IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 007018

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF BABY A

Findings of:	Coroner Catherine Fitzgerald
Delivered On:	27 February 2023
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Date:	7 February 2023
Assisting the Coroner:	Jess Syrjanen
Lawyer for Department of Families Fairness and Housing	Cassandra Nolan

INTRODUCTION

1. On 26 December 2020, Baby A was six weeks old when he passed away at Ballarat Base Hospital. At the time of his death, Baby A lived with his Mother and older Sister at Redan, Victoria. The Mother had an older son, from a previous relationship. Baby A's Father had two older children from a previous relationship.

2. In September 2020, prior to Baby A's birth, the (then) Department of Health and Human Services (**DHHS**) was notified of concerns for the Sister's wellbeing and safety in the care of her Mother. It was reported that the Father was allegedly perpetrating family violence towards the Mother, in the presence of the Sister. It was also reported that the Father was residing at the Mother's address, in contravention of previous directions by DHHS, and, at times, the Sister was left alone in his care.

3. An Interim Accommodation Order (**IAO**) was put in place to protect the Sister. When Baby A was born, DHHS applied for and were granted an IAO in relation to Baby A on the day he was born. The conditions of the IAO required Baby A and his Sister to reside with their Mother. Another condition of the order was that their Father was not to reside with or have any contact with either child, other than in accordance with court-ordered contact once per week, amongst other conditions[1]. Both IAOs were in place at the time of Baby A's passing.

4. Baby A was born premature and underweight via emergency caesarean section. He was admitted to the special care nursery for two weeks after he was born to support his feeding and increase his weight[2], after which time he was taken home by his mother.

THE CORONIAL INVESTIGATION

5. Baby A's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes. An inquest was mandatory in this case, as Baby A was subject to an IAO by DHHS and was therefore "*a person placed in custody or care*[3]" pursuant to the Act.

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1 Coronial Brief (**CB**), Protection Application, 182.
2 CB, Statement of the Mother, 40.
3 Section 4(2)(c) *Coroners Act 2008* (Vic).

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Baby A's death. The Coroner's Investigator conducted inquiries on the Coroner's behalf and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Baby A including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[4]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

10. On 24 December 2020, the Father stayed at the Mother's house overnight with Baby A and the Sister, in contravention of the IAO. The next morning, Christmas Day, the family remained together. They had Christmas lunch at home, with two of the Mother's friends also in attendance[5].

11. The family then attended the Paternal Grandmother's house in Wendouree for Christmas dinner. They arrived at about 7.30pm and returned home at about 11.00pm, according to the Mother[6].

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[4] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[5] CB, Statement of the Father, 49.

[6] CB, Statement of the Mother, 42.

According to the Father, they arrived home between 9.30pm and 10.00pm[7]. The discrepancy as to times is not relevant.

12. When the parents arrived home, the Mother changed the Sister's nappy, and put her to sleep in her cot. The Father changed Baby A and put him to sleep in his basinet in the master bedroom, next to the Mother's bed. He was dressed in an orange jumpsuit and was wrapped in a muslin wrap, with a blanket placed over him[8].

13. Between 11.00pm and 12.00am, the Mother's sister contacted the Mother as she was in hospital and wanted some cigarettes. The Father went to the hospital to drop off cigarettes, while the Mother stayed home, tidied the house and made some bottles for Baby A to have during the night. The Father returned home between 1.00am and 2.00am and fed a bottle of formula to Baby A, before putting him down to sleep in his bassinet. The Father then went to sleep next to the Mother in her bed[9].

14. At about 6.00am, Baby A woke up and the Mother fed him a bottle and changed his nappy. She recalled that he nearly finished the bottle, only leaving around 10mL, before she put him back to sleep in his bassinet[10].

15. According to the Father, the Sister woke up crying at about 8.00am[11], although according to the Mother, this occurred at about 8.45am[12]. The Father attended to the Sister, took her from her cot and placed her in her high chair, so that she could have some breakfast. While the Sister was eating, Baby A woke up and the Mother called out to the Father to heat up a bottle of formula[13].

