IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 1993

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, Caitlin English, Coroner having investigated the death of Hailey Holmes

without holding an inquest:
find that the identity of the deceased was Hailey Holmes
aged five months
and the death occurred on 1 June, 2011
at Maroondah Hospital
from:

1 (a) SUDDEN INFANT DEATH SYNDROME II

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to the following circumstances:

Hailey Holmes' death was reported to the Coroners Court of Victoria (CCOV) on 1 June 2011. It was an investigation originally undertaken by Coroner Spooner. I have had carriage of the investigation since February 2014.

One of the purposes of the coroner's investigation is to contribute to the reduction of the number of preventable deaths. The focus of this investigation has been to consider what might prevent similar deaths in the future.

Background

1. Hailey Holmes was a five month old infant who resided with her mother and father in a rental property in Ringwood East. The house was shared with her maternal grandfather and two others. Hailey's mother was a childcare worker, and her father a baker/pastry chef.

2. Hailey was born following a natural labour with no complications on 9 December 2010, at Box Hill Hospital after a full-term pregnancy, weighing 7.9 lbs. Hailey was monitored in

hospital for two days before being brought to her family home. A maternal and child health nurse visited Hailey at home in accordance with the 'Key Ages and Stages' consultations provided by Maroondah City Council.

3. Hailey was breastfed for the first six weeks, and then went onto a bottle and formula. Formula S26 was used for one month, however Hailey was having troubles with constipation and the formula was changed to Kari Care Gold. No further problems were noted.

4. Hailey was described as a content baby from birth. She was often able to sleep all through the night after being put down. She was generally in very good health.

5. At four months of age, Hailey developed croup. Hailey's father took her to Maroondah Hospital emergency department, where she was treated and released that same day. The treating practitioner gave Hailey's father medication to alleviate the coughing. Vapour rub and infant Panadol was also given to Hailey and her symptoms disappeared within two weeks.

6. One week later, Hailey suffered from diarrhoea and was sent home from day care. She was treated by her local general practitioner, who advised her mother that given time, it would pass. Hailey then developed a rash and her mother took her to Maroondah Hospital emergency department where she was told that Hailey had contracted a viral rash. Within a couple of days all symptoms had disappeared and Hailey was only experiencing cold like symptoms.

7. Hailey was immunised for Hepatitis B at birth, and received all subsequent vaccinations through to four months of age. Hailey was unable to receive her 4 month immunisations due to her developing croup. Hailey's mother was advised to have her 4 month immunisations just prior to her turning 6 months of age, and then shortly after, she would be able to receive her 6 month immunisations.

8. Hailey's father and the other members of the home smoked, however only outside the house and never in Hailey's presence.

Sleeping arrangements

9. For the first 6 weeks of Hailey's life she slept in an infant bassinet. Hailey's mother stated that the entire time Hailey slept in the bassinet she was always placed on her back to sleep. Hailey soon outgrew the bassinet.

10. She then began sleeping in a portable cot, given to Hailey's parents by neighbours. The portable cot was in Hailey's own room. In the portable cot she would be placed to sleep on

her stomach as Hailey's mother's view was that she was less restless and would sleep longer when placed in this position. Hailey's mother stated she was hesitant, however spoke to family and friends and was '*told it was OK because she slept with head to the side.*'[1]

11. Inside the portable cot, Hailey's mother placed thick blankets on the base '*...because it was hard and I wanted to make it soft...*'[2] and then a fold out child's foam couch on top. In the gaps beside the couch and the sides of the portable cot, Hailey's mother rolled up blankets to make the sleeping environment flat. Hailey's mother stated: '*I had no loose bedding because I knew it was dangerous because of SIDS.*'[3] Hailey would be put to bed, wrapped and with a dummy. Hailey's mother stated: '*I put a blanket over her and tucked her tight under the couch mattress. I didn't ever have toys or anything in the cot. I always put her up the top end where the foam border was.*'[4]

12. After Hailey had transitioned out of her bassinet, Hailey's mother spoke with a parent from the childcare centre where she worked and told her that Hailey was sleeping in a portable cot with a sofa fold out couch. The parent, who worked at a store selling baby nursery furniture, told her: '*they actually recommended portable cots and that if she's comfortable sleeping in there, then that's fine.*'[5]

Summary of Circumstances of Death

13. At approximately 6:30 pm on Wednesday 1 June 2011, Hailey was wrapped and placed into her portable cot '*on her tummy with her dummy right up the top end*' [6] by her mother. Between 8:00 and 8:30 pm, Hailey's father heard her grizzling and alerted Hailey's mother. Hailey's mother has found her in the bottom right hand corner of the portable cot, with her face lying into the mesh.

