IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 002599

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Baby F
Date of birth:	11 September 2021
Date of death:	14 May 2022
Cause of death:	1(a) Unascertained
Place of death:	Mildura, Victoria, 3500
Keywords:	Infant death; co-sleeping; unascertained cause of death

INTRODUCTION

1. On 14 May 2022, Baby F was 8 months old when she was found deceased while sleeping with her mother. At the time of her death, Baby F lived in Mildura with her parents, grandmother and older sister.

2. Baby F was born premature at 34.5 weeks gestation via normal vaginal delivery and remained at Mildura Base Hospital for three weeks. Baby F was diagnosed with hypothyroidism for which she was treated with thyroxine. She was otherwise a happy and healthy baby. Her mother, Ms H, had a history of hyperthyroidism.

3. A month or two prior to Baby F's death, her father and grandmother tested positive for Covid-19 and isolated within the home. Baby F did not test positive but did have a cough.

4. Baby F usually slept on a fold out couch with her mother and sister in the dining area of their home. The household was described as a 'happy one'.

THE CORONIAL INVESTIGATION

5. Baby F'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.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding 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. This finding draws on the totality of the coronial investigation into the death of Baby F 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.[1]

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

Circumstances in which the death occurred

9. The day before Baby F's death she had a larger appetite than usual and consumed more formula. She had a runny nose and cough for which she took 3ml of ibuprofen.
10. At 7am on 14 May 2022, Ms H fed Baby F 60ml of formula and burped her as usual. As Baby F had difficulty sleeping unless she was being held, Ms H lay on the fold out couch with her. Baby F was laying on her side in the crook of Ms H's right arm, under a doona.
11. Ms H woke up at 9:30am and noticed Baby F was not awake. Her head flopped back, and her lips were blue.
12. Ms H called for her husband, Mr H, who called emergency services and commenced cardiopulmonary resuscitation (**CPR**) on the instruction of the call-taker. Paramedics arrived shortly thereafter but tragically Baby F was unable to be revived.

Identity of the deceased

13. On 14 May 2022, Baby F, born 11 September 2021, was visually identified by her father, Mr H, who completed a Statement of Identification.

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

Medical cause of death

15. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on the body of Baby F on 16 May 2022 and provided a written report of her findings dated 30 May 2022. Dr Zhou considered the following materials:

    a) Victoria Police Report of Death (Form 83);

    b) Sudden unexplained death in infancy checklist;

[1] 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.

c) Department of Health and Human Services response to notification of child death;

d) Scene photographs;

e) Post mortem computed tomography (**CT**) scan;

f) Royal Children's Hospital skeletal survey and whole-body CT scan report;

g) Royal Children's Hospital Laboratory Services procalcitonin report;

h) Victorian Infectious Diseases Reference Laboratory COVID-19 report;

i) Melbourne Health Pathology CRP and vitreous biochemistry reports; and

j) VIFM toxicology report.

16. Dr Zhou recommended an autopsy but Baby F 's parents expressed a preference that one not be performed. Dr Zhou noted that in the absence of an autopsy, the cause of death as well as the presence of any potential natural disease processes that may have relevance to Baby F's family are unable to be elucidated.

17. The post mortem examination revealed no significant external injuries. The pattern of post-mortem lividity indicates that the child was lying slightly face down on her right side. The CT scan showed no evidence of acute or remote skeletal trauma.

18. Toxicological analysis of post mortem blood and hair samples did not identify the presence of any alcohol or any commons drugs or poisons.

19. Dr Zhou commented that at the time of her death, Baby F was co-sleeping with her mother on a couch and was located in the crook of her mother's right arm. This sleeping position raises the possibility of mechanical asphyxia, although this is unable to be established without a full post mortem examination and the exclusion of other possible competing causes of death. Co-sleeping is potentially hazardous due to a body size discrepancy and the inability of an infant to extricate themselves from a position of respiratory compromise.