16. The Mother fed Baby A, while the Father changed the Sister and put her back in her cot to sleep. When Baby A finished his bottle, the Mother placed two L-shaped pillows in the centre of her bed, in opposing positions. The pillows touched in the middle, and the Mother placed Baby A on top of the pillows, on his back. Baby A was still wrapped in his muslin wrap, and the Mother stated that no other blankets or sheets were placed near him. The Mother went to sleep on one side of the

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[7] CB, Statement of the Father, 49.
[8] CB, Statement of the Mother, 42.
[9] Ibid, 43.
[10] Ibid.
[11] CB, Statement of the Father, 50.
[12] CB, Statement of the Mother, 43.
[13] Ibid.

pillows, while the Father went to sleep on the other side. The Mother stated that neither of them were touching Baby A as the placement of the pillows prevented that from occurring[14].

17. Just before 11.00am, the Mother woke up to use the bathroom. As she stood up, she noted that Baby A "*didn't look right*[15]". He was still in the same position as he was when the Mother put him to sleep earlier, and she noted that there were no blankets or sheets around his face. The Mother woke up the Father and informed him that she thought something was wrong. She listened to Baby A's chest and could not hear or feel him breathing[16].

18. The Father called 000 on his phone at 10.57am and passed the phone to the Mother. She informed the 000 call-taker that Baby A was not breathing and she was instructed to place him on a hard surface and commence cardiopulmonary resuscitation (**CPR**). The Mother moved Baby A to the living room and placed him on the floor to perform CPR. While performing CPR, the Mother noticed some dry blood in Baby A's right nostril. The 000 call-taker directed the Mother to open Baby A's mouth and give him oxygen, however the Mother stated that Baby A's mouth was "*dry and stuck closed*[17]".

19. The Mother and Father then heard ambulance sirens approaching their house. The Father said, "*I'm not supposed to be here*[18]". He unlocked the front door for the paramedics and walked into the backyard. The Father called the Paternal Grandmother and informed her of what had occurred, before jumping over the back fence and leaving the property[19].

20. Fire Rescue Victoria (**FRV**) arrived at the house at about 11.04am, followed closely by Ambulance Victoria (**AV**). FRV and AV members took over performing CPR from the Mother. Upon their initial assessment, Baby A was found to be in cardiac arrest[20]. Paramedics intubated Baby A and administered multiple rounds of adrenaline, without success. At some point during this time, the Maternal Grandmother (**MGM**) also arrived at the property.

21. Paramedics conveyed Baby A via ambulance to Ballarat Base Hospital (**BBH**), leaving at about 11.26am. The Mother and MGM were transported via a second ambulance to BBH. Baby A arrived at BBH at about 11.32am, where resuscitation efforts were continued. Baby A was noted to be pale

[14] Ibid.
[15] CB, Statement of the Mother, 44.
[16] Ibid.
[17] Ibid.
[18] CB, Statement of the Father, 51-52.
[19] CB, Statement of the Father, 52.
[20] CB, Ambulance Victoria Patient Care Record, 143.

and unresponsive, his pupils were fixed and dilated, and no spontaneous breathing effort was observed[21]. Clinicians spoke with the Mother and MGM and advised that Baby A's chance of survival was poor, and recommended comfort care. The Mother and MGM agreed with the proposal and active care was withdrawn. Baby A passed away peacefully at 12.05pm.

22. At about 3.40pm that day, Victoria Police members arrived at the Mother's house to speak with her and photograph her bedroom[22]. They also attempted to obtain a statement from the mother regarding the events of that morning and complete the "Sleep-Related Sudden Unexpected Death of an Infant or Child" checklist, however the Mother was too distraught to complete either. The checklist was completed on 28 December 2020 and a statement was obtained from the Mother on 5 January 2021. The SIDS checklist recorded that the Mother stated Baby A's mouth was stiff and wouldn't open easily, as though it was "glued together" .