14. Hailey's mother immediately picked Hailey up and screamed, saying '*She's lifeless.*'[7] Hailey's father and flat mate Jacqueline Hubbard attended and took Hailey into the lounge room where Hailey's father commenced CPR for a couple of minutes. After calling for an ambulance, a decision was made it would be quicker to drive Hailey to Maroondah Hospital

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[1] Coronial brief, 7.

[2] Ibid, 3.

[3] Ibid.

[4] Ibid.

[5] Coronial brief, 7.

[6] Ibid, 5

[7] Ibid.

which was only a short distance away. While Hailey's father found his car keys, Ms Hubbard took over CPR.

15. Hailey's father drove, with Ms Hubbard continuing CPR on Hailey in the car on the way to hospital. Hailey's mother and Ms Hubbard's partner, Fiona Latham followed on foot to the hospital.

16. Hailey was in cardio-respiratory arrest upon arrival at hospital at 8.45pm. She was immediately taken to the resuscitation area where she had no respirations or cardiac activity, with underlying asystole. A team of nurses and doctors worked on Hailey, with Dr Evangelos Klonis as team leader.

17. She was intubated and CPR was continued. She was administered intravenous fluids and medications and she had standard treatment for cardio-respiratory arrest including saline, multiple doses of adrenaline, sodium bicarbonate and calcium gluconate. Blood results showed severe metabolic acidosis. After consultation with the Royal Children's Hospital paediatric team leader, it was deemed further treatment was futile.

18. Hailey was pronounced dead at 9.30pm.

Coroner's Investigation

19. Forensic Pathologist Doctor Yeliena Baber from the Victorian Institute of Forensic Medicine performed an autopsy on 6 June 2011 and determined that the cause of death was *Sudden Infant Death Syndrome Category II.* I accept Dr Baber's determination. In her report, Dr Baber states: *'Category II SIDS is used in cases where according to the circumstances suffocation cannot be determined or excluded with certainty. In this instance I notice that Hailey was asleep in a Porta-cot with an ill-fitting mattress. It is not known if the portacot met the Australian Standard. This, therefore, is a sleeping environment which must be considered potentially hazardous.* [8]

20. Routine toxicology testing revealed no common drugs or poisons.

21. Detective Senior Constable Clayton Bickerton of Victoria Police prepared a detailed coronial brief about the circumstances surrounding Hailey's death. The focus of the investigation was Hailey's sleeping arrangements, position and environment.

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[8] Coronial Brief, 36.

22. On the basis of Detective Senior Constable Bickerton's brief of evidence, Coroner Spooner requested the Coroners Prevention Unit[9] (CPU) to:

- identify sources, content and timing of information provided by maternal and child health (MCH) nurses to caregivers about maintaining a safe sleeping environment for infants during the first year of life;
- review the records of Hailey's MCH attendances to identify what advice was provided to Hailey's caregivers about infant safe sleeping;
- review the suitability of a portable cots as a permanent sleeping environment; and
- identify sources and content of advice to caregivers about the dangers of introducing additional material or items to the portable cot to soften the sleep surface.

23. A meeting was held at the CCOV on 13 January 2013, with Coroner Spooner to discuss with various stakeholders[10] the frequency of sleep related infant deaths by sleeping environment between 2008-2012.

24. During that period, 111 suspected sleep-related infant deaths occurred in Victoria. In seven of those deaths, the infant was sleeping in a portable cot. In those seven, additional items had been introduced to the portable cot to 'soften' the sleeping surface. Items included: ill fitting mattresses, adult and infant doonas (used as mattress or padding), adult blankets, cushions, towels and pillows.

25. The purpose of the meeting was to identify possible recommendations the coroner could make regarding safety information about the suitability of portable cots as permanent sleeping environments and the risks associated with placing the additional items into a portable cot. Also discussed was the information provided to caregivers when transitioning infants from bassinets to cots.

