IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2019 2669**

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**PHILLIP BYRNE, CORONER**
Deceased:	**BABY M**
Date of birth:	**26 MARCH 2019**
Date of death:	**OVERNIGHT 26 – 27 MAY 2019**
Cause of death:	**I(a) SIDS CATEGORY 2**
Place of death:	[redacted]

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*Section 67 of the **Coroners Act 2008***

I, PHILLIP BYRNE, Coroner having investigated the death of BABY M
without holding an inquest:
find that the identity of the deceased was BABY M
born on 26 March 2019
and the death occurred on 27 May 2019
at [redacted]

from:

I(a) SIDS CATEGORY 2

Pursuant to section 67(1) of the **Coroners Act 2008** I make findings with respect to **the following circumstances**:

BACKGROUND

1. Baby M was born to Ms M at the Royal Women's Hospital on 26 March 2019, his biological father being Mr P. Ms M had a significant complex past history including mental health issues and illicit drug usage.

2. Department of Health and Human Services (DHHS) Child Protection were involved with Baby M from birth as Ms M was assessed in hospital as drug dependent. For the first week of his life Baby M remained in the special care nursery where he was monitored by nursing staff.

3. On 27 March 2019 the child protection investigation concluded Baby M would be at risk should he be in the care of his parents. Consequently on 27 March 2019 a Protection Application was issued and Baby M was placed on a protection order while the options for his ongoing care were considered.

4. Investigations established that Ms A, Baby M's maternal aunt, her husband Mr L and their three children aged 10, 9 and 4 would best provide care of Baby M, and on 1 April 2019 a

Children's Court Interim Accommodation Order (IAO) was made in favour of Ms M. Baby M was discharged from the Royal Women's Hospital into the care of his aunt Ms A.

BROAD CIRCUMSTANCES SURROUNDING DEATH

5. At about 7pm on 26 May 2019 after his bottle of formula Baby M was put to bed in his bassinet in the master bedroom. He wore a singlet and a zip-up jumpsuit and was swaddled in a blanket and placed on his back.

6. Apparently Baby M did not wake for his usual 11pm bottle. Ms A awoke at about 11pm to go to the toilet. She stated she did not check Baby M at the time. Mr L awoke at about 2:30am and checked Baby M who would then usually be ready to be fed. Mr L found Baby M unresponsive and cold to the touch. A call was made to the 000 emergency number and Ms A and Mr L commenced CPR as instructed by the call-taker. In response to the 000 call Ambulance Victoria paramedics attended the address and took over CPR. Despite full resuscitation measures by paramedics Baby M could not be revived and was declared formally deceased at the home address.

REPORT TO THE CORONER

7. Baby M's death was reported to the coroner. Having considered the circumstances surrounding Baby M's untimely death, particularly having regard to the fact he was on a protection order in the care of his aunt, I directed an autopsy and ancillary tests. Subsequently an application to reconsider my previous order was submitted. Having considered that application I declined to revoke the earlier direction and affirmed my previous direction. For completeness I include in this finding an excerpt from that determination:

> *"... without autopsy the cause of death would be unascertained which would be totally inappropriate in the circumstances of [Baby M] being in the care of his aunt under a DHHS order. Furthermore the circumstances suggest the death may ultimately be categorised as SIDS, a cause of death founded on the EXCLUSION of other possible causes which can't be excluded without autopsy."*

8. The directed autopsy was performed at the Victorian Institute of Forensic Medicine by Forensic Pathologist Dr Yeliena Baber. Following exhaustive autopsy and ancillary tests, including toxicology, microbiology, radiology and metabolic screening together with a neuropathological examination by Dr Linda Iles which included macroscopic and microscopic examinations, Dr Baber advised Baby M's death was due to:

I(a) SIDS CATEGORY 2

Dr Baber commented:

> *"The cause of death in this 8 week old male infant remains undetermined following post mortem and as such it is appropriate to invoke the acronym of SIDS (Sudden Infant Death Syndrome). The definition agreed upon by Krous et al was the sudden unexpected death of an infant less than 1 year of age with the onset of the fatal episode occurring during sleep, that remains unexplained after a thorough investigation, including performance of a complete autopsy and review of the circumstances of death and the clinical history."*

Toxicological analysis of post mortem specimens was unremarkable.

FURTHER INVESTIGATION

9. I note following established protocol a Sleep-Related Sudden Unexpected Death of an Infant or Child (SUDI) report was undertaken at the scene on 27 May 2019 by Detective Senior Constable (DSC) Benjamin Manning of Central Goldfields Crime Investigation Unit, who took on the role of coroners investigator.

10. My registrar requested a coronial brief of evidence be submitted by the coroners investigator.

11. On 5 June 2020 DSC Manning lodged a comprehensive, commendable brief of evidence. Importantly it contained statements from Ms A, Mr L, attending paramedics and police officers together with scene photographs and a copy of the SUDI checklist. Also helpful in relation to understanding the background, and providing insight into the circumstances of Baby M being on a protection order at the time of his death, is a comprehensive statement by Ms Kerri Felemonow, senior social worker at the Royal Women's Hospital Alcohol and Drug Service (WADS). It demonstrates the significant support provided to Ms M throughout her pregnancy. Regrettably she was unable to maintain the commitment to remain stable and drug-free hence the involvement of DHHS protective workers.

12. I had my coroners solicitor Mr Darren McGee seek from DHHS a statement addressing their involvement with Baby M and Ms A's family once Baby M was placed in their care. I received a letter under the hand of Ms Leng Phang of the Legal Services Branch of DHHS. I include in this formal finding two important excerpts from Ms Phang's report; she wrote:

> *"Throughout the IAO period, Child Protection continued to oversee and monitor [Baby M's] wellbeing. Safety screening of the carers and a SIDS check at the home were completed by child protection and no concerns were raised regarding the sleeping environment."*

And:

> *"Throughout [Baby M's] short life, [Ms A] and her family provided [Baby M] with the very best start in life. [Baby M's] physical, emotional and developmental needs were fully met by a loving and caring family."*

CONCLUSION

13. I unreservedly accept the advice provided by Ms Phang in relation to the level of care provided to Baby M by Ms A and her family. It heightens the tragedy visited upon all concerned when Baby M died in this manner.

FINDING

14. I formally find Baby M died at [redacted] sometime overnight on 26 – 27 May 2019 due to SIDS Category 2.

DISTRIBUTION OF FINDING

15. Pursuant to section 73 (1) (A) of the *Coroners Act 2008* (Vic), I direct that this finding be published on the Coroners Court of Victoria website.

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

- [redacted], Senior Next of Kin;
- [redacted];
- Ms Leng Phang, Managing Principal Solicitor, Legal Services, DHHS; and
- Detective Senior Constable Benjamin Manning, Coroner's Investigator, Victoria Police.

Signature:

PHILLIP BYRNE
CORONER
Date: 8 October 2020