Identity of the deceased

23. On 26 December 2020, Baby A, born 13 November 2020, was visually identified by his Mother[23].

24. Identity is not in dispute and requires no further investigation.

Medical cause of death

25. Following the initial report of this death, the case was presented to Coroner Philip Byrne by Forensic Pathologist, Professor Noel Woodford. An autopsy was recommended by Professor Woodford. Coroner Byrne directed that an autopsy be performed on Baby A. However, the Mother submitted a request for reconsideration of the direction as she strongly objected to an autopsy. Coroner Byrne then revoked the direction to perform an autopsy[24].

26. Detective Senior Constable (**DSC**) Kieran Mullett, of the Ballarat Sexual Offences and Child Abuse Investigation Team (**SOCIT**), then submitted a Form 27 – Request for Autopsy on 5 January 2021[25]. DSC Mullett provided reasons in support of the performance of an immediate autopsy. In summary, DSC Mullett stated that an autopsy was necessary to determine whether Baby A's death was the result of a natural medical event, an accident, or a deliberate act.

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[21] CB, Ballarat Base Hospital records, 174.
[22] CB, Statement of Detective Senior Constable Sheree Boyle, 70.
[23] CB, Statement of Identification, 7.
[24] CB, Email from the Mother to CCoV dated 30 December 2020, 133-134.
[25] CB, Requests for immediate autopsy to be performed upon Baby A, 126-132.

27. The Mother objected to this application[26] and Coroner Byrne subsequently refused DSC Mullett's application for an autopsy.

28. Professor Woodford provided a written report of his findings based on an external examination of the body and other information known to him.

29. The post-mortem examination did not reveal any evident injuries to the body. The reported findings were consistent with the clinical history[27].

30. Examination of a full post-mortem CT scan and radiographic skeletal survey by Dr Padma Rao (Consultant Paediatric Radiologist) indicated there was subtle buckling of the inner cortex of the ribs consistent with resuscitation fractures. No further evidence of unexpected skeletal trauma was identified. A high-density focus within the left renal collecting system could possibly represent a calculus[28].

31. Toxicological analysis of post-mortem blood samples did not identify the presence of alcohol or any commonly encountered drugs or poisons[29]. However, toxicological analysis of post-mortem hair samples identified the presence of 3,4-methylenedioxy-N-methylamphetamine (**MDMA**)[30], methylamphetamine and its metabolite amphetamine[31], delta-9-tetrahydrocannabinol[32], and tramadol[33], but did not identify the presence of alcohol or any other commonly encountered drugs or poisons[34].

32. Toxicological testing of hair provides a historical drug profile after chronic use or a single exposure. Drugs can be incorporated in hair from consumption or external exposure to drugs (or both).

33. Professor Woodford provided an opinion that the medical cause of death was "*1(a) Unascertained*"[35].

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[26] CB, Email from the Mother to CCoV dated 6 January 2021, 135.
[27] CB, Medical Examiner's Report (**MER**) by Professor Noel Woodford, 15.
[28] Ibid.
[29] CB, Victorian Institute of Forensic Medicine (**VIFM**) Toxicology Report, 16.
[30] Methylenedioxymethamphetamine (**MDMA**) is a designer amphetamine also known as ecstasy, XTC.
[31] Methamphetamine is a strong stimulant drug that acts like the neurotransmitter noradrenaline and the hormone adrenaline.
[32] Delta-9-tetrahydrocannabinol (**THC**) is the active form of cannabis (marijuana).
[33] Tramadol is a synthetic opioid analgesic indicated for moderate pain.
[34] CB, VIFM Toxicology Report, 16.
[35] CB, Medical Examiner's Report (**MER**) by Professor Noel Woodford, 15.

