



**STATE CORONER'S COURT
OF NEW SOUTH WALES**

Inquest:	Inquest into the deaths of Kayla Ewin and Iziah O'Sullivan
Hearing dates:	2 September 2019 – 4 September 2019
Date of findings:	29 November 2019
Place of findings:	State Coroners Court, Lidcombe
Findings of:	State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – cause and manner of death – investigation and management of sudden unexpected death in infancy (SUDI) deaths in NSW – recommendations as to the adequacy of the policy and procedures of the relevant agencies in responding to SUDI deaths in NSW
File number:	Kayla - 2012/398593 Iziah - 2014/221198

<p>Representation:</p>	<p>(1) Counsel Assisting</p> <p>Ms Kate Richardson SC and Ms Tracey Stevens of counsel, instructed by Ms Clara Potocki of the NSW Crown Solicitor’s Office</p> <p>(2) NSW Commissioner of Police</p> <p>Ms Danielle New of counsel, instructed by Ms Emma O’Brien of New South Police Force, Office of General Counsel</p> <p>(3) NSW Ministry of Health and NSW Health Pathology</p> <p>Mr Stuart Kettle of counsel, instructed by Ms Rosslyn Cooke of Hicksons Lawyers</p> <p>(4) Ambulance Service of NSW</p> <p>Ms Kathleen Crilly, NSW Ambulance Service</p>
<p>Findings for Kayla:</p>	<p>Identity of deceased: The deceased person was Kayla Ewin.</p> <p>Date of death: Kayla died on 23 December 2012.</p> <p>Place of death: Kayla died at her home in Nowra, NSW.</p> <p>Cause of Death: Unascertained (SUDI 0+)</p> <p>Manner of death: Sudden Unexpected Death in Infancy (SUDI) within the category SUDI 0+.</p>

Findings for Iziah:	Identity of deceased: The deceased person was Iziah O’Sullivan. Date of death: Iziah died on 26 July 2014. Place of death: Iziah died at his home in Quakers Hill, NSW. Cause of Death: Unascertained (SUDI 0) Manner of death: Sudden Unexpected Death in Infancy (SUDI) within the category of SUDI 0.
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<p>Recommendations:</p>	<p><u>To the Ambulance Service of NSW:</u></p> <ol style="list-style-type: none"> 1. That the Ambulance Service of NSW consider amending its policies to instruct attending paramedics to take the aural temperature of a deceased infant under 12 months (and the time that it was taken) where clinically appropriate. <p><u>To NSW Police:</u></p> <ol style="list-style-type: none"> 2. That NSW Police revise the 'SUDI' section of the Police Handbook to contain an instruction to police officers attending a scene or managing an investigation to assess whether it is preferable to use the term 'coronial scene' rather than 'crime scene' and in doing so, consider the impact of the use of the terminology on the family. 3. That NSW Police Forensic Evidence and Technical Services Branch and the Crime Scene Services Branch use the term 'coronial scene' rather than 'crime scene' in regard to infant deaths determined to be accidental. 4. That NSW Police revise the 'SUDI' section of the Police Handbook to explicitly state that the officer in charge of a SUDI investigation should minimise the police presence at both the scene and the hospital. 5. That NSW Police review its policies and training procedures in order to ensure that guidance is provided to officers in dealing appropriately with a family seeking time to say goodbye to their child in the context of a SUDI death. 6. That NSW Police consider amending the P79A form and the Standard Operating Procedures entitled "Crime Scene Manual (Specialist) – Death Investigation" and SUDI section 2.4.14 to include additional SUDI questions on the matters as set out in paragraph 90 of these Findings.
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To NSW Health Pathology:

7. That NSW Department of Forensic Medicine review its policies to encourage forensic pathologists to routinely request, and then review, crime scene photographs prior to signing off an autopsy report.
8. That the Department of Forensic Medicine review its policies to ensure that the role of the Clinical Nurse Consultant (CNC) includes ensuring that the SUDI medical history form has been received and provided to the case forensic pathologist in a timely manner.

To NSW Ministry of Health:

9. That NSW Ministry of Health review its training policies to determine whether guidance is given to staff in dealing appropriately with a family seeking time to say goodbye to their child in the context of a SUDI death.
10. That NSW Ministry of Health implement their proposed audit of the revised SUDI medical history form over a period of 12 months and evaluate whether the form is being sufficiently completed and whether it is consistently being provided to the Department of Forensic Medicine in a timely manner.
11. That NSW Ministry of Health implement their proposal to monitor the issue of duplication in taking a medical history from the family of a deceased infant over the next 12 months in order to ascertain the most useful and sensitive approach.

To NSW Ministry of Health and NSW Police:

12. That NSW Ministry of Health and NSW Police implement the proposal for an interagency early clinical review meeting to take place within 1 week of every SUDI death in NSW, or as soon as practicable thereafter and no later than 1 month after the death, and evaluate the implementation of this proposal within 12 months from the date of its commencement.

To the State Government of NSW:

13. That the State Government give consideration to the creation of the role of a paediatric clinical nurse consultant (CNC) at the Coronial Case Management Unit (CCMU) trained in SUDI investigations in order to provide centralised support available 24 hours a day to agencies in NSW investigating SUDI and accidental child deaths in NSW.

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The Coroners Act in s. 81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the deaths of Kayla Ewin and Iziah O'Sullivan.

Introduction

1. This inquest concerns the deaths of infants Kayla Ewin and Iziah O'Sullivan.
2. In NSW every year between 40 and 50 infants under the age of 12 months die suddenly and unexpectedly.¹ Kayla Ewin and Iziah O'Sullivan were two such infants, each under the age of 12 months and died unexpectedly in their homes.
3. The role of a Coroner, as set out in s. 81 of the *Coroner's Act 2009* (the Act), is to make findings where possible as to:
 - a. The identity of the deceased person;
 - b. The date and place of the person's death;
 - c. The physical or medical cause of death; and
 - d. The manner of death, in other words, the circumstances surrounding the death.
4. A secondary purpose of an inquest, as set out in s. 82, is to determine whether it is necessary or desirable to make any recommendations in relation to any matter connected with the death. With the support of the Ewin and O'Sullivan families, an inquest was held in order to determine not only the manner and cause of the deaths of Kayla and Iziah, but also to consider any recommendations as to the adequacy of the policy and procedures of the relevant agencies in responding to SUDI deaths in NSW. To this end, NSW Police, NSW Ministry of Health, the Ambulance Service of NSW, and Department of Forensic Medicine have participated in the hearing. These agencies have all participated in the inquest in a positive and collaborative manner. The NSW Police and NSW Ministry of Health have provided constructive submissions that are supportive of the implementation of various recommendations proposed by Counsel Assisting. The Ambulance Service of NSW supported the submissions and recommendations proposed by Counsel Assisting.
5. Numerous experts have also provided evidence to this Court on the management of SUDI in NSW. An expert conclave comprised of Dr Matt O'Meara (Chief Paediatrician, NSW Ministry of Health), Ms Deborah Matha (Director, Maternity Child Youth and Paediatrics, NSW Ministry of Health), Mr Allan Loudfoot (Executive Director Clinical Services, NSW Ambulance), Professor Heather Jeffrey (International Maternal and Child Health, University of Sydney), Detective Superintendent Scott Cook (Head of Homicide, NSW

¹ NSW Health 2019 revised policy, tab 66A at p.1.

Police) and Dr Loraine Du Toit-Prinsloo (Forensic Pathologist, Staff Specialist, NSW Health Pathology, Department of Forensic Medicine). In addition, single experts Professor Noel Woodford and Ms Rebecca Shipstone provided expert reports and gave evidence before the Court. I am very grateful for their assistance in this regard.

6. The evidence before the Court included the current SUDI classification scale utilised in NSW in order to categorise SUDI infant deaths. A copy of the SUDI Classification is **annexed** to these findings.

Kayla Ewin

7. On 30 September 2012 Kayla was born to Terri and Matthew Ewin in Shoalhaven Hospital. She was born naturally and breastfed by Terri from a few days after birth. Terri and Matthew remember Kayla as a gorgeous, sweet little girl with big eyes and curly hair like a little doll. Terri said she had “a sweet Cheshire smile that would crack the hardest heart.”²
8. According to the hospital notes, as at Kayla’s birth and while breastfeeding, Terri was prescribed and was taking antidepressants (in the form of 40 mg a day of fluoxetine and 100 mg a day of olanzapine).³ Terri was taking fluoxetine prior to pregnancy, stopped when she found out she was pregnant with Kayla, and then reduced her dose throughout the pregnancy. She was taking the medication when Kayla was born and up until about four weeks after the birth. In the interview on the day after Kayla’s death Terri said that “I haven’t been on anti-depressants for a couple of months now and we have been doing really well.”⁴
9. At the time of Kayla’s birth, Terri and Matthew had been in a relationship for approximately one year and had married only weeks before Kayla’s death.⁵
10. Terri had two other children, aged 5 and 7 years at the time of Kayla’s death. The family were living in a four bedroom house with friends. All four adults smoked cigarettes outside the house and Terri smoked throughout her pregnancy with Kayla.⁶
11. Terri described Kayla as a ‘great’ baby, though she had some trouble with breastfeeding. She says that Kayla was not putting on enough weight and so she transitioned to bottle feeding with formula around the 8th or 9th of December.⁷
12. On 14 December 2012 (nine days before her death), Kayla was admitted to Shoalhaven Hospital Emergency Department. She was reported as presenting with reduced feeding following a change from breast-feeding to

² Transcript, Day 3, Terri Ewin, p.11.

³ Shoalhaven Memorial Hospital Clinical Records, Kayla Ewin, tab 28 at pp.275-276.

⁴ Interview with Terri Ewin, tab 18 at pp.110-111.

⁵ Interview with Matthew Ewin, tab 19, p.184.

⁶ Interview with Terri Ewin, tab 18, p.146.