20. Dr Zhou provided an opinion that the medical cause of death was 1 (a) UNASCERTAINED.

CORONERS PREVENTION UNIT REVIEW

1. At my request, the Coroners Prevention Unit (**CPU**)[2] provided me with a summary of deaths involving co-sleeping between 2008 and 2023.[3] The CPU defined a co-sleeping death as *the non-intentional death of an infant which occurred while the infant was sharing a sleep surface (a bed, couch, mattress, blanket, armchair or so on) with another person or people and/or pets.*

2. The CPU identified 163 Victorian co-sleeping deaths of infants between 2008 and 2023[4], with a great fluctuation in numbers from year to year. 77.8 percent (n=127) of the deaths occurred while the infant was sleeping with an adult or adults in an adult bed. 9 deaths occurred in infants aged 181 to 270 days, including Baby F.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. I acknowledge that co-sleeping is common in many cultures and can have significant wellbeing benefits for both parents and baby. Co-sleeping is a personal choice and I do not intend to criticise that choice, however it would be remiss of me not to note with emphasis that sharing a sleeping surface with an infant carries inherent risks, including the risk of sudden unexpected death in infancy.

2. Victorian Coroners have investigated numerous co-sleeping deaths and made pertinent recommendations. Coroner Spanos, in her *Form 37 Finding into Death with Inquest*[5] in the matter of Baby Isabella Rose, stated:

   A number of coronial findings contain comments and recommendations aimed at reducing the number of preventable deaths of infants, and essentially reiterating safe sleeping practices and SIDS awareness for infants and young babies. An important finding in this area is that of

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[3] Coroners Prevention Unit issues brief: Deaths of Victorian infants in a co-sleeping context, updated 5 September 2023.

[4] Between 1 January 2008 and 31 July 2023.

[5] https://www.coronerscourt.vic.gov.au/sites/default/files/2018-12/babyisabellarose_373113.pdf

my colleague Coroner John Olle in the matter of Baby J (2010 2580) which was a cluster investigation of four infant deaths.

The known risk factors for SIDS noted in that finding, based on international research, relevantly include sleeping with an adult other than the mother, maternal exhaustion, alcohol or drug use (whether recreational or prescription) by the adult caregiver sharing the sleeping surface, thermal regulation and ventilatory control (such as a warm environment) and infection suffered by the infant.

3. It is reassuring to note that several initiatives and educational materials have stemmed from coronial recommendations regarding co-sleeping. For example, in July 2021, Safer Care Victoria released their infant safe sleeping clinical guidance[6], aimed at assisting maternal and neonatal health care providers to provide consistent advice to parents and caregivers and to model safe sleeping practices within their health service.[7]

4. I hope that Baby F's untimely passing serves as a reminder, albeit a tragic one, of the potential consequences of co-sleeping, and reinforces the importance of promoting the inherent risks of co-sleeping in order to prevent similar deaths from occurring in the future.

5. Finally, I wish to note that the circumstances of Baby F's death are not the fault of her parents, who loved her very much. This tragic outcome is all too common; Baby F is one of many infants who have passed away in similar circumstances, while co-sleeping with adults.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Baby F, born 11 September 2021;

   b) the death occurred on 14 May 2022 in Mildura, Victoria, 3500;

[6] https://www.safercare.vic.gov.au/sites/default/files/2021-06/Clinical%20guidance_Infant%20safe%20sleeping.pdf

[7] The clinical guidance states that the safest place for an infant to sleep is in their own cot, in the same room as the parent/adult caregiver until at least six months of age (preferably 12 months). It advises clinicians to advise parents of the risk of co-sleeping for all infants under three months of age, and to warn parents of the significantly increased of co-sleeping if the parents smoke, drink alcohol or take drugs.

c) I accept and adopt the medical cause of death as ascribed by Dr Chong Zhou and I find that Baby F died from unascertained causes, in circumstances where she was sharing a sleeping surface with her mother.

I convey my sincere condolences to Baby F's family for their loss.

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

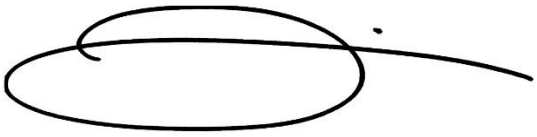
I direct that a copy of this finding be provided to the following:

Mr and Ms H, Senior Next of Kin

Commission for Children and Young People

Sergeant Jamin Middleton, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 6 March 2024

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 investigation. 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.