am on 25 September 2011 Baby W's foster carer located him, unresponsive, in his bassinet. She realised immediately he was dead and called emergency services.

On their arrival St John of God Ambulance officers confirmed Baby W had died and there followed a police investigation into the circumstances of his death in accordance with the established protocols for the investigation of sudden and unexpected death in infants (SUDI).

Baby W was nine weeks and six days of age.

At the time of his death Baby W was in the care of the CEO of the Department for Child Protection and Family Support (the Department) and by sections 3, 22(1)(a) and 25(3) of the *Coroners Act 1996* his death must be subject of a public hearing by way of inquest, and the coroner conducting the hearing must comment upon the quality of the supervision, treatment and care of Baby W while in the care of the Department.

BACKGROUND

Parents

Baby W's mother had three older children after five prior pregnancies. Her first two children were born by normal delivery and the third by non-elective caesarean section due to his mother's state of health.

Baby W's father had been in a defacto relationship with his mother for two years prior to his birth. Baby W was their first child together. His father had six other children from a different relationship.

Although Baby W's mother was relatively well during her pregnancy with Baby W and only required iron tablets, she had a significant health history of rheumatic heart disease with severe mitral valve regurgitation and of gestational diabetes mellitus.[1]

Baby W's mother also had a history of smoking during the early part of her pregnancy before she realised she was pregnant. She stopped smoking when she realised she was pregnant, but took it up again later in the pregnancy.

Baby W's case worker had been working with his mother since September 2010 in relation to one of her previous

[1] Ex 1, Tab 5

children who had been born prematurely and was in care. Baby W's older brother had high medical support needs as a result of being born very prematurely and his mother was not considered able to look after him, partly because of her health concerns. As a result of that care situation Catherine Lawrence, Baby W's Departmental case worker, had a considerable amount of contact with Baby W's mother and father prior to his birth. Ms Lawrence was aware of problems in their domestic situation involving alcohol consumption, domestic violence, transience, as well as Baby W's mother's serious health problems.[2]

Ms Lawrence's contact with Baby W's mother with respect to Baby W's older brother made her aware Baby W's mother was pregnant.[3] That occurred in March 2011 and the Department entered into some pre-birth meetings with Baby W's parents in order to determine his best placement once born. During those meetings a number of options were considered including remaining with his parents, being cared for by extended family, or being fully taken into the care of the Department, if no suitable carers could be located within the family sphere.

The pre-birth meetings involved Baby W's mother with the Department and various medical and support officers. His father was also present at the meetings. Although some arrangements were made for extended family members to be

[2] Ex 1, Tabs 5, 6 & 27
[3] Ex 1, Tab 7

assessed as carers, the assessments did not take place and events were overtaken by the need for Baby W's mother to be hospitalised on 16 June 2011 due to her state of health.

By the final pre-birth meeting on 27 June 2011 the Department considered historical information in relation to Baby W's parents and their capacity to care for a new baby, his mother's personal health and the unknown effect on her health of the birth and her situation post-birth, including his parents' capacity to continue to work with the Department in caring for Baby W. The Department decided a time limited order for Baby W would be put in place once he was born to ensure the stability of placement, whilst his parents continued to resolve their own relationship, health and alcohol issues.[4]

The plan for Baby W's birth was that he be subject of a 'care and protection two year limited order' application.[5] His parents were to seek legal advice as to the plan. The Department, Baby W's parents and extended family attempted to develop a safety plan addressing Baby W's ongoing safety and care needs post-discharge, and the Department continued to explore the ability of extended family to assist with support of Baby W once born.

It was expected Baby W would be born on 31 July 2011. His mother was already in hospital being cared for and

[4] Ex 1, Tab 27
[5] Ex 1, Tab 7

consequently his pre-birth care was under constant review by the clinicians in King Edward Memorial Hospital (KEMH).

Baby W's Birth

Baby W's mother went into spontaneous labour at 38 weeks gestation and her labour was augmented with artificial rupture of membranes and syntocinon. Labour progressed to full dilation but delivery was assisted with forceps out of concern for Baby W's mother's cardiac condition.