⁷ Interview with Terri Ewin, tab 18, p.114.

bottle feeding; with a temperature; restlessness and crying. On examination Kayla's vital signs were within the normal range and she was afebrile. Kayla was assessed as well and happy and discharged on advice to recommence feeding.⁸

13. In the week preceding her death, Kayla routinely slept in a cradle in Terri and Matthew's bedroom from around 7pm-8pm; would wake most nights around 1am – 2am and fed and changed, and then would wake again at around 4am or 5am.⁹ When Matthew would get up to attend to Kayla in the night he would often feed her in the lounge room and then put her back to sleep in a bassinet in the spare room. She slept routinely in a nappy and wrap or a 'woombie' (a zipped baby sleeping bag).¹⁰ The 'woombie' was described by Terri as a body-sized sleeping bag without sleeve holes or arm lengths, with a zipper opening from the top down that Kayla slept in and felt secure.¹¹
14. At around 8.30pm on the evening prior to her death, Saturday 22 December 2012, Kayla appeared to be feeding normally. She was put to bed in her cradle in the main bedroom.¹²
15. At around 2:30am on Sunday 23 December 2012 Kayla woke up and was restless. She was bottle fed and changed by Terri and put back to bed in her cradle in the main bedroom at around 3am. She remained restless until about 4.30am.¹³
16. At around 4.30am Terri woke up Matthew so she could return to sleep. Kayla was wearing a nappy and her Woombie.¹⁴ Matthew took Kayla out of the main bedroom. Matthew changed her on the lounge.¹⁵ Matthew then fed Kayla in the spare room and attempted to settle her.¹⁶ Matthew noticed that Kayla's head was sweaty when he picked her up.¹⁷ Matthew dressed her in her Woombie and placed her on her back in her portable carrier. I accept the evidence of Matthew and Terri that that the portable carrier was made out of a soft cotton material and was pliable and had a foam mattress and a hood that could be folded over.
17. I also accept Matthew's evidence that the fabric cover on the bassinette was unzipped and folded back so as to not cover Kayla in any way on the night she died. He put Kayla to bed at around 5.30am in the portable carrier on her back with her head at the end of the carrier (where the hood was located).¹⁸

⁸ Expert certificate of Dr Stuart Clarke, Shoalhaven Memorial Hospital, tab 22, p.240; and Shoalhaven Memorial Hospital Clinical Notes, Kayla Ewin, tab 28, pp. 264-266; and interview with Terri Ewin, tab 18, p.129.

⁹ Interview with Terri Ewin, tab 18, pp.117-118.

¹⁰ Interview with Terri Ewin, tab 18, p.136.

¹¹ Transcript, Day 1, Terri Ewin, p.14.

¹² Interview with Matthew Ewin, tab 19, p.202.

¹³ Interview with Terri Ewin, tab 18, pp.155-156.

¹⁴ Interview with Matthew Evans, tab 19, p.205.

¹⁵ Interview with Matthew Evans, tab 19, p.206.

¹⁶ Interview with Matthew Ewin, tab 19, p.206.

¹⁷ Interview with Matthew Ewin, tab 19, p.207.

¹⁸ Transcript, Day 1, Matthew Ewin, p.21.

18. I accept the meteorological evidence before the Court that between the early hours of the morning and 9.30am the temperature in Nowra ranged from 18 – 25 degrees.¹⁹
19. Sometime after 9:30am, Matthew checked on Kayla and found her on her back in the bassinet, with her eyes slightly open, pale in colour and not breathing.²⁰ At this time Kayla looked bloated with her hair sweaty and her body quite warm.²¹ I accept Matthew's evidence that he picked Kayla up and she was damp and not breathing. I also accept that when Terri was alerted to Kayla's condition, she saw that Kayla's lips and eyes had lost their colour and she did not have her normal pink skin tone.²²
20. At 9.48am Matthew called emergency services and attempted resuscitation.²³
21. At 9.56am an ambulance attended the house. Ambulance Officer Egan assessed Kayla to be "very hot to touch. Her hair was wet around the back of her head ... The skin on the baby's torso was clammy to touch."²⁴ Officer Egan, when inspecting the bassinet, could see what appeared to be wetness on the bassinet mattress material. He did not know whether the wetness was from spilt milk from the bottle or possibly from vomit or mucus from the baby's mouth.²⁵ Officer Egan observed that the room: "was warm with a stuffy feel to it... I noticed a north facing window in the room but I am not sure if it was open or shut. I formed my opinion that the baby may have suffered heatstroke or some sort of heat related stress which resulted in the death."²⁶ Officer Egan formed the view, which I accept, that Kayla had been deceased for approximately half an hour.²⁷
22. At approximately 10am police (Senior Constable Jason Klein²⁸ and Sergeant Andrew Drane) were informed of a death of a baby and attended the house at 15 Ernest Street Nowra.²⁹
23. At 10.30am Senior Constable Vicki Ferraris and Senior Constable Granado attended the house and spoke with ambulance officers and the family. They obtained permission from Kayla's parents to enter the house and a crime scene was established.³⁰ Senior Constable Ferraris noticed the home was cluttered but not dirty and the air was heavy. The spare room where Kayla

¹⁹ Bureau of Meteorology Data, tab 16.

²⁰ Interview with Matthew Ewin, tab 19, p.211.

²¹ Interview with Matthew Ewin, tab 19, pp.217-18.

²² Transcript, Day 1, Terri Ewin, p.16.

²³ Ambulance Electronic Medical Record, tab 25, p.248.

²⁴ Statement of Jeffrey Egan, tab 24, [11].

²⁵ Statement of Jeffrey Egan, tab 24, [12].

²⁶ Statement of Jeffrey Egan, tab 24, [16].

²⁷ Statement of Jeffrey Egan, tab 24.

²⁸ As he then was. He is now Detective Senior Constable Klein and is the officer in charge of the coronial investigation.

²⁹ Statement of Senior Constable Jason Klein, tab 7, p.52 at [5] and crime scene log at tab 10, p.77.

³⁰ Statement of Senior Constable Vicki Ferraris, tab 9, p.75 at [5].

had been sleeping was airless and unventilated and the room was warmer than the rest of the house.³¹

24. At 10.40am Senior Constable Klein and Sergeant Drane attended the house and spoke with the ambulance officers and Matthew and Terri. Senior Constable Klein observed that the room in which Kayla was sleeping was congested and messy. Kayla was situated in her portable carrier in a nappy. She had very pale skin and her hair was sweaty, with some frothy bubbles around her mouth.³²
25. Investigating police spoke with Matthew and Terri at their house where Terri was understandably very distressed, in shock and not able to speak when asked questions. Investigating police decided, quite properly, to remove Kayla and take her to Shoalhaven Hospital. Terri and Matthew travelled with the police and Kayla in the ambulance.³³ Senior Constable Klein explained in oral evidence that: “we made the decision to take the body to Shoalhaven Hospital, and the reason was I think our crime scene officer had to travel from Wollongong on that particular day and that would have been – we were given the estimated time of about two hours. That’s a long time to leave a baby at the scene with mum and dad in a grieving state. So we took our initial photos and then made the decision to, to take the baby in the ambulance to the hospital where the crime scene officer could examine the baby in due course as well as examine the scene.”³⁴
26. On arrival at the hospital, Senior Constable Klein placed Kayla in a cradle in a quiet room in the Emergency Department. Matthew and Terri were directed to social workers and later spent time with Kayla in the room. A religious support person attended the hospital and spent time and said prayers with Kayla and her parents.³⁵
27. At 12pm Kayla was declared deceased at Shoalhaven District Memorial Hospital.³⁶ Matthew formally identified Kayla to Senior Constable Klein and he completed the identification statement.³⁷
28. Unfortunately, there is no record of the completion of any SUDI Medical History Form at the hospital. This is contrary to the requirement of the NSW Health Policy Directive PD 2008-70 at tab 65).
29. Kayla’s parents remained at the hospital for some hours and upon leaving, Senior Constable Klein took Kayla to the mortuary, where police undertook a forensic examination including taking photographs. Kayla was then conveyed to the Glebe morgue.³⁸

³¹ Second statement of Senior Constable Vicki Ferraris, tab 9A, at [7].

³² Statement of Senior Constable Jason Klein, tab 7, p.53 at [8].

³³ Statement of Senior Constable Jason Klein, tab 7, p.54 at [11-13].

³⁴ Transcript, Day 1, Detective Senior Constable Klein, p.11.

³⁵ Statement of Senior Constable Jason Klein, tab 7, p.55 at [15].

³⁶ Life Extinct Form, tab 2, p.10.

³⁷ Identification statement, tab 3, p.11.

³⁸ Statement of Senior Constable Jason Klein, tab 7, p.55 at [16].

30. At 5.50pm an entry was made by the hospital social worker in the clinical notes for Kayla, indicating that Terri and Matthew had a number of supportive family members attend the hospital during the day. The social worker commented that the parents: “were not in a place to discuss anything past the ‘now’ so I gave the father and the mother papers” to consider when appropriate. It is not clear what ‘papers’ were provided to the family, though it is likely these related to further available support and information. The social worker further commented that “I will also ring them in a few days and if appropriate arrange to see them next weekend.”³⁹
31. Senior Constable Klein completed a report of death to the Coroner on a Form P79A.⁴⁰ In evidence Senior Constable Klein explained that it was routine procedure for this form to be completed as soon as possible and before any further and formal statements are taken by family and witnesses.⁴¹

The expert evidence in relation to Kayla’s death

32. An autopsy was performed by forensic pathologist Dr Rebecca Irvine and Kayla’s cause of death was unascertained.⁴²
33. Dr Irvine concluded that the total body post-mortem x-rays revealed no deformity or acute or chronic injury (though the x-rays were not reviewed by a paediatric radiologist).⁴³
34. Dr Irvine was initially of the opinion that Kayla may have died of hyperthermia due to environmental heat exposure (where she likely had an inborn error of metabolism). However, following Kayla’s death further screening was undertaken for the metabolism disorder (Isovaleric Acideamia (IV)) and Dr Carolyn Ellaway, Senior Staff Specialist at the Genetic Metabolic Disorders Service at the Sydney Children’s Hospital Network, confirmed that Kayla did not have mutations of the relevant gene and did not present with the clinical features of a baby with this disorder. Accordingly, I do find that Kayla suffered from this disorder and there is an insufficient basis for any finding of hyperthermia.
35. Dr Irvine is of the opinion, which I accept, that Kayla’s death should be classified as SUDI 0+.⁴⁴ She commented that: “The scene investigation was not sufficient, not only because it did not meet current standards of infant death investigation in general, but because a potentially unsafe environment (hot room), a major extrinsic risk factor, was recognised but was not objectively documented. The only other risk factor that I can identify is smoking in the household (extrinsic risk factor). Although the SUDI 3 category mentions overdressing, which is also a potential significant factor in this case,

³⁹ Shoalhaven Memorial Hospital Clinical Records, Kayla Ewin, tab 28 at pp.258-259.