34. I accept Professor Woodford's opinion.

Investigations and conclusions regarding certain facts

35. Victoria Police investigated Baby A's death and collected statements from his parents, the attending FRV members and paramedics, as well as from neighbours who lived near the Mother. During interviews with police, the Father explained the reason he left the Mother's property prior to paramedics arriving. The Father stated that he knew the IAOs were in existence for Baby A and the Sister and that he was not permitted to be at the Mother's house, and left the house for that reason. Police identified some inconsistencies in the accounts provided by the Mother and the Father, but did not identify any other suspicious circumstances or signs of third-party intervention in connection with Baby A's death.

36. Further advice was sought from Professor Woodford in relation to the cause of death and the medical investigations. Professor Woodford explained that certain avenues of investigation were lost in the absence of an autopsy. For example, an autopsy can reveal subtle signs of trauma such as deep bruising. Organ histology can exclude potentially significant lung, heart, or brain inflammation, and microbiological sampling can be performed on the middle ears and lungs.

37. However, Professor Woodford also noted that in SIDS-type cases, a full autopsy may not provide any additional information to further clarify the cause of death. There are also causes of death with little or nothing in the way of significant findings at autopsy including accidental or deliberate obstruction of the airways, primary cardiac rhythm disturbance and seizures. Meaning an autopsy may, or may not, discern evidence of homicide, accident or natural disease. I note that Professor Woodford believed there were no findings in the post-mortem examinations which were conducted which raised concerns regarding non-accidental death.

38. Baby A did have some risk factors for Sudden Infant Death Syndrome (**SIDS**). Notably, Baby A was sleeping on an adult mattress, with soft objects (the L-shaped pillows) and was sleeping near adult blankets and other loose bedding and was co-sleeping next to his parents. He was also exposed to cigarette smoke in utero and in the environment after birth. He was born premature and underweight, both of which are SIDS risk factors. However, in the absence of an autopsy the death cannot be attributed to SIDS.

39. Additional enquires were also made with Professor Woodford regarding the observations made about the inability to open Baby A's mouth when the Mother attempted to perform CPR, and what

that may indicate about the time of death, noting that paramedics did not observe rigor when they assessed and treated Baby A, and the parents reported last seeing Baby A alive approximately two hours before he was found non-responsive. Professor Woodford opined that it was "possible for discernible rigor affecting the jaw to be observed at 2 hours after death. Of note, warm or hot environments can accelerate the onset of rigor." He noted that "it is also possible that dried secretions sticking the lips together might be perceived as rigor. Or that rigor, broken by the mother in an attempt to open the mouth was not subsequently observable by ambulance personnel (who note that no rigor was present- but it's not at all clear to how this was assessed)." It is therefore not possible to determine exactly when Baby A died, but the evidence is consistent with the death having occurred in the timeframe described by his parents.

40. Regarding the presence of dried blood around the nostril of Baby A, Professor Woodford explained that "[b]lood-stained secretions are not uncommonly seen in the setting of sudden infant deaths and probably represent pulmonary congestion and oedema in the setting of terminal heart failure/agonal respirations." In the context of this case, the observed dried blood is therefore inconsequential.

41. The evidence of the post-mortem toxicology testing (which shows exposure to numerous illicit drugs) is an alarming finding in a six-week-old baby. However, there is no evidence that this exposure caused or contributed to the death.

42. Ultimately, I am satisfied that there are no other avenues of investigation open to further elucidate the cause of death, and the cause of death remains as "*Unascertained.*"

FINDINGS AND CONCLUSION

43. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Baby A, born 13 November 2020;

    b) the death occurred on 26 December 2020 at Ballarat Health Services, Ballarat Base Hospital, 1 Drummond Street North, Ballarat, Victoria, 3350, from unascertained causes; and

    c) the death occurred in the circumstances described above.

Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I convey my sincere condolences to the parents and family of Baby A.

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

The Mother, Senior Next of Kin

The Father, Senior Next of Kin

Secretary, Department of Families, Fairness, and Housing

Commissioner for Children and Young People

Detective Senior Constable Kieran Mullett, Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

Date: 27 February 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.