Records indicate Baby W was in good health at his birth on 18 July 2011, with birth apgar score of 9 & 9 at 1 & 15 minutes respectively. He was a good birth weight, length and head circumference and neonatal examination confirmed normal findings. He was allowed to stay with his mother in the special care unit, where she was transferred after delivery, for observation because of her cardiac status. All reviews of Baby W were normal and his inpatient stay was entirely uneventful. He developed mild jaundice which did not require any tests or additional management and he had his routine vitamin K administration and immunisations whilst in hospital.[6]

Baby W was discharged from KEMH on 22 July 2011 into the care of the Department following the pre-arranged plan. There was no necessity for any further review by KEMH due

[6] Ex 1, Tab 23

to there being no concerns for Baby W's health on discharge. There was no indication he was at any risk of any underlying medical problems and he was a healthy boy child.[7]

The Department applied for a provisional care order for Baby W on 22 July 2011, the day he was discharged from hospital, and that was confirmed on 29 August 2011 for a two year limited order ending on 28 August 2013.[8]

BABY W's TIME IN CARE

Pending Baby W's discharge from hospital inquiries had been made with extended family to ascertain their suitability for Baby W's placement or support to his parents. Those inquiries did not reveal any suitable support for Baby W's parents or Baby W and as a result, pursuant to the court order, Baby W was placed in an emergency foster care placement with a general departmental carer for the short term.

The emergency carer was non-aboriginal and considered culturally inappropriate for Baby W, but was available to care for him while the Department attempted to obtain a culturally appropriate placement.

[7] Ex 1, Tab 23
[8] Ex 1, Tab 7

Arrangements were in place for Baby W's parents to have contact visits with him whilst he was in emergency care. This occurred on one date as arranged. His parents failed to attend for the second contact visit whilst he was in emergency care.

Following a request from the Department to various non-government organisations for assistance with finding a suitable carer for Baby W, Ms Lawrence was contacted by Yorganop Association Inc. (Yorganop) who had identified a carer for Baby W. The proposed carer was Aboriginal with two older children already in her care. She was a registered carer with Yorganop which meant she had to qualify for all the Departmental criteria for a registered carer.[9] The Yorganop carer (Baby W's carer) had recently cared for a baby and had done so very well. Baby W was moved into his carer's home on 29 July 2011.

Yorganop

Yorganop Association Inc. (Yorganop) is funded by the Department for the provision of foster care placements for Aboriginal and Torres Strait Islander children requiring care. The service intends to provide nurturing and support in the homes of approved and registered foster families to meet the placement's individual needs, including cultural and spiritual guidance.

[9] Ex 1, Tab 26

For those children who are in the care of the Department, the Department retains a case worker responsible for the child, but Yorganop also provides the carer family and child with a case worker. In this case that was Chipo Nchimunya.

Yorganop manages and monitors its foster carer service, but the foster carers it provides must meet the competencies of foster carers as defined in the *Children and Community Services Regulations 2006*. It is required they can provide routine daily care, supervision and guidance in a living situation, using professionally designed interventions with support with specialist staff to address individual children's emotional or behavioural needs. There is a contractual obligation between the Department and Yorganop which defines the minimum competencies as those required in the regulations.

The Yorganop and departmental case workers work together to ensure appropriate case management. The departmental case worker remains responsible for departmental contact requirements with the biological parents, if there are any.

In the case of Baby W the Yorganop case worker, Ms Nchimunya, visited the home where Baby W was staying, although Ms Lawrence observed the home on first taking Baby W there, and observed Baby W's progress on

the times she transported him for contact with his biological parents.

Placement

On 29 July 2011 Ms Lawrence collected Baby W from his emergency carer's home and took him to the home of his Yorganop facilitated carer. Ms Lawrence noticed Baby W's carer appeared to be very happy to see Baby W and was eager to take him into her home with her other children. Ms Lawrence collected Baby W's items to take them into the home and his carer showed her where his bassinet was to be placed, which was in the room of her other children.