⁴⁰ P79A, tab 1 at p.1.

⁴¹ Transcript, Day 1, Detective Senior Constable Klein, p. 9.

⁴² Addendum Autopsy report, tab 4, p.12.

⁴³ Addendum Autopsy report, tab 4, p.14.

⁴⁴ Supplementary report of Dr Irvine, tab 4A, p.3 of report. For a description of the various SUDI classifications (including “SUDI 0+”) see tab 66 p.2 (vol 3).

the unsafe (modifiable) factors in this category relate to asphyxia and suffocation.”⁴⁵

36. Professor Woodford gave written and oral evidence at the inquest and agreed that Kayla’s death should be classified as SUDI 0+.⁴⁶

Iziah O’Sullivan

37. On 30 June 2014, Iziah O’Sullivan was born to Thomas O’Sullivan and Maddison Wadsworth in Blacktown hospital. He was a natural birth.⁴⁷ Maddison suffered from premature contractions and was admitted to hospital on numerous occasions in the weeks leading up to the birth.⁴⁸
38. At the time of his birth, Thomas and Maddison had been together for approximately one year. On return from the hospital Iziah slept in a bassinet next to his parents’ bed. Iziah was breast fed for approximately one week and was then transitioned to formula. Iziah’s family remember Iziah as a beautiful boy. His paternal grandfather Robert told the Court that “Tom and Maddison were the best parents.”⁴⁹
39. In the weeks prior to Iziah’s death, he would routinely wake at around 8am and would be fed and changed every few hours throughout the day. He would have a final feed at around 10pm and would then sleep until approximately 4am.⁵⁰
40. On 7 July 2014 Iziah attended at Blacktown General Practice and assessed as a ‘well infant’ by Dr David Wang at his one week check-up.⁵¹
41. On the afternoon before Iziah’s death, Maddison and Thomas took him to visit family and watch a soccer game. During the outing Iziah became upset and restless and unsettled.⁵² Iziah’s maternal grandmother observed he was a little bit sweaty and red in the face.⁵³
42. Iziah was given an evening feed at 10pm and a further feed at 12.30pm. I accept Maddison’s evidence that she dressed Iziah in a two piece pyjama outfit, wrapped him in a grey woollen blanket and laid him on his back in the bassinette (tucked into a sheet from the waist down).⁵⁴ I also accept her oral

⁴⁵ Supplementary report of Dr Irvine, tab 4A, p.3 of report.

⁴⁶ Report of Professor Woodford, tab 71A, p.4.7 and 4.9 of report.

⁴⁷ Blacktown Hospital clinical records, tab 58, pp.514-515 and tab 59, p.651.

⁴⁸ Statement of Maddison Wadsworth, tab 44, p.371 at [5-6] and Blacktown Hospital clinical notes, tab 58, pp.452-477.

⁴⁹ Transcript, Day 3, Robert Wadsworth, p.11.

⁵⁰ Statement of Maddison Wadsworth, tab 44, p.373 at [11].

⁵¹ Blacktown General Practice medical records, tab 61, p.711.

⁵² Statement of Maddison Wadsworth, tab 44, p.373 at [16-17].

⁵³ Statement of Janelle Wadsworth, tab 47, p.386 at [13].

⁵⁴ Statement of Maddison Wadsworth, tab 44, p.374 at [18].

evidence that it was cold on that night and she wrapped him and placed him on his back and tucked him in with a sheet.⁵⁵

43. At about 3am that night, Iziah woke up crying and Thomas fed him, burped him, “rugged him up again” and returned him to his bassinette.⁵⁶
44. At around 4.15am Thomas woke up to get ready for work. I accept Thomas’ account of events that at around 4.30am he discovered Iziah unresponsive with a small amount of blood coming out of both of his nostrils.⁵⁷ In oral evidence he said that Iziah was in the same position in which he left him earlier that morning (on his back and tucked into bed).⁵⁸ Professor Woodford described the position of Iziah as a “sleeping environment [that is] as optimal as can be.”⁵⁹
45. Once Thomas alerted the family, Iziah’s maternal grandmother, Janelle Wadsworth, called 000.⁶⁰
46. Iziah’s maternal grandfather, Robert Wadsworth, attempted resuscitation. During CPR, a small amount of vomit came out of Iziah’s mouth.
47. At 5.30am the first ambulance arrived at Iziah’s family house.⁶¹ The ambulance officers took over resuscitation on Iziah and placed an oropharyngeal airway. At this time Iziah was cool to touch, was not breathing, had no pulse and had some mottled skin. Following the arrival of the further ambulance officers, Iziah was administered adrenaline and intubated.⁶² His heart remained asystole and he was monitored accordingly.⁶³
48. At 5.41am the second ambulance arrived at Iziah’s family house and ambulance officers provided further assistance.⁶⁴ Iziah was placed in the ambulance and taken to Westmead Children’s Hospital.
49. At 6.18am Iziah was admitted into the Emergency Department of Blacktown Hospital. Further unsuccessful attempts were made to resuscitate Iziah at the hospital.⁶⁵
50. At 7.30am at the hospital Iziah was moved to a parents room with his immediate family. Thomas and Maddison were present, with Maddison’s parents and five younger siblings.⁶⁶

⁵⁵ Transcript, Day 1, Maddison Wadsworth, p.28.

⁵⁶ Statement of Thomas O’Sullivan, tab 45, p.379 at [18].

⁵⁷ Statement of Thomas O’Sullivan, tab 45, p.379 at [19].

⁵⁸ Transcript, Day 1, Thomas O’Sullivan, p.34.

⁵⁹ Transcript, Day 2, Professor Woodford, p.8.

⁶⁰ Statement of Janelle Wadsworth, tab 47, p.387 at [16].

⁶¹ Ambulance Incident Detail Report, tab 52, p.397.

⁶² Statement of Caitlin McAlister, tab 49, p.390 at [9-13] and statement of Philippa Matthews, tab 51, p.395 at [9].

⁶³ Ambulance Electronic Medical Record, tab 53, p.403.

⁶⁴ Statement of John Hando, tab 48, p.388 at [7-8].

⁶⁵ Westmead Hospital Clinical Records, tab 60, pp.666-667and 688.

⁶⁶ Westmead Hospital Clinical Records, tab 60, p.669.

51. At 10am Detective Senior Constable David Boylan⁶⁷ attended Iziah's family house with other police officers and assisted with taking crime scene photographs.⁶⁸ After this task was completed, he travelled with other police to Westmead Children's Hospital and took forensic photographs of Iziah.⁶⁹ Iziah's family house was secured as a crime scene with a crime scene log.⁷⁰
52. At 10.40am the next on-call social worker was contacted and arrived at 11.45am to assist with Iziah's grieving family. The social worker already present stated in the clinical notes that: "I had anticipated leaving and handing over at this point at that point however the enormous grief reaction and police involvement I made the decision that we needed 2 social workers to assist the family... Eventually each family member held and said goodbye to Iziah." The social worker also noted that "Eventually baby was handed over to police for eventual escort to Coroner... Jenni L (a social worker) will call hand over to Coroner this afternoon and to ensure counselling is offered and the process explained again from here."⁷¹
53. At some stage on 26 July 2014, Iziah was formally identified by his father Thomas.⁷²
54. The Westmead Hospital clinical records only contained an inadequate and incomplete "SUDI Medical History" form for Iziah.⁷³ Moreover, this incomplete form was not provided to the forensic pathologist.

The expert evidence in relation to Iziah's death

55. An autopsy was conducted by forensic pathologist Dr Rianie Janse Van Vuuren and she concluded that his cause of death was undetermined.⁷⁴ In the hearing Dr Van Vuuren was provided the opportunity to consider the (incomplete) SUDI Medical History and no information contained therein changed her opinion.⁷⁵ Both Dr Van Vuuren and Professor Woodford confirmed in evidence that the discharge of blood from the nose is a commonly reported occurrence in the circumstances and is usual after death.⁷⁶
56. Although there was some evidence of agonal aspiration in Iziah (being thick yellow mucus found in focal areas), there is no basis for any finding that this was relevant to the cause of death (such as due to the potential aspiration of milk). Dr Van Vuuren found no evidence of aspiration pneumonia or any

⁶⁷ Officer in charge of the coronial investigation.

⁶⁸ Statement of Detective Senior Constable David Boylan, tab 36, p.343 at [8].

⁶⁹ Statement of Detective Senior Constable David Boylan, tab 36, p.344 at [11].

⁷⁰ Statement of Sergeant Gregory Frail, tab 39, p.366 and crime scene log tab 42.

⁷¹ Westmead Hospital Clinical Records, tab 60, p.670.

⁷² Identification statement, tab 31, p.298.

⁷³ Westmead Hospital Clinical Records, tab 60, p.685.

⁷⁴ Autopsy report, tab 34, p.326.

⁷⁵ Supplementary report of Dr Van Vuuren, tab 35A, at p.2 of report.

⁷⁶ Supplementary report of Dr Van Vuuren, tab 35A, at p.1 of report and Report of Professor Woodford, tab 71A, p.5.5 of report.

reaction associated with the agonal aspiration of fluid.⁷⁷ Professor Woodford was unable to determine whether the thick yellow mucus found in focal areas comprised the residuum of feeds, respiratory secretions (including sputum) or a combination of the two.⁷⁸

57. In the original autopsy Dr Van Vuuren identified that Iziah had an atrial septal defect together with a probe patent ductus arteriosus.⁷⁹ She concluded – under the heading ‘microscopic examination of tissues’ – that “the heart is unremarkable. The ductus arteriosus is probe patent, with a thickened tunica media. There are no abnormalities.”⁸⁰
58. In her original autopsy report, Dr Van Vuuren commented on an association between an atrial septal defect, abnormally large fontanelle and tetrasomy 9p (a rare condition where a person has too much of one gene, though the condition is not usually associated with death).⁸¹
59. However, Dr Van Vuuren has since re-examined her report and the photographs taken at autopsy. Following this re-examination, she is of the opinion that Iziah more likely had a patent foramen ovale (where the foramen ovale fails to close), as opposed to an atrial septal defect (where there is no septal tissues between the atria.) She states that the significance in Iziah is not known.⁸² Dr Van Vuuren confirmed before the Court that the finding was more likely a patent foramen ovale and this was a finding that is seen often in infants.⁸³
60. Professor Woodford agrees that a patent foramen ovale is a not uncommonly observed finding and is unlikely to be of significance.⁸⁴ I accept the evidence of Professor Woodford and the revised evidence of Dr Van Vuuren in this regard.
61. Dr Van Vuuren is of the opinion that Iziah’s death should be classified as SUDI 0.⁸⁵
62. Professor Woodford agrees that Dr Van Vuuren’s finding appears reasonable and that Iziah’s death should be classified as SUDI 0.⁸⁶ I accept that the appropriate classification for the death of Iziah is SUDI 0.