Review of Safe Sleeping Advice Provided by the Maternal and Child Nurse Health Visits

26. Hailey was visited at home by Maroondah City Councils' Ringwood East maternal and child care nurse on 15 December 2010. Notes from the computer record keeping system and 'Key Ages and Stages Information' indicate Hailey's *'sleeping position sighted'* and it was noted

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[9] The Coroners Prevention Unit is a specialist service for Coroners created to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

[10] Representatives from the Coroners Prevention Unit, the Department of Education and Early Childhood Development, SIDS & Kids, Kidsafe Victoria, Infant & Nursery products, Australia, Australian Competition & Consumer Commission.

that the 'Sudden Unexpected Deaths in Infancy (SUDI) Safe Sleeping Checklist' was completed.

27. A second home visit took place on 23 December 2010 and the notes indicate the safe sleeping checklist was followed up.

28. Hailey's mother took her to an appointment on 10 February 2011, at the MCH Centre and Hailey's development assessment was noted to be consistent with her age. The notes indicate:

'When discussing sleep, Jessica stated that she sleeps baby on her tummy and that is the only way she will settle. Says she has a baby monitor and can hear her. Advised again of the SUDI [Sudden Unexpected Death in Infancy] Guidelines and the importance of baby sleeping on her back. Given details to book into Sleeping and Settling Talk so that she can get some strategies for settling Hailey without sleeping her prone.'[11]

29. The 'Key Ages and Stages'[12] appointment information notes that the Safe Sleeping Checklist was completed by the MCH nurse at the two and eight week appointments, but there was no evidence of it being completed at the four week or four month appointments, as the information was not filled out or noted in the computer record keeping system provided.[13]

Portable cots as a permanent sleeping environment

30. Hailey's mother stated that a parent from the child care centre told her that portable cots were '*fine*' for baby's sleeping arrangements. She described the portable cot given to them by neighbours as '*brand new.*'[14]

31. Hailey's father stated: '*We intended to get a normal cot but money was tight as we had just moved into the new house.*'[15]

32. There are differing views amongst key stakeholders regarding the use of portable cots as a permanent sleeping environment for a baby.

33. Infant & Nursery Products Australia takes the view:

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[11] Maroondah City Council maternal and child health computer record keeping system entry 10/2/2011.

[12] Key Ages and Stages consultations with maternal and child health nurses comprise the initial home visit to new born, and thereafter at ages: two weeks, four weeks, eight weeks, four months, eight months, twelve months, two years and three and a half years.

[13] Letter and enclosures from Maroondah City Council to CCOV dated 19/12/2012.

[14] Coronial Brief, 3.

[15] Ibid, 10.

'Whilst a household cot is the preferred sleeping arrangement for infants, a portacot is a safe sleeping environment, providing no additional mattresses are placed in the cot and the cot is in good condition.' [16]

34. Likewise, Kidsafe Victoria stated:

'The safest sleeping environment for an infant is an Australian Standards compliant household cot. However, with the introduction of mandatory standards for portable cots in 2009, Kidsafe Victoria believes that portable cots are fit for use as permanent sleeping environments when used correctly.' [17]

35. SIDS and Kids was of the view that since mandatory standards were in place for portable cots, they do not stipulate whether a portable cot should or should not be used on a permanent basis. Instead, SIDS and Kids provide advice and warnings about the product, and how to sleep baby in the product to reduce the risk of SIDS and sleeping accidents.[18]

36. The Australian Competition and Consumer Commission (ACCC) took the view that:

'...portable cots should only be used as temporary sleeping facilities. They are not suitable for long term sleeping arrangements. Because these cots are foldable and transportable, they are subject to more wear and tear and are generally less robust than permanent sleeping enclosures such as household cots.' [19]

37. The ACCC 2011 publication, 'Keeping Baby Safe: A guide to infant and nursery products' lists a number of hazards associated with portable cots, including suffocation. The following advice is provided regarding the use of portable cots as a permanent sleeping environment:

"Safety habits – Never use a portable cot for long term sleeping arrangements." [20]

38. The Maternal and Child Health Service 'Safe Sleeping Checklist' produced by the Department of Education and Early Childhood Development (Victoria) under 'Topics for discussion with parents' states:

'Portable cots are only intended for temporary use and convenience when travelling and should not be used on a long-term or permanent basis.'