Although Ms Lawrence expressed some concern with the state of Baby W's carer's home on her first attendance there, she was reassured by Ms Nchimunya this was unusual and due, in part, to Baby W's carer attempting to re-organise the house to provide Baby W with proper sleeping arrangements.

Ms Nchimunya advised the court in evidence that when any baby is placed with a carer, Yorganop buys everything from the bassinet and mattress, bedding and clothing to ensure that the carer is well equipped with the things they will need for the new baby.[10]

[10] t 7.10.14, p27

The intention was for Baby W to share a room with the carer's two other foster children, however, Ms Lawrence was concerned Baby W may disturb the other children. Baby W's carer was clear she would move Baby W into her room in the bassinet if that was a problem. However, she was certain she would be able to get Baby W into a routine sleeping pattern fairly quickly. She had previously been successful in establishing routines for babies.

This was the only occasion upon which Ms Lawrence went into Baby W's carer's home. On other occasions the carer always met her at the door with Baby W dressed and ready to go for his contact visit.

Ms Lawrence noted Baby W was always clean and healthy when she collected him from his carer for his contact visits with his parents.[11] The only concern was Baby W's biological parents failing to attend for numerous of the contact visits. This was very disruptive if Ms Lawrence was not advised beforehand, after having collected Baby W from his carer's home to enable contact to occur.

Ms Nchimunya advised the court she had been into the home on 1 August 2011 and had no concerns about the placement. In addition, she kept in contact with Baby W's carer by telephone and all the contacts and concerns

[11] Ex 1, Tab 5

seemed to be entirely routine and the placement progressing well.[12]

The last time Ms Lawrence saw Baby W was on 13 September 2011 when she supervised a contact visit between him and his biological parents. Ms Lawrence said on that occasion she had no reason to have any concern for Baby W's placement. He was asleep initially but when he was awake he was alert and active appropriate to a baby of his age. He drank from his bottle when offered and interacted well with those caring for him.

On that occasion Baby W's biological mother informed Ms Lawrence she and Baby W's father were planning on leaving Perth and there would be difficulty with the regularity of the proposed contact visits. Baby W's biological mother advised Ms Lawrence she would keep in contact with her by telephone.

A care plan review was planned for 29 September 2011 to discuss Baby W's placement and ongoing arrangements for his care.

Baby W's carer advised the court Baby W had no medical issues as far as she was concerned and that he was a happy cuddly baby, who loved to be cuddled. Initially, she found he was very unsettled at night and not sleeping well but

[12] t 7.10.14, p27

would settle if he was held tightly whilst he went to sleep.[13] Initially she had great trouble settling him at night but she did eventually get him into a routine where he would sleep the night through. This was an improvement for the whole house hold.

Baby W's carer noted he had very dry skin and she always needed to rub baby oil into his body in an attempt to keep him soothed.

Baby W was taken for a routine check-up at the Stratton Community Health Centre on 19 September 2011 to see a Child Care Nurse. There were no health issues, and he was taken back to the Community Health Care Centre on 21 September 2011 for his eight week immunisations needle.

The community nurses at the Midvale Clinic confirmed they vaccinated Baby W on 21 September 2011 and he was well, with neither of the nurses having concerns as to his health or appropriateness for immunisation. Both nurses knew Baby W's carer from previous contacts and described her as a happy person always compliant with the immunisation of her children. All mothers are advised that if the baby is going to have a reaction to the immunisation, it will be immediately after the injection, and they are asked to watch the baby for the next 48 hours for further reaction.[14]

[13] t 7.10.14, p25
[14] Ex 1, Tab 14

Baby W's carer confirmed her experience from her previous children and babies was they sometimes had 'flu like symptoms following immunisation. She bought some children's Panadol in case Baby W needed it following his immunisation.