⁷⁷ Supplementary report of Dr Van Vuuren, tab 35A, at p.1 of report.

⁷⁸ Report of Professor Woodford, tab 71A, p.5.7 of report.

⁷⁹ Autopsy report, tab 34, p.328.

⁸⁰ Autopsy report, tab 34, p.337.

⁸¹ Autopsy report, tab 34, pp.328-329.

⁸² Supplementary report of Dr Van Vuuren, tab 35A, at p.2 of report.

⁸³ Transcript, Day 1, Dr Van Vuuren, p.38.

⁸⁴ Report of Professor Woodford, tab 71A, p.6.2 and Transcript, Day 2, Professor Woodford, p.7.

⁸⁵ Supplementary report of Dr Van Vuuren, tab 35A, at p.2 of report. For a description of the various SUDI classifications (including “SUDI 0”) see tab 66 p.2 (vol 3).

⁸⁶ Report of Professor Woodford, tab 71A, p.6.5 and 6.9.

Issues arising in the investigation and management of SUDI deaths in NSW

Overview

63. As at the time of Kayla and Iziah's deaths, the primary policy in relation to the management of SUDI deaths was the 'NSW Health Policy Directive – Death – Management of Sudden Unexpected Death in Infancy' (PD2008_70).⁸⁷
64. In July 2019, NSW Health significantly revised this policy: 'Management of Sudden Unexpected Death in Infancy (SUDI)' (PD2019_XXX).⁸⁸ The new version of the policy was produced following lengthy engagement with other agencies and participation in the NSW SUDI Cross Agency Working Group and NSW Child Death Review Team.
65. The recently revised NSW Health Policy is a significant improvement on the policy in force as at the time of Kayla and Iziah's deaths. This has been the product of engagement with the other relevant agencies and reflects the actual practice of management of SUDI deaths in recent years and the adoption of a local hospital response to the management of SUDI deaths in NSW.⁸⁹
66. A key change under the revised NSW Health Policy is that, instead of being taken to a designated hospital, the deceased infant is to be taken to the nearest local hospital by ambulance in order for medical professionals to take a timely SUDI medical history and provide care for the family.⁹⁰ Another key change is the different approach that is now to be taken when compiling the SUDI medical history form (as discussed at paragraphs [102-110] below).
67. Given these considerable recent policy improvements, the expert evidence at the hearing was adduced by Counsel Assisting in order to identify only current concerns in the management of SUDI deaths in NSW in light of the experience of Kayla and Iziah's families. The purpose of this evidence was to identify any further practical improvements to policy and practice for the future. The expert evidence in this regard focused on the roles of the NSW Police, the Ambulance Service of NSW, NSW Ministry of Health and the Department of Forensic Medicine: from the point at which a family seek the assistance of police and paramedics in the event of a death; to the role of medical professionals at hospital; through to the determination of the cause of death by forensic pathologists.

⁸⁷ Tab 65.

⁸⁸ Tab 66A.

⁸⁹ Transcript, Day 2, Dr O'Meara, p.74. This sentiment was echoed by representatives of NSW Police and Ambulance NSW and by Ms Shipstone, who stated that a localised response is more appropriate and responsive to the needs of families. See Transcript, Day 3, Ms Shipstone, p.3.

⁹⁰ Transcript, Day 2, Dr O'Meara, p.46.

68. In my view there are further practical improvements that can be made in regard to the management of a SUDI death in NSW by a number of the key agencies, as set out below.

The body temperature of the infants at the scene of a SUDI death

69. In the case of Kayla, the temperature of the room and the body of the infant was relevant in consideration of the likely cause of death. Dr Irvine stated that “extremely strong circumstantial evidence” would need to be available to a forensic pathologist in order to find that a cause of death in an infant was hyperthermia.⁹¹ The evidence clearly supported a finding that the temperature of the room in which an infant died is important circumstantial evidence (particularly when coupled with evidence of the difference between the temperature of the room and the temperature of the child). Dr Irvine stated that the temperature of the child would need to be taken as soon as possible to be of value.⁹² Professor Woodford agreed that this clinical information was very useful for determination of cause of death. His evidence was that the temperature of an infant should be taken with an aural thermometer and as rapidly as possible by a person with medical training.⁹³
70. Professor Woodford suggested that an ambulance officer would be in the ideal position to perform this task.⁹⁴ The Ambulance Service of NSW, through Mr Loudfoot, accepted that paramedics could and should undertake this task.⁹⁵ Dr Du-Toit Prinsloo confirmed that, if paramedics were to take the temperature, forensic pathologists would be able to readily access it given that paramedic records sit with NSW Ministry of Health (of which they are a part).⁹⁶ NSW Ambulance did not make any submissions against this proposal.
71. I accept the submission made by Counsel Assisting that it is important and useful for the temperature of a deceased infant to be taken as soon as possible by responding paramedics where there has been concern about overheating.

Recommendation: That the Ambulance Service of NSW consider amending its policies to instruct attending paramedics to take the aural temperature of a deceased infant under 12 months (and the time that it was taken) where clinically appropriate.

The exposure of the deceased infant to other children at the scene

72. In oral evidence Terri expressed her concern that her two older children were present when the ambulance arrived and said that: “the ambulance officer walked into the lounge room holding Kayla in his arms with her little arm

⁹¹ Transcript, Day 1, Dr Irvine, p.53, p.64.

⁹² Transcript, Day 1, Dr Irvine, p.55.

⁹³ Transcript, Day 2, Professor Woodford, p.4.

⁹⁴ Transcript, Day 2, Professor Woodford, p.4.

⁹⁵ Transcript, Day 2, Mr Loudfoot, p.21.

⁹⁶ Transcript, Day 2, Dr Du-Toit Prinsloo, p.45.

dangling down in front of the children.”⁹⁷ Matthew agreed that it was difficult for the older children to deal with the memory of the paramedic taking Kayla out to the ambulance in front of them.⁹⁸ I agree with the submission of Counsel Assisting, and no doubt shared by the other parties in the hearing, that this situation aptly demonstrates the challenges faced by family and attending medical professionals in the event of the death of an infant.

73. Mr Loudfoot, on behalf of Ambulance NSW, responded to this concern and properly accepted that paramedics attending such a scene should certainly take into account the exposure of the infant to older and other children.⁹⁹ He also conveyed to the Court that SUDI deaths are tragic but rare and, as a result, many paramedics may have never encountered the death of an infant. Mr Loudfoot stated in conclave: “The reality ... is that these cases are rare. We would do a million cases a year [in NSW]. Out of those million cases there are 40 to 50 cases like this.”¹⁰⁰

The use of the term ‘Crime Scene’ by NSW Police when investigating a SUDI death

74. In 2014 police attended Iziah’s family house in response to an emergency call regarding Iziah and established a crime scene. Detective Senior Constable Boylan gave evidence that the usual procedure in these circumstances is to obtain the consent of the family to establish a crime scene, and in the absence of consent, to seek a crime scene warrant.
75. The family of Iziah were concerned and distressed that their house was labelled and treated as a ‘crime scene’. I accept this was and remains a legitimate concern for this, and indeed any family confronted with the unexpected death of an infant.
76. Detective Senior Constable Boylan explained in oral evidence that from the perspective of NSW Police, the establishment of a crime scene was a necessary process because the location of the death and the deceased “become evidentiary” in terms of the investigation. He said that the terminology is used for consistency and clarity and is used whether or not police have suspicions about the cause of death. He agreed that it may well be more appropriate for police to apply for a coronial scene order rather than a warrant in such circumstances.¹⁰¹
77. This issue was addressed in the conclave and alternatives to the term ‘crime scene’ were explored, including the use of the term ‘coronial scene.’ On behalf of NSW Police, Detective Superintendent Cook expressed reservations: “Police are in a difficult situation when they arrive on these scenes. On the one hand, there may be a crime. It may be many weeks or

⁹⁷ Transcript, Day 1, Terri Ewin, p.17.

⁹⁸ Transcript, Day 1, Matthew Ewin, p.22.

⁹⁹ Transcript, Day 2, Mr Loudfoot, p.66.

¹⁰⁰ Transcript, Day 2, Mr Loudfoot, p.20.

¹⁰¹ Transcript, Day 1, Detective Senior Constable Boylan, pp.26 – 27.

months before they know if there is a crime or not. It may be that the evidence they collect, the conversations that they have, are all required to be admissible in a criminal jurisdiction. At the same time, they are required to be empathetic to a family who is suffering and so police are having to walk a fine line.”¹⁰²

78. The position of NSW Police is that it is preferable to “err on the side of suspicion” in the circumstances, and hence, consider the use of the term ‘crime scene’ to be necessary.¹⁰³
79. Detective Superintendent Cook acknowledged that the term ‘coronial scene’ may be used in some circumstances other than ‘crime scene’, but this issue should be determined on a case by case basis.¹⁰⁴
80. It is noted that the evidence before the Court was that approximately 95% of all child deaths are not suspicious.¹⁰⁵
81. It was submitted by Counsel Assisting that NSW Police should be encouraged to use the term ‘coronial scene’ where appropriate rather than refer to the home as a ‘crime scene’. In response, the Commissioner proposes to appropriately update the NSW Police Handbook in the manner set out in the Recommendations below:

Recommendation: That NSW Police revise the ‘SUDI’ section of the Police Handbook to contain an instruction to police officers attending a scene or managing an investigation to assess whether it is preferable to use the term ‘coronial scene’ rather than ‘crime scene’ and in doing so, consider the impact of the use of the terminology on the family.