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[16] Letter Nursery & Infant Products Australia to CCOV dated 22/1/2013.

[17] Letter Kidsafe Victoria to CCOV 30/1/2013.

[18] Letter SIDS & Kids to CCOV dated 1/2/2013.

[19] Letter ACCC to CCOV dated 23/9/2013.

[20] ACCC 2011 publication, 'Keeping Baby Safe: A guide to infant and nursery products'.

39. Although there is not a consensus, both the national consumer body and the relevant state government department, (the ACCC and the Department of Education and Early Childhood Development (Victoria)) do not recommend portable cots for long term or permanent use.

The use of additional bedding in a portable cot

40. The ACCC in its on-line publication, 'Keeping Baby Safe: A guide to infant and nursery products', provides the following advice regarding the introduction of additional material into portable cots:

Only use one snug fitting mattress. Gaps caused by using an extra mattress can trap a baby and cause suffocation.

Compulsory warning labels include:

The inside of all folding cots must have permanent and clear warning labels covering:

- either a warning to use a mattress of specified dimensions or a warning to use only the mattress supplied by the manufacturer, and;

- a warning not to add an extra mattress as this may cause suffocation

These mandatory standards apply to the supply of all new and second hand folding cots from 1 March 2009.

Products with mandatory standards can only be legally sold if they meet the mandatory requirements.

41. Kidsafe Victoria state that misuse of portable cots, including the introduction of additional items such as mattresses and padding, is a major factor in sleep related deaths. Kidsafe is of the view that there is a perception the mattress provided with a portacot is not comfortable enough for a child, hence the addition of extra mattresses or padding.

42. SIDS & Kids provide the following advice regarding the use of portable cots:

'Only use the firm, thin, well-fitting mattress that is supplied with the portable cot (portacot). Never add a second mattress or additional padding under or over the mattress, which has been specifically designed for the portacot, as baby may become trapped face down in gaps between the mattress and the sides.'[21]

[21] 2012 publication titled Sudden Unexpected Death In Infancy (SUDI): Frequently Asked Questions.

43. The Safe Sleeping Checklist prepared by the Department of Education and Early Childhood Development and used by the maternal and child care nurses states, in respect of portacots:

- use the mattress that is supplied with the cot;

- never add a second mattress or additional padding under or over the mattress supplied with the portacot;...'

44. The evidence of all stakeholders consulted is consistent that no additional mattresses or padding should be placed in the portable cot to 'soften' the sleeping environment as these are potential suffocation risks.

FINDING

I find that unfortunately Hailey Holmes died from SIDS II.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008,** I make the following comments connected with the death:

As they grow, babies transition to different sleeping environments at different ages and this may occur multiple times, for example from bassinet to cot and from cot to bed. Maternal and child health nurses have a large volume of health and safety information to convey to parents and caregivers in a short period of time and safe sleeping is given some primacy. It is crucial that maternal and child nurses address the issue of safe sleeping at every key ages and stages appointment, in particular the issue of transitioning from one sleeping environment to another.

Mandatory standards have been in place since March 2009, for portable cots and prescribed visible warnings are now required. Health professionals such as maternal and child health nurses who are responsible for providing advice to those caring for babies must continue to provide education about the suffocation dangers of introducing items to portable cots such as extra or ill-fitting mattresses, padding, bumpers, quilts, doonas, duvets, lambs wool or soft toys.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:

1. That maternal and child care nurses address the issue of safe sleeping, including the transition to different sleeping environments, at every 'Key Ages and Stages' appointment with infant's caregiver.

2. That maternal and child care nurses continue to educate caregivers about the suffocation dangers of using extra mattresses or padding in portable cots.

3. That the Australian Competition and Consumer Commission include a mandatory warning on all portable cots that they should only be used for temporary use only and are not suitable for long term or permanent sleeping arrangements.

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

Ms Jessica Bamford
Mr Bradley Holmes
Corporate solicitor, Maroondah City Council
Jill Green, SIDS & Kids
Executive Director, Kidsafe Victoria
Director, Child Health and Wellbeing, Department of Education and Early Childhood Development
General Manager, Public Safety Branch, Australian Competition and Consumer Commission

Signature:

CAITLIN ENGLISH
CORONER
Date: 28 November 2014