Baby W's carer advised the court that by Friday 23 September 2011 Baby W had a bit of a cough and runny nose, although it was not serious. It was not at a level which would have caused him any discomfort, but resulted in a clear fluid discharge.[15]

24 SEPTEMBER 2011

During the day before his death Baby W's carer noted he still had his slight cough and runny nose. She bathed him in the morning and rubbed baby oil into his skin. Other than the very slight cough and runny nose Baby W seemed well and this was confirmed when Baby W's carer's extended family visited during the afternoon, after Baby W had been asleep. The family were sitting outside in the backyard of the home with Baby W in a rocker. Baby W drank most of his bottle of feed in the afternoon and Baby W's carer's sister said she was holding Baby W and he was smiling at her, and gurgling at her whilst she cuddled him.

The family left at approximately 5-5:30pm and Baby W's carer and Baby W and the other children went into the

[15] t 7.10.14, p36

home. Baby W's carer placed Baby W in his rocker on the kitchen floor while she cooked her older children's dinner and then after dinner she gave Baby W another bottle. She sat and held him in her arms whilst she was watching television and he drank the entire bottle. She then gave him a dose of the children's Panadol and he fell asleep in her arms.

Baby W's carer advised the court Baby W was in what she termed a 'snuggle bed' which is a blanket which can be wrapped around a baby to simulate someone holding them in their arms. It holds a baby securely in place and makes them feel safe. She described it as a bit like wrapping fish and chips in that you wrapped the bottom bit around and then another two pieces, which holds everything in place and it was a special blanket which could be bought for that purpose.[16]

Once Baby W was asleep his carer took him into his room and settled him down in his bassinet. She was not really clear about the time but believed it to be sometime around 8-8:30pm. She advised the court Baby W was capable of sleeping the night through, and slept by himself in his bassinet in the front bedroom.

Baby W's carer originally advised she had placed Baby W asleep in his bassinet on his back, however, confirmed in

[16] t 7.10.14, p38

evidence she could no longer remember whether she placed him on his back or on his front. She advised the court she was aware of the fact the recommendations were babies be placed upon their backs to sleep, however, she believed individual children settled better in different positions and she had not yet worked out which position suited Baby W best for sleep.

However she put him to sleep, she confirmed he was asleep when she put him into the bassinet and did not wake on being placed in the bassinet. He remained asleep and she left the room.[17] She was clear he was definitely asleep when she put him into the bassinet, and he was incapable of rolling, so would have stayed in the position in which she put him down to sleep, at which time he did not waken.

Baby W's carer did not check on him before she went to bed because he had not appeared to waken and cry, and she did not want to disturb him now she had him in the routine of sleeping the night through. She was quite content everything had seemed fine when she had put him to sleep and she had no reason to believe there would be any problem.

[17] t 7.10.14, p40

25 SEPTEMBER 2011

The following morning Baby W's carer awoke at about 7:30am and went straight into the kitchen to put the kettle on for his morning bottle. She then went into Baby W's room to wake and change him before he had his bottle.

Baby W's carer advised that as soon as she looked at him she knew there was something wrong. She picked him up and blew on his face to see if he would react and let out a breath, however, there was no response and she was certain he was dead. She described him as stiff and cold.

Yorganop Carers are trained in basic resuscitation and Baby W's carer advised the court she did not attempt resuscitation because it was obvious to her he was dead. She was very traumatised and ran out into the rest of the house holding Baby W. She went into the kitchen and called 000 asking for the St John Ambulance Service.

The operator advised Baby W's carer the ambulance would be coming shortly and it seems he managed to calm her down because she said she was ok to wait until the ambulance arrived. Baby W's carer then took him into the bedroom and changed his clothing because she didn't want him to be taken away with a dirty nappy.

The ambulance officers arrived as Baby W's carer was holding Baby W and the ambulance officer[18] asked her to place him back in his cot. She did so and the ambulance officers began their assessment but had to advise Baby W's carer that he was deceased and there was nothing they could do.[19] One of the ambulance officers observed Baby W's carer place dirty nappies in the rubbish and advised the police on their attendance at the address.