Recommendation: That NSW Police Forensic Evidence and Technical Services Branch and the Crime Scene Services Branch use the term ‘coronial scene’ rather than ‘crime scene’ in regard to infant deaths determined to be accidental.

The presence of police officers at the hospital with a deceased infant

82. In oral evidence Iziah’s family questioned the necessity for the attendance of police officers at the hospital following the death of an infant. Iziah’s family found this experience to be understandably intrusive and stressful. Maddison gave evidence to the Court that there were a number of police officers in the room at the hospital and: “we didn’t even know what happened ... and I think because there were so many police officers in the room and when we were saying goodbye to our son we didn’t even know ... we didn’t know if we’d

¹⁰² Transcript, Day 2, Detective Superintendent Cook, p.23

¹⁰³ Transcript, Day 2, Detective Superintendent Cook, p.23

¹⁰⁴ Transcript, Day 2, Detective Superintendent Cook, p.23.

¹⁰⁵ Transcript, Day 2, Professor Jeffrey, p.33; Transcript, Day 2, Detective Superintendent Cook, p.34.

done anything wrong”.¹⁰⁶ Thomas also gave evidence and explained that the police presence made them feel as though the family had done something wrong and they were unclear about whether they had done ‘something wrong’ for a long period of time after the death.¹⁰⁷ Maddison acknowledged that an investigation of the death was necessary by police but reflected that better communication by police and hospital staff could have been achieved.¹⁰⁸

83. The position of NSW Police remains that it is necessary for two police officers to attend the hospital in order to properly investigate an infant death and acknowledges that police presence must be minimal. This issue was directly addressed by Detective Superintendent Cook in oral evidence, who apologised to Iziah’s family and acknowledged that the presence of police can be intimidating. He explained that while there is no prescriptive policy on the number of police who attend the hospital, it is necessary for two police officers to attend (rather than one officer only) in order to investigate the death and complete the necessary tasks.¹⁰⁹ He assured the Court the attendance of two police officers at a hospital should not stop the family from spending appropriate time with the infant in the circumstances.¹¹⁰
84. However, NSW Police supports the amendment of the Police Handbook to explicitly state that the officer in charge of a SUDI investigation should minimise the police presence at both the scene *and the hospital*. I agree that such an amendment would be an appropriate step and so I will make a recommendation in those terms.

Recommendation: That NSW Police revise the ‘SUDI’ section of the Police Handbook to explicitly state that the officer in charge of a SUDI investigation should minimise the police presence at both the scene and the hospital.

Support and time for the family with the deceased infant at the hospital

85. At the hearing, the O’Sullivan family recounted that they did not feel comfortable at the hospital and found the experience confronting and very distressing. Maddison recalls not having enough time with Iziah. She stated to the Court: “I thought that there was, you know, he was going to be okay, that there was something they could do to help him or – so I, I was just coming to terms. I was 18. It was my first baby. I was clueless so I was just coming to terms with why he passed away.”¹¹¹
86. This issue was raised with Dr O’Meara in the conclave and he said that he would expect the clinicians to be “very much supporting the family.”¹¹²

¹⁰⁶ Transcript, Day 1, Maddison Wadsworth, p.30.

¹⁰⁷ Transcript, Day 1, Thomas O’Sullivan, p.34.

¹⁰⁸ Transcript, Day 1, Maddison Wadsworth, p.32.

¹⁰⁹ Transcript, Day 2, Detective Superintendent Cook, p.65.

¹¹⁰ Transcript, Day 2, Detective Superintendent Cook, p.82.

¹¹¹ Transcript, Day 1, Maddison Wadsworth, p.30.

¹¹² Transcript, Day 2 Dr O’Meara, p.84.

87. The complex question of how agencies, particularly hospitals, can best support families to have meaningful time with their infant in such difficult circumstances was also explored in the evidence of Ms Shipstone. In her view, agencies could offer more support to families.¹¹³ The issue was dealt with constructively in conclave. Dr O'Meara said: "I'm sorry the O'Sullivan family had that experience. That shouldn't occur. There is no time frame. There just isn't. It depends on the family. It varies and with other family members coming in it can take hours and we expect it to take hours and that's fine."¹¹⁴
88. Detective Superintendent Cook also gave evidence that there is no imperative from a police perspective for families to be cut short in the time they have in saying goodbye to their child.¹¹⁵ He agreed that the police could provide guidance to its officers about the sensitivities involved with families in saying goodbye to their child and that, if a recommendation were as proposed below, it could be implemented across the entire police organisation in a short space of time.¹¹⁶ In this respect, NSW Police is open to updating the SUDI section of the Police Handbook to ensure that guidance is provided to officers to be mindful of the impact of police presence on a family in the context of a SUDI death (noting that the matter may not eventuate as a crime; to treat family members appropriately and ensure that they are given sufficient time to say goodbye to their child).
89. It was not clear from the evidence at the conclave whether NSW Ministry of Health provided any specific training in relation to the approach that NSW Ministry of Health staff should take in relation to a family seeking time to say goodbye to their child in the context of a SUDI death.¹¹⁷ In my view, it is necessary and appropriate for NSW Ministry of Health to ensure their staff are properly trained to support the family in the event of an infant death. The NSW Ministry of Health supports this approach and has identified a number of options to continue to improve the ability of staff to meet the needs of the infant and parents / carers including the provision of education for all staff and utilising staff with bereavement skills from other areas such as midwifery.

Recommendation: That NSW Ministry of Health review its training policies to determine whether guidance is given to staff in dealing appropriately with a family seeking time to say goodbye to their child in the context of a SUDI death.

Recommendation: That NSW Police review its policies and training procedures in order to ensure that guidance is provided to officers in dealing appropriately with a family seeking time to say goodbye to their child in the context of a SUDI death.

¹¹³ Transcript, Day 3, Ms Shipstone, p.2. Ms Shipstone in particular spoke about the approaches in other jurisdictions and the potential to approach the management of SUDI deaths from a more health based rather than criminal-justice based approach.

¹¹⁴ Transcript, Day 2, Dr O'Meara, p.81.

¹¹⁵ Transcript, Day 2, Detective Superintendent Cook, p.67.

¹¹⁶ Transcript, Day 2, Detective Superintendent Cook, p.67.

¹¹⁷ Transcript, Day 2, Dr O'Meara, p.83.

The P79A form and the potential for more fulsome documentation of the sleeping environment of the deceased infant

90. The Court was presented with an example of a Victorian police form ('Investigative Checklist: Sleep-Related Sudden Unexpected Death of an Infant or Child') used by investigating police in Victoria (Exhibit 6). The form contains an extensive list of medical and general questions and a diagram for completion by the investigating officer on the sleeping arrangements necessary for a thorough investigation. I accept the submission of Counsel Assisting that this form contains useful general (and non-medical) information for police in a SUDI investigation, including:¹¹⁸
- a. The details of the primary caregiver at the time of death;
 - b. The details of the people at the premises at the time of death;
 - c. The details of the siblings of the child (both alive and deceased);
 - d. Details of the incident (including the status of the child when found, person who found the child, their relationship to the child, the date and time found, the circumstances in which the child was found, and whether resuscitation was attempted by someone other than a paramedic);
 - e. Details of the sleeping location and surface where the child was found (including whether a bassinette / adult bed / cot / porta cot / pram / couch / other), whether the sleeping place was the normal place for the child to sleep, whether there was any signs of damage to the sleeping environment, the mattress type (foam / fabric / innerspring / water / other), the firmness of the mattress, whether the mattress was wrapped in plastic / sagging / was stained, whether there was a gap between the cot / basket and the mattress, and whether there was an additional mattress or padding placed in the bedding);
 - f. Details of the bedding (including how many blankets were underneath and on top of the child, the number, type and condition of sheets, and whether the bedding was tucked in) and whether the bedding was soiled / wet / damp and whether there was a pillow and anything else in the bed;
 - g. Details of the appearance of the child (characteristics of the child when found and whether any visible debris / signs of injury);
 - h. Details of the child's airway (and whether airway obstructed and any objects covering or near the face);
 - i. Details of the child's last feed and clothing worn;

¹¹⁸ Exhibit 6, Investigative Checklist: Sleep-Related Sudden Unexpected Death of an Infant or Child.

- j. Details of the sleeping arrangements for the child (including who put the child to sleep, why the child was put to sleep, the wrapping of the child, any pets present);
 - k. Description of the position of the child when placed to sleep and when found deceased (with diagrammatic options to nominate whether the child was placed with their head placed at the top of the cot, the middle of the cot or feet at the foot of the cot);
 - l. Description of any co-sleeping / bedsharing (and if so, with who, in what position when put to sleep, in what position when found, duration of co-sleeping, and alcohol and drug use by co-sleepers);
 - m. Details of the child's normal sleeping pattern (arrangements, time, any recent changes);
 - n. Details of the child's household environment (weather, heating and cooling in the child's room and house);
 - o. A narrative of events as described by the parent or carer in their own words;
 - p. Observations by police officer as to whether any cigarette odour or signs of drug or alcohol use in the house.
91. NSW Police agree that the inclusion of extra detail in the relevant P97A form may be useful to prompt and structure specific questions about sleeping environment and routines.¹¹⁹ In conclave, Detective Superintendent Cook said that adding in additional prompts and structured questions to the P79A form would be beneficial because it would encourage police officers to focus on the level of detail that is required in a SUDI investigation (that might not otherwise be obvious to an officer).¹²⁰
92. Some concern was later raised in submissions on the part of NSW Police that not all this information may be able to be obtained by the officer in charge in the circumstances. NSW Police submitted that:
- a. the Crime Scene Officer may, instead, be the officer best trained to answer such questions;
 - b. while the P79A form may be updated to include the matters set out at paragraph 90 above, as a matter of practicality and proper approach, not all of those matters could or would be answered in a P79A form;
 - c. the Standard Operating Procedures (SOPs) that are to be followed by Crime Scene Officers in relation to a SUDI death (being SOPs

¹¹⁹ Transcript, Day 2, Detective Superintendent Cook, p.58.

