BAC-DM-28423
COR 2022 006477

[redacted]
Coroner's Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Service via email: [redacted]

Dear [redacted]

Investigation into the death of Baby M

Thank you for your email of 30 September 2025, enclosing Coroner Sarah Gebert's finding without inquest into the death of Baby M and the recommendation made to Safer Care Victoria.

Safer Care Victoria acknowledges the tragic death of Baby M and accepts in principal Coroner Gebert's recommendation:

"*That Safer Care Victoria consider requiring Victorian health services to ensure that staff who attend deliveries undertake neonatal resuscitation training and that this training include high-fidelity simulation training*".

Safer Care Victoria is not a regulator and has no authority to mandate training to health services. However, in the interim, given the critical nature of this training and the concerns highlighted by the coroner, Safer Care Victoria considers it essential to issue an advisory alert to health services and will proceed accordingly. We will consult with the Department of Health to find a more appropriate pathway to ensure this is considered as a requirement of all health services that birth women.

Should you have any queries relating to this response, please contact Meri Talevski, Senior Project Officer for Coronial matters, Safer Care Victoria via [redacted]

Yours sincerely

Ms Louise McKinlay
Chief Executive Officer
Safer Care Victoria
Date: 18/12 /2025