It is routine for police to attend at the scene of all sudden unexplained baby deaths. There are a range of protocols in place which require doctors, nurses and ambulance officers to contact police in the event of an apparently unexplained baby death, usually when they are sleeping, to enable the police, with the assistance of a nurse, to elucidate the history of the circumstances of the death. This is not because there are specific concerns with a particular death, but a desire for understanding by the community as a whole, as to the reasons which may underlie some of these unexplained baby deaths. They are termed sudden unexpected death in infants (SUDI) and largely replace the old concept of a syndrome being responsible for all sudden infant deaths.

The fact police attend the death of a baby is not because it is expected to be suspicious, but rather to ensure there is an appropriate scene investigation, so all evidence may be

[18] Ex 1, Tab 15
[19] Ex 1, Tab 15

gathered for the forensic pathologists who review the death to attempt to clarify the circumstances of the infant's death. It is hoped in this way patterns may emerge which will inform health practitioners and paediatricians as to risk factors which may be relevant and assist with minimising these tragic events.

In the case of Baby W police attended at Baby W's carer's home with a nurse and a questionnaire was filled out in an attempt to assist with clarifying the circumstances surrounding his death.

POST MORTEM REPORT[20]

The post mortem examination of Baby W was carried out by Dr Clive Cooke, Chief Forensic Pathologist at the PathWest Laboratory, on 27 September 2011.

At post mortem Dr Cooke noted Baby W had a mild nappy rash which seemed to be healing. He appeared to be a healthy, developmentally appropriate for his age, baby. While there was some dirt between his toes this was explained by Baby W's carer outlining her back garden, where she had been with Baby W on the afternoon of 24 September 2011. It comprised black sand and she had

[20] Ex 1, Tab 24

not yet bathed him when she located him on the morning of 25 September 2011.[21]

On internal examination Dr Cooke found there was some congestion of his lungs, a nonspecific finding, however, there was apparent aspiration of regurgitated vomit into his main airways. Initially the death was described as undetermined, while Dr Cooke conducted further investigations to try and elucidate a cause of death.

On 22 November 2011 Dr Cooke finalised his final post mortem examination report by confirming the aspiration of vomit appeared to be terminal, but that microscopy revealed some bronchitis, particularly well seen in the upper part of the left lung.

A viral infection investigation identified human metapneumovirus RNA in his lung and trachea but no other common viruses. Microbiological testing showed the presence of *Streptococcus pneumonia* in his left ear, with mixed bacteria in his lungs and spleen, without identifying a specific infection in those organs specifically.

Toxicology showed the presence of paracetamol at a level which was consistent with Baby W's carer providing him

[21] t 7.10.14, p37

with child Panadol the evening before. There was no concern as to the level of the paracetamol.[22]

Dr Cooke gave a cause of death of 'sudden infant death in a boy with bronchitis and otitis media'. In evidence Dr Cooke confirmed that in today's environment that would be described as an 'unascertained' cause of death, 'in a boy with bronchitis and otitis media'.[23]

Dr Cooke clarified the extent of the viral and bacterial infections observed in Baby W's system were not enough to account for his death as they were very mild and insignificant and were not affecting his smaller airways, bronchioles, to the extent he thought was significant to a cause of death.[24]

Overall, Dr Cooke was not of the view any of the clinical findings at post mortem were enough to account for the death of Baby W.

There were, however, some findings that may be of significance in the context of general concerns as to risk factors for sudden infant death.

The most striking feature when observing Baby W externally was the post mortem lividity of Baby W, and the areas of

[22] Ex 1, Tab 25
[23] t 7.10.14, p15
[24] t 7.10.14, p12

post mortem pallor observable on the right side of his face. Dr Cooke described that when any person dies in a particular position and remains in that position for a period of time the blood settles in the most dependant area and causes darker colouring known as post mortem lividity. Where the body has been on a surface so there is a pressure point, then the blood does not settle in the same way and the surfaces in contact with another surface tend to show pallor against the lividity.[25]

In Baby W, his post mortem lividity was clear on his front and on his face, confirming Baby W was on his front when he died, with his face turned to the right. It would also seem he remained in this position for some hours after death because by the time he was located that pattern of lividity and pallor was established and remained in that pattern despite the fact that from the time of location to post mortem, he would have been placed on his back. This would seem to indicate Baby W was placed on his front when he was placed in his bassinet, as it would seem highly unlikely he had the capacity to roll from his back onto his front.