¹²⁰ Transcript, Day 2, Detective Superintendent Cook, p.58.

section 2.4.14) already deal with a number of the matters set out in paragraph 90 above (although in broader terms);

- d. NSW Police is open to a recommendation that section 2.4.14 of the SOPs be updated to include the matters set out at paragraph 90 above in order to encourage Crime Scene Officers to consider those matters in that level of detail.

93. While NSW Police raised some reservations in its written submissions about updating the P79A form to include the matters set out at paragraph 90 above, I note the evidence of Detective Superintendent Cook at the hearing that the inclusion of extra detail in the relevant P97A form may be useful to prompt and structure specific questions about sleeping environment and routines. I accordingly propose to make a recommendation that NSW Police consider amending both the P79A form and the SOPs to include additional SUDI questions on the matters as set out in paragraph 90 above.
94. Mr Loudfoot of NSW Ambulance agreed that these extra prompts and structured questions would be useful given that, in the vast majority of cases, there is no photographic representation of the infant in situ because either family or attending paramedics remove the infant from the environment to attempt resuscitation.¹²¹

Recommendation: That NSW Police consider amending the P79A form and the Standard Operating Procedures entitled “Crime Scene Manual (Specialist) – Death Investigation” and SUDI section 2.4.14 to include additional SUDI questions on the matters as set out in paragraph 90 above.

The value of photographs in SUDI investigations

95. The forensic pathologists in the cases of Kayla and Iziah were not provided with any photographs of the environment in which the infants died and did not request them from NSW Police. When provided in Court with a photograph of Kayla’s portable carrier and surrounding environment (Exhibit 4), it was clear that this evidence would be useful corroborative material in determination of manner and cause of death. In particular, Dr Du-Toit Prinsloo gave evidence in conclave that it would be useful to have access to the police photographs of the deceased infant at the scene (including the position of the deceased infant and surroundings, including bedding and environment) in as timely a manner as possible.¹²²
96. The P79A form is completed by police officers after speaking with family members and other witnesses at the scene. The NSW Police Handbook dictates that the P79A form is completed on the day of the death and sent to the Coroner. It is ordinarily completed prior to the crime scene photographs being available. As such, there is currently no process whereby police

¹²¹ Transcript, Day 2, Mr Loudfoot, p.58.

¹²² Transcript, Day 2, Dr Du Toit-Prinsloo, p.41.

photographs (either crime scene photographs or otherwise) are included with this document.

97. The current informal practice in the Department of Forensic Medicine is such that forensic pathologists may request crime scene photographs from police via the Coronial Case Management Unit (CCMU). However, it became apparent in the expert conclave that this request process is likely under-utilised because police photographs are usually taken of the deceased once removed from the scene and not in the environment in which they died.¹²³ Moreover, an autopsy is usually performed within 24 hours of the death and police crime scene photographs are generally not available at this time (and do not accompany the P79A form as a matter of course, as set out above).¹²⁴ I accept the evidence of Detective Superintendent Cook that crime scene officers generally process and upload photographs of a crime scene within 1-2 days of the death.¹²⁵
98. It became clear in the conclave evidence that forensic pathologists are not able to directly access such photographs.¹²⁶ Rather, it is up to the forensic pathologist to make a request of a police officer to provide them with such photographs. In Sydney, that request would be made to a police officer in the CCMU.¹²⁷
99. Dr Du Toit-Prinsloo observed that forensic pathologists should be encouraged to routinely make a request of police to provide them with crime scene photographs.¹²⁸ She observed that, even though those photographs were unlikely to be available at the time of doing the actual autopsy, they would still be valuable if they were received a day or two later (and prior to the pathologist signing off the autopsy report).¹²⁹ Dr Du Toit-Prinsloo was unsure whether the manual or policy that forensic pathologists are required to follow when conducting autopsies requires the pathologist to review crime scene photographs prior to signing off an autopsy report.¹³⁰
100. In my view, the work of forensic pathologists would be significantly assisted by efficient and timely access to crime scene photographs. Counsel Assisting proposed a recommendation whereby NSW Police consider amending the Police Handbook and the P79A form to provide that any crime scene photographs of a deceased infant under the age of 12 months are to be provided to the CCMU as soon as is practicable. However, this recommendation was not supported by NSW Police and it is their position that it would be more practicable for forensic pathologists to routinely request the photographs.

¹²³ Transcript, Day 2, Dr Du Toit-Prinsloo, p.41.

¹²⁴ Transcript, Day 2, Dr Du Toit-Prinsloo, p.41.

¹²⁵ Transcript, Day 2, Detective Superintendent Cook, p.39.

¹²⁶ Transcript, Day 2, Dr Du Toit-Prinsloo, p.40.

¹²⁷ Transcript, Day 2, Dr Du Toit-Prinsloo, pp.40-41.

¹²⁸ Transcript, Day 2, Dr Du Toit-Prinsloo, pp.41-42.

¹²⁹ Transcript, Day 2, Dr Du Toit-Prinsloo, pp.42.

¹³⁰ Transcript, Day 2, Dr Du Toit-Prinsloo, p.43.

101. It is clearly necessary for forensic pathologists to have timely access to such photographs. So much is supported by the NSW Ministry of Health. The NSW Ministry of Health proposed that any recommendation on the issue should not be couched in mandatory terms. I am therefore making a recommendation that the NSW Department of Forensic Medicine review its policies to encourage a forensic pathologist to obtain crime scene photographs prior to signing off an autopsy report.

Recommendation: That NSW Department of Forensic Medicine review its policies to encourage forensic pathologists to routinely request, and then review, crime scene photographs prior to signing off an autopsy report.

The completion of a SUDI medical history at the Hospital

102. A significant issue addressed in the evidence was that in neither Kayla nor Iziah's case was a complete and comprehensive SUDI medical history provided by the hospital to the forensic pathologist. Dr Van Vuuren gave evidence that a SUDI medical history is necessary in order to perform an infant autopsy and, in her experience, it was not always provided.¹³¹
103. The evidence before the Court was that prior to the recently revised NSW Health policy, the SUDI medical history form was completed and provided to the Department of Forensic Medicine on less than half the occasions it was required. This failure was accepted by NSW Ministry of Health. Dr O'Meara frankly acknowledged a clear problem in the 2008 policy and stated that: "The reasons for that are not clear ... in the professional meetings with other clinicians they describe the tension between caring for the family and asking detailed questions at that moment, a few hours after the baby's died."¹³²
104. Dr O'Meara further expressed the view that, as at the time of Kayla and Iziah's deaths, the form was not being adequately completed because it was long and the format was not clinically intuitive for practitioners to complete. He readily accepted that he could not explain why practitioners were not providing the form to the forensic pathologist.¹³³
105. In response to this failure, the SUDI medical history form in the current (revised) policy has been redesigned in order to reflect how a clinician would ordinarily take a medical history in the sensitive context of the death of an infant.
106. NSW Ministry of Health proposes an audit of the revised SUDI medical history form to assess whether these changes are effective.¹³⁴ In my view, given the previous non-compliance with completion of this history form, this audit is necessary and should be implemented. The NSW Ministry of Health has embraced this approach and supports the recommendation I make below. I

¹³¹ Transcript, Day 1, Dr Van Vuuren, p.42.

¹³² Transcript, Day 2, Dr O'Meara, p.47.

¹³³ Transcript, Day 2, Dr O'Meara, p.48.

¹³⁴ Transcript, Day 2, Dr O'Meara, pp.47 – 48, Ms Matha, p.60.

note that Dr Du-Toit Prinsloo observed that the information contained in the SUDI medical history form is significant to forensic pathologists in terms of their ability to determine a cause of death.¹³⁵

107. The evidence from the expert conclave was that given the recent introduction of the role of a clinical nurse consultant (CNC) at the CCMU in the Department of Forensic Medicine, this has ‘improved matters’ in terms of having someone to chase up the SUDI medical history form from the hospital (if it was not provided with the body of the infant, as should ordinarily be the case).¹³⁶ Dr Van Vuuren confirmed that if the form is not provided then the CNC will request and obtain the information.¹³⁷ The NSW Ministry of Health does not consider it the role of the CNC to ‘chase up records’ and comments that it may not be the best use of this scarce and highly specialised resource. However, given the crucial importance of the SUDI medical history, I consider that it is a necessary role for the CNC in the circumstances.

Recommendation: That NSW Ministry of Health implement their proposed audit of the revised SUDI medical history form over a period of 12 months and evaluate whether the form is being sufficiently completed and whether it is consistently being provided to the Department of Forensic Medicine in a timely manner.

Recommendation: That the Department of Forensic Medicine review its policies to ensure that the role of the CNC includes ensuring that the SUDI medical history form has been received and provided to the case forensic pathologist in a timely manner.

The duplication in taking a SUDI medical history from the family

108. It was apparent from the evidence of the various agencies in the conclave that some form of medical history taking is necessary to be taken by each relevant agency in regard to management of a SUDI death. For example, Detective Superintendent Cook explained that investigating police must consider and address the suspicion of a non-accidental injury or death and some medical history needs to be taken for this purpose.¹³⁸ In his view, there is some duplication, but “P79A is a very limited medical precis ... it’s not a comprehensive clinical history.”¹³⁹
109. Mr Loudfoot, for the Ambulance Service of NSW, commented that it is also necessary for some form of medical history to be taken by treating paramedics in order to fully inform resuscitation attempts and the provision of medical care at the scene. Mr Loudfoot said: “I think each of the environments is quite unique ... I think it gives the greatest opportunity to get a true picture of what’s occurred, that each individual [from each agency] can ask the

¹³⁵ Transcript, Day 2, Dr Du Toit-Prinsloo, p.51.

¹³⁶ Transcript, Day 2, Dr Du Toit-Prinsloo, pp.49-54.

¹³⁷ Transcript, Day 1, Dr Van Vuuren, p.50.

¹³⁸ Transcript, Day 2, Detective Superintendent Cook, p.59.

¹³⁹ Transcript, Day 2, Detective Superintendent Cook, p.55.

questions each time.”¹⁴⁰ Further, by way of example: “when the paramedics are there with the families, it’s extremely emotive ... the families say as it happened and we get the information from them. Later on in the process, they may not remember what actually occurred even an hour ago because it’s been so much of a whirlwind of emotions.”¹⁴¹ He also commented: “So I think if we do that in a really sensitive way and a careful way, there’s a greater opportunity to get ... a more comprehensive and clearer picture of what really occurred from the family’s perspective.”¹⁴²

110. It was apparent that each of the agencies are aware of the potential for duplication of taking a medical history from the family of a deceased infant and the added trauma which may result. The NSW Ministry of Health supports the monitoring of this issue further over the next 12 months in order to ascertain the most useful and sensitive approach.¹⁴³

Recommendation: That NSW Ministry of Health implement their proposal to monitor the issue of duplication in taking a medical history from the family of a deceased infant over the next 12 months in order to ascertain the most useful and sensitive approach.

Early clinical review meeting in SUDI cases

111. Ms Matha provided valuable evidence to the Court that NSW Ministry of Health has committed to implementing a protocol whereby an early interagency clinical review meeting takes place in relation to each SUDI death.¹⁴⁴ The proposed early clinical review meeting:
- a. would include the case forensic pathologist and CNC from the Department of Forensic Medicine, investigating NSW Police and the paediatrician or medical professional who completed the SUDI medical history form at the hospital;¹⁴⁵
 - b. would take place by way of teleconference after the post mortem has been conducted in order to identify progress in determining the cause of a SUDI death;¹⁴⁶
 - c. would take place within the first week of the death of the infant;¹⁴⁷
 - d. would provide a forum in which to identify what information is missing and what steps still need to be taken;¹⁴⁸

¹⁴⁰ Transcript, Day 2, Mr Loudfoot, p.59.

¹⁴¹ Transcript, Day 2, Mr Loudfoot, pp.59-60.

¹⁴² Transcript, Day 2, Mr Loudfoot, p.60.

¹⁴³ Transcript, Day 2, Ms Matha, p.60.

¹⁴⁴ Joint Statement of Ms Matha and Dr O’Meara, Exhibit 3, pp.12-13.

¹⁴⁵ Transcript, Day 2, Ms Matha, Dr O’Meara, and supported by Dr Du Toit-Prinsloo, pp.60–62.

¹⁴⁶ Joint Statement of Ms Matha and Dr O’Meara, Exhibit 3, p.12.

¹⁴⁷ Transcript, Day 2, Dr O’Meara, and supported by Dr Du Toit-Prinsloo, pp.61-62.

¹⁴⁸ Transcript, Day 2, Dr Du Toit-Prinsloo, p.62.

- e. would also address the requisite care needs of the family of the infant.¹⁴⁹
112. Dr Du-Toit Prinsloo noted that the early clinical review meeting would be similar to a major crime review that takes place in relation to homicide or suspicious cases.¹⁵⁰
113. The early review meeting would be of significant value in that it would provide accountability and peer review for the paediatrician or medical professional who was involved in the death and the completion of the SUDI history form.¹⁵¹ As Dr O'Meara observed, the opportunity for the paediatrician / medical professional who completed the SUDI medical history form at the hospital to participate in the early clinical review meeting will allow them to see the value of the medical history form in the process and where it "fits in". Then, through communication and networking of paediatricians, they will spread the message that completion of the SUDI medical history form is important and therefore increase the likelihood that it will be completed by them in a fulsome way.¹⁵²
114. The NSW Ministry of Health supports the introduction of an early review meeting and the proposed recommendation by Counsel Assisting, but proposed that such a review take place within one week or as soon as practicable thereafter. I accept that there may be circumstances where such a review is not possible within one week but I consider it is necessary for there to be a fixed time frame for the completion of such a process.

Recommendation: That NSW Ministry of Health and NSW Police implement the proposal for an interagency early clinical review meeting to take place within 1 week of every SUDI death in NSW, or as soon as practicable thereafter and no later than 1 month after the death, and evaluate the implementation of this proposal within 12 months from the date of its commencement.

The specialisation and training of forensic pathologists in SUDI deaths

115. The expert conclave also addressed whether it is appropriate for forensic pathologists to perform autopsies or whether specialist paediatric pathologists are required. Dr Van Vuuren informed the Court that the training for forensic pathologists is the same in regard to both adults and children and on average forensic pathologists perform three or four paediatric autopsies per year.¹⁵³ In her view it is within the general expertise of a general forensic pathologist to

¹⁴⁹ Transcript, Day 2, Dr O'Meara, p.63.

¹⁵⁰ Transcript, Day 2, Dr Du Toit-Prinsloo, p.62.

¹⁵¹ Transcript, Day 2, Dr O'Meara, p.63. This should address the fact that many practitioners may only see one SUDI case in their professional experience and otherwise may have little or no practical experience with SUDI.

¹⁵² Transcript, Day 2, Dr O'Meara, p.63.

¹⁵³ Transcript, Day 1, Dr Van Vuuren, p.43.

perform paediatric autopsies.¹⁵⁴ This view was supported by Dr Du Toit-Prinsloo in the conclave and endorsed by Ms Shipstone.¹⁵⁵

116. The Court also heard evidence about the scarcity of specialist paediatric pathologists in NSW and in Australia generally.
117. In addition, the Court heard evidence from Dr Du Toit-Prinsloo that a specialist paediatric pathologist is likely to be engaged by the Department of Forensic Medicine in the near future on a 0.2 part-time basis. The role of that specialist paediatric pathologist would be available for consultation to the general forensic pathologist in charge of the SUDI case, for example in relation to histological slides.¹⁵⁶
118. Given the circumstances as set out above, I do not consider that there is any sufficient basis to consider any recommendation in relation to the introduction or use of paediatric forensic pathologists in NSW.

The delay in completion of paediatric post-mortem reports in NSW

119. In both Kayla and Iziah's cases there was a significant delay in the completion of the post-mortem report and very limited information provided to the families in this regard. The assessment by Dr Irvine is that as at the current time, the average timeframe in NSW for a paediatric autopsy report is between eight or nine months. The primary reason for this extended time period is the delay in receipt of specialist reports such as a neuropathology report, which are necessary in SUDI matters and routinely take months to be prepared due to a high workload and in circumstances where "you're talking about very scarce specialists who are extremely busy."¹⁵⁷
120. Dr Du Toit-Prinsloo endorsed this assessment and said: "It's absolutely a human resource issue. We've got [at the Department of Forensic Medicine in NSW] one neuropathologist who is not full-time appointed in forensic pathology ... so he has got a part-time appointment only and he manages all the neuropathology across the State so it's not just the SUDI deaths."¹⁵⁸
121. These circumstances can be compared with greater resources in other parts of Australia. For example, Professor Woodford informed the Court that the benchmark in the state of Victoria is to have 80% of forensic cases completed within three months.¹⁵⁹ Moreover, in Victoria the allocation of resources allow for neuropathology to be performed when required by a dedicated forensic

¹⁵⁴ Transcript, Day 1, Dr Van Vuuren, p.43.

¹⁵⁵ Transcript, Day 2, Dr Du Toit-Prinsloo, pp.67-68 and Transcript, Day 3, Ms Shipstone, p.5.

Ms Shipstone informed the Court that she had spoken with Professor Roger Byard and he is of the view that the case pathologist in a SUDI death should be a general forensic pathologist.

¹⁵⁶ Transcript, Day 2, Dr Du Toit-Prinsloo, p.68.

¹⁵⁷ Transcript, Day 1, Dr Irvine, p.61.

¹⁵⁸ Transcript, Day 2, Dr Du Toit-Prinsloo, p.69.

¹⁵⁹ Transcript, Day 2, Professor Woodford, p.10.

neuropathologist and radiology by forensic paediatric radiologists from the Children's Hospital.¹⁶⁰

122. In NSW, Dr Irvine commented that although it was within the expertise of a forensic pathologist to review and provide an opinion on paediatric x-rays, it would be preferable for a paediatric radiologist to undertake this review but this was "simply not possible" in NSW.¹⁶¹
123. I accept the submission of Counsel Assisting that the limited resourcing of the Department of Forensic Medicine is the cause of ongoing significant delays in the completion of post-mortem reporting in the NSW coronial jurisdiction.

The potential for the implementation of doll re-enactments in SUDI investigations

124. The use of dolls in re-enacting the placement of an infant (in their cot or bassinette in the environment in which they died) as part of a SUDI investigation was discussed by the expert conclave. The method was endorsed by Ms Shipstone and Professor Jeffery and requires the use of specialists such as death scene investigators or forensic pathologists attending the scene of the death.¹⁶²
125. However, this was not supported by a majority of the conclave. NSW Ministry of Health has indicated that such an endeavour is outside the scope of the current policy due to resources.¹⁶³ The Ambulance Service of NSW expressed concern that such an exercise can be re-traumatising for paramedics if they are required to be involved in a re-enactment.¹⁶⁴
126. On behalf of NSW Police, Detective Superintendent Cook expressed significant reservations and concerns about doll re-enactments, in particular in relation to disturbance of the crime scene and in relation to the evidentiary implications of such re-enactments in a death that later turns out to have been a suspicious death.¹⁶⁵
127. Dr Du Toit-Prinsloo gave evidence that such re-enactments are used in other jurisdictions (such as South Africa) but in circumstances where the jurisdiction and procedures are materially different from that of Australia and in any case, doll re-enactments only assist in determination of cause of death in a small percentage of sudden infant deaths. Moreover, the value of such re-

¹⁶⁰ Transcript, Day 2, Professor Woodford, pp.10-11.

¹⁶¹ Transcript, Day 1, Dr Irvine, pp.50–51. This view was supported by Dr Du Toit-Prinsloo who stated that it is "really very difficult to get a paediatric radiologist to comment on a forensic CT scan."

¹⁶² Transcript, Day 2, Ms Jeffery, p.28; and Transcript, Day 3, Ms Shipstone, pp.3-4.

¹⁶³ Transcript, Day 2, Ms Matha, p.24.

¹⁶⁴ Transcript, Day 2, Mr Loudfoot, p.24.

¹⁶⁵ Transcript, Day 2, Detective Superintendent Cook, pp.27-38.

enactments can be largely replicated by careful documentation of the scene of an infant death (including photographs and detailed descriptions by police).¹⁶⁶

128. I accept the evidence of the majority of the conclave that the use of doll re-enactments in NSW is not necessary in the coronial jurisdiction, due to the requirement for further significant resourcing and the other matters raised, namely; the potential trauma to the family and paramedics in re-enactment, practical limitations due to the remote and regional location of many infant deaths and implications for police investigations.