The main issue of concern is the fact the area of pallor seems to extend to both sides of Baby W's nose and mouth, just, and implies his airways may well have been occluded once he was fully relaxed. That would be consistent with

[25] t 7.10.14, pp8 ,9,10

the pattern of pallor observable at post mortem examination.

Overall, the extent of Baby W's compression pallor noted by Dr Cooke led him to believe it was more likely Baby W had died on the evening of the morning before he was located. It is likely death occurred sometime during the hours of 24 September 2011.[26]

In addition Dr Cooke noted the distribution of the compression pallor would support the proposition Baby W's mouth and nose were also partially compressed and pressed into his bedding at the time of death. This would have compromised his ability to breathe easily.[27] Dr Cooke was far more guarded about the extent of bronchitis he observed in Baby W's lungs as being a contributing factor to his ability to breathe easily. While Dr Cooke believed it was probably true to a certain extent that Baby W also had a compromised airway because of his bronchitis he was anxious to point out the extent of the bronchitis should not be over emphasised in the scenario surrounding Baby W's death.[28]

In today's environment Dr Cooke confirmed his cause of death would likely have been 'unascertained in a baby with bronchitis and otitis media' as opposed to 'sudden infant

[26] t 7.10.14, p9
[27] t 7.10.14, p10
[28] t 7.10.14, p12

death in a boy with bronchitis and otitis media'.[29] This is to emphasise the fact sudden infant death is not a diagnosis but an acknowledgement by pathologists there is no reasonable explanation for the death of a sleeping baby from the post mortem examination results alone.

There is also growing evidence that Aboriginal babies are very susceptible to infections becoming life threatening in a very short time frame. This has led to the institution of specific treatment responses, especially in remote areas, which would not normally be considered for mild infections.[30] This may also be a risk factor to be considered when attempting to frame safe sleep practises.

CONCLUSION AS TO THE DEATH OF BABY W

I am satisfied Baby W was an almost 10 week old baby Aboriginal boy. His biological parents had a number of children between them, but were not in a position to adequately care for those children. Baby W's mother had serious health problems which negatively affected her ability to care well for a new born baby, and his biological parents' dysfunctional and itinerant lifestyle could have caused serious developmental problems for Baby W in his infancy.

The Department made a decision to remove Baby W from his biological parents care during his infancy, although that

[29] t 7.10.14, p15
[30] t 7.10.14, p17

care and protection order was time limited in the hope, ultimately, Baby W's parents may be in a position to care for him appropriately. He was initially placed in emergency care on his discharge from hospital following birth for one week, and thereafter was then in a long term placement with his carer.

It is clear from the evidence of the departmental case worker and the Yorganop case worker Baby W's carer provided a happy, responsive, loving, and nurturing environment. Due to the involvement of Yorganop, Baby W's placement was culturally appropriate and he was seen to respond well to that environment by his continued appropriate development for age and more settled sleep patterns.

The community nurses involved in immunising Baby W at approximately eight weeks of age both commented Baby W's carer, and Baby W, appeared to be happy and healthy and the placement was progressing well.

While there may have been concerns initially as to the somewhat chaotic home environment, it is clear this did not impact negatively on Baby W's development. Relatives and friends of Baby W's carer, who had contact with him in the days immediately prior to his death, all commented upon his apparently contented interactions with them in that household.

I am further satisfied Baby W's carer, while being culturally appropriate for Baby W's development, had also received training from Yorganop, as required by the Department and statute, to assist her to care appropriately and responsibly for Baby W's needs. This included the understanding of the safe sleeping practises suggested by SIDS and Kids and used in Yorganop's training.[31]

On the evening of 24 September 2011 Baby W's carer took her three foster children indoors once her extended family had left. She fed the two older children while Baby W was in his rocker. She had noticed Baby W had developed a slight runny nose that day and when she fed him, before putting him to sleep, she also gave him a dose of children's Panadol which she had purchased following his immunisations.

After feeding, Baby W's carer sat with him in the lounge room while he was wrapped in his snuggle blanket He fell asleep in her arms while she was watching television. Once Baby W was settled and asleep Baby W's carer placed him in his bassinet in his snuggle blanket. I am satisfied Baby W was placed on his tummy, with his face turned to the left.

Initially Baby W's carer believed she had placed Baby W on his back because her memory, after the event, was of looking into his face. In evidence she agreed it was quite

[31] t 7.10.14, p41-42 & p53-56

possible she placed him on his stomach. In her experience some babies settle more easily on their front than on their back. She had not yet decided on Baby W's preferred sleeping position, but was happy she had just recently achieved his sleeping throughout the night and not disturbing the rest of the household.

There was nothing about Baby W when she put him to sleep which gave her any concern he was not as settled and contented as he had been recently.

Baby W's carer left the room and did not re-enter the room for fear of disturbing him and his sleep.

The next morning Baby W's carer located Baby W in his bassinet deceased. She understood immediately he had died and contacted all the relevant services to assist her and report the death.

St John Ambulance officers and the police attended and responded to established protocols for the investigation of a sudden unexpected death in an infant (SUDI). This includes a nurse having as much information as possible about the events preceding an infant's death, and the police forensically examining the environment in an attempt to determine whether there are environmental factors which may be involved in the unexplained death.

The police seized Baby W's bedding, also in accordance with the protocols, and all items which may shed some light on the whole vexed issue of SUDI.

The photographs of the scene indicate an area of light staining on an otherwise clean sheet from Baby W's bassinet. I am unable to determine whether this was consistent with the fluid Dr Cooke observed in the vicinity of Baby W's upper airways at post mortem examination due to it not being biologically analysed. Baby W's carer was too distressed at the time of locating him to confirm the origin of the staining.

I am satisfied from the post mortem examination results, and the scene investigation, the precise cause for Baby W's death cannot be determined.

It seems most likely, on the whole of the evidence, his ability to breathe freely and affectively was compromised to some extent; possibly by his positioning; and perhaps by a very mild respiratory deficiency due to his mild infections.

There is no evidence he was not appropriately cared for and Dr Cooke noted his healing nappy rash, and the fact his mild respiratory infections would appear to have been treated appropriately with children's Panadol.[32] Infections tend to elevate respiration due to an additional need for

[32] t 7.10.14, p18

oxygen with which to fight infections. A partially occluded airway may compromise effective respiration by both a restriction in available oxygen and/or an elevation in the carbon dioxide level known as re-breathing. Once unresponsive the potential for further occlusion of the airways, as the face relaxes into the adjoining surfaces, increases.

It was common ground Baby W was not of an age where he would be in a position to roll and therefore protect himself by freeing his airway.[33] Other than a likely compromised airway, there appears to be little explanation for Baby W's death.

It is impossible to determine whether it was a completely naturally occurring death or whether some environment factors were of relevance.

Consequently, in all the circumstances I make an Open Finding into the death of Baby W.

COMMENTS ON THE SUPERVISION, TREATMENT AND CARE OF BABY W

I am satisfied Baby W was appropriately placed in the care of the Department from the time of his discharge from hospital. He was at that stage an apparently healthy

[33] t 7.10.14, pp10, 41

thriving infant and there were real concerns his biological parents would not be able to maintain the level of care necessary to ensure his continued appropriate development.

I am satisfied Baby W was placed into a loving foster home, as soon as was practicable in the circumstances of this case, and that Baby W's carer was an experienced, registered, and appropriately trained carer. The evidence would support the fact she provided Baby W with loving, caring and nurturing appropriate to his developmental stage. His supervision, treatment and care was of a good standard.

I think it appropriate at this point to comment upon the work done by SIDS and Kids with respect to their promotion of safe sleeping practices for babies. Historically, with the introduction of SIDS and Kids suggestions for safe sleeping for infants, there was a reduction in the incidence of sudden infant deaths while sleeping. This was largely attributed to SIDS and Kids advice that babies should be placed upon their back to sleep. At that stage no one knew precisely why, and there is continued research, angst, and willingness to attempt to categorise risk factors which contribute to the phenomena of sudden death in sleeping infants.

It should be noted there are also sudden deaths in adults that are largely unexplained. Advances in modern science

and technology are suggestive a number of these unexplained adult deaths may be accounted for by cardiac, metabolic and other genetic issues. It may be in future there is also some correlation with those deaths and the unexpected deaths of sleeping babies. Only time and research will tell.

Meanwhile the whole issue of the sudden and unexplained death of sleeping babies, and whether it is a natural, accidental, or combined phenomena, remains largely unexplained. However, the introduction of an awareness of contributing risk factors has seen a reduction of the numbers of deaths of sleeping infants in the last few years with the education of the community at large of factors it is believed may be risky for sleeping infants.

With the apparent, anecdotal, reduction of the numbers of deaths of sleeping babies with the placement of infants on their backs to sleep, there has been more emphasis on the risk factors relevant to co-sleeping. Significantly, many of the factors considered to be risk factors in the co-sleeping of children (infants sleeping on the same sleep surface as another breathing entity) are the same as were originally espoused for safe sleeping generally by SIDS and Kids. I am concerned the more recent emphasis on preventing infant deaths while co-sleeping has led to a dilution of the message with respect to placing sleeping babies on their backs.

In evidence Baby W's carer acknowledged she was aware of the preferred practice of placing babies on their backs, but emphasised there were at times good reasons for preferring to place a child on its stomach, with its head turned to its side, to encourage settled sleep. To some extent this was echoed by the placement service program manager for Yorganop Association Inc.[34]

I am concerned that while both the Department and Yorganop require their carers to be trained in safe sleep practices for sleeping infants, more recently with the emphasis on co-sleeping, the impressive results received by the original response to SIDS and Kids sleep practises in reducing sudden infant deaths while sleeping by placing babies on their backs, has been forgotten as part of the message for a safe sleeping practice.

[34] t 7.10.14, p59

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safe sleeping

'Sleep Safe, My Baby'

sids and kids®


1. Sleep baby on back
Back
Side
Tummy
Sleeping baby on the side or tummy increases the risk of sudden infant death

Six ways to reduce the risk of sudden unexpected death in infancy and sleep baby safely:

- Sleep baby on back
- Keep head and face uncovered
- Keep baby smoke free before and after birth
- Safe sleeping environment night and day
- Sleep baby in safe cot in parents' room
- Breastfeed if you can

Special thanks to SIDS and Kids ACT and ACT Health and the Department of Disability, Housing and Community services for original development.

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It can be seen from the above information, largely reproduced in the fostering fact sheet[35] provided by the Department, Baby W exhibited two of the recognised risk factors for the unexplained death of a sleeping baby;

- maternal smoking during pregnancy;
- placed on his front to sleep;

to which can be added;

- he was under 11 weeks of age;[36]and
- had an elevated oxygen requirement due to his mild respiratory infection.[37]

In addition, Dr Cooke indicated Aboriginal babies seemed to be particularly vulnerable to the infection caused by the bacteria *Streptococcus pneumonia*, (otitis media), and that infants generally are susceptible to infections caused by both the virus metapneumovirus and otitis media, in combination. Aside from possibly affecting the respiration of a child, any infection will increase the requirement for accessible oxygen.

Baby W's need to be able to breathe effectively at the time of his death was high and anything which potentially impeded his effective respiration was a risk factor which could contribute to an unexplained death at that time.

[35] Ex 3
[36] Health Department Operational Direction 0139/08
[37] t 7.10.14, p12

It is essential deaths like that of Baby W are remembered when training anyone with the care of infants as to best practices for safe sleeping in an effort to minimise the trauma and distress caused by these so far, largely unexplained deaths.

E F VICKER

DEPUTY STATE CORONER

19 December 2014