A joint agency approach to SUDI investigation

129. In an effort to further improve the investigation of SUDI deaths in NSW, the conclave canvassed the viability of adopting a 'joint agency' approach to the investigation and management of SUDI deaths in NSW. That is, involving forensic pathologists, paediatricians or other death investigators in death scene investigations and conducting an interview with the family jointly with police and health professionals.
130. Dr Irvine gave evidence of the use of medical death investigators (particularly in North America) and considered they are appropriate and better trained than police in regard to infant death investigation.¹⁶⁷
131. The conclave discussed the value of this approach against the need to conduct a death scene investigation within a reasonable time frame and given geographic considerations in NSW and other resourcing issues.¹⁶⁸
132. NSW Police indicated that a joint agency approach in NSW would likely be prohibitively resource intensive.¹⁶⁹
133. Ms Shipstone stated that whilst a joint agency approach such as that adopted in the United Kingdom may be considered to be 'optimal' this must not be simply 'overlaid' in Australia given the vast geographical differences and some cultural differences.¹⁷⁰
134. For the reasons set out above, I do not consider that a joint agency approach to the management of SUDI deaths is currently viable or appropriate. Instead, as set out below, I accept the submissions of Counsel Assisting that a less

¹⁶⁶ Transcript, Day 2, Mr Loudfoot, Mr Matha, Dr Du Toit-Prinsloo, pp.28 – 32. Ms Shipstone also identified that in the event doll re-enactments are used, the dolls must be appropriately weighted and the enactment conducted in a very particular manner in order for the exercise to be useful for pathologists (see Transcript, Day 3, Ms Shipstone, p.3).

¹⁶⁷ Transcript, Day 1, Dr Irvine, p.58.

¹⁶⁸ Transcript, Day 2, Dr O'Meara, Professor Jeffrey, pp.75 – 76. Ms Jeffrey promoted the centralised model, as based on the model developed and implemented in the United Kingdom. However, Dr Du Toit-Prinsloo expressed particular concerns about the viability and appropriateness of a pathologist attending the scene of an infant death.

¹⁶⁹ Transcript, Day 2, Detective Superintendent Cook, p.78.

¹⁷⁰ Transcript, Day 3, Ms Shipstone, p.6.

resource-intensive approach, in the form of a new centralised contact point for the agencies involved in a SUDI death, ought to be implemented.

A centralised contact point for SUDI investigations in NSW

135. The investigation of SUDI deaths in NSW would greatly benefit from the creation of the role of a paediatric clinical nurse consultant (CNC) at the Coronial Case Management Unit (CCMU). The CNC would be trained in SUDI investigations in order to provide resources, telephone support, advice and follow-up to police, ambulance and health professionals involved in the management of a SUDI death. This role would likely require two full time roles in order to provide a service 24 hours a day.
136. NSW Police supported the proposal, with Detective Superintendent Cook stating “if there is a paediatric specialist available 24/7 even if it’s by telephone, police will take that opportunity to engage with them for advice and I think particularly in rural areas ... that would be a massive advance forward in this type of investigation.”¹⁷¹
137. Mr Loudfoot, on behalf of the Ambulance Service of NSW also supported the proposal.¹⁷² He agreed that a centrally coordinated position available 24 hours a day would be “really valuable” in terms of getting a consistent approach from paramedics in dealing with a SUDI death (after resuscitation efforts have been exhausted).¹⁷³
138. Dr O’Meara, Chief Paediatrician, agreed that the proposal has potential. He agreed that if the person in the central position had training in relation to SUDI investigations that they could add value both in the first few hours following the death of an infant and then thereafter in terms of coordinating the receipt of information as part of the SUDI investigation.¹⁷⁴
139. Ms Shipstone’s view was that it is an exceptionally good idea and has the potential to respond to some concerns ventilated in the evidence as to the limited experience of professionals in dealing with a SUDI death in the community.¹⁷⁵ Ms Shipstone suggested that it would be both useful and appropriate for a specialised central contact in NSW to be trained and available to respond to all accidental and non-intentional coronial child deaths in the state.¹⁷⁶ This would enable the role to be viable, resourced and available 24 hours a day.
140. The evidence supports the creation of two full time roles for a paediatric CNC, so as to provide a service 24 hours a day, where the roles would extend to:

¹⁷¹ Transcript, Day 2, Detective Superintendent Cook, p.71.

¹⁷² Transcript, Day 2, Mr Loudfoot, p.71.

¹⁷³ Transcript, Day 2, Mr Loudfoot, p.71.

¹⁷⁴ Transcript, Day 2, Dr O’Meara, p.72.

¹⁷⁵ Transcript, Day 3, Ms Shipstone, p.6.

¹⁷⁶ Transcript, Day 3, Ms Shipstone, p.7. Ms Shipstone stated that other such child deaths where agencies would benefit from such expertise include low speed run overs in driveways; child suicides; and drownings in dams or on residential properties.

- a. following-up the SUDI medical history form from the hospital and ensuring it is provided to the case forensic pathologist in a timely manner;
 - b. following-up and liaison with the family (for example in relation to the timing of the autopsy report and expectations in relation to the coronial process);
 - c. being the point of liaison in relation to genetic testing undertaken by the family and ensuring that the results of any such genetic tests are provided to the case forensic pathologist (and can be taken into account in determining the cause of death of the child).
141. In my view the new role of a paediatric CNC could and should be extended to all accidental coronial child deaths in the state (i.e. not just SUDI deaths).

Recommendation: That the State Government give consideration to the creation of the role of a paediatric clinical nurse consultant (CNC) at the Coronial Case Management Unit (CCMU) trained in SUDI investigations in order to provide centralised support available 24 hours a day to agencies in NSW investigating SUDI and accidental child deaths in NSW.

Closing remarks

142. I would like to thank the interested parties for their co-operation and the constructive approach they have taken in the lead up to and throughout this inquest. I thank my counsel assisting, Ms Kate Richardson SC and Ms Tracey Stevens and their instructing solicitor, Ms Clara Potocki from the NSW Crown Solicitor's Office. They approached this inquest with great compassion, thoughtfulness and intelligence.
143. Finally, I extend my sincere sympathy to the Ewin and O'Sullivan families for the loss of Kayla and Iziah in such tragic and unexpected circumstances. I also wish to acknowledge the gracious and generous manner in which the Ewin and the O'Sullivan families have approached and participated in the coronial process. Their contributions have been invaluable.

Findings required by s. 81(1)

144. As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the deaths occurred and make the following findings in relation to them.

145. **Inquest into the death of Kayla Ewin:**

The identity of the deceased

The person who died was Kayla Ewin.

Date of death

Kayla died on 23 December 2012.

Place of death

Kayla died at her home in Nowra, NSW.

Cause of death

Unascertained (SUDI 0+)

Manner of death

Sudden Unexpected Death in Infancy (SUDI) within the category SUDI 0+.

146. **Inquest into the death of Iziah O’Sullivan:**

The identity of the deceased

The person who died was Iziah O’Sullivan.

Date of death

Iziah died on 26 July 2014.

Place of death

Iziah died at his home in Quakers Hill, NSW.

Cause of death

Unascertained (SUDI 0)

Manner of death

Sudden Unexpected Death in Infancy (SUDI) within the category SUDI 0.

Recommendations

147. I make the following recommendations, pursuant to s. 82 of the Act:

To the Ambulance Service of NSW:

1. That the Ambulance Service of NSW consider amending its policies to instruct attending paramedics to take the aural temperature of a deceased infant under 12 months (and the time that it was taken) where clinically appropriate.

To NSW Police:

2. That NSW Police revise the 'SUDI' section of the Police Handbook to contain an instruction to police officers attending a scene or managing an investigation to assess whether it is preferable to use the term 'coronial scene' rather than 'crime scene' and in doing so, consider the impact of the use of the terminology on the family.
3. That NSW Police Forensic Evidence and Technical Services Branch and the Crime Scene Services Branch use the term 'coronial scene' rather than 'crime scene' in regard to infant deaths determined to be accidental.
4. That NSW Police revise the 'SUDI' section of the Police Handbook to explicitly state that the officer in charge of a SUDI investigation should minimise the police presence at both the scene and the hospital.
5. That NSW Police review its policies and training procedures in order to ensure that guidance is provided to officers in dealing appropriately with a family seeking time to say goodbye to their child in the context of a SUDI death.
6. That NSW Police consider amending the P79A form and the Standard Operating Procedures entitled "Crime Scene Manual (Specialist) – Death Investigation" and SUDI section 2.4.14 to include additional SUDI questions on the matters as set out in paragraph 90 of these Findings.

To NSW Health Pathology:

7. That NSW Department of Forensic Medicine review its policies to encourage forensic pathologists to routinely request, and then review, crime scene photographs prior to signing off an autopsy report.
8. That the Department of Forensic Medicine review its policies to ensure that the role of the CNC includes ensuring that the SUDI medical history form has been received and provided to the case forensic pathologist in a timely manner.

To NSW Ministry of Health:

9. That NSW Ministry of Health review its training policies to determine whether guidance is given to staff in dealing appropriately with a family seeking time to say goodbye to their child in the context of a SUDI death.
10. That NSW Ministry of Health implement their proposed audit of the revised SUDI medical history form over a period of 12 months and evaluate whether the form is being sufficiently completed and whether it is consistently being provided to the Department of Forensic Medicine in a timely manner.

11. That NSW Ministry of Health implement their proposal to monitor the issue of duplication in taking a medical history from the family of a deceased infant over the next 12 months in order to ascertain the most useful and sensitive approach.

To NSW Ministry of Health and NSW Police:

12. That NSW Ministry of Health and NSW Police implement the proposal for an interagency early clinical review meeting to take place within 1 week of every SUDI death in NSW, or as soon as practicable thereafter and no later than 1 month after the death, and evaluate the implementation of this proposal within 12 months from the date of its commencement.

To the State Government of NSW:

13. That the State Government give consideration to the creation of the role of a paediatric clinical nurse consultant (CNC) at the Coronial Case Management Unit (CCMU) trained in SUDI investigations in order to provide centralised support available 24 hours a day to agencies in NSW investigating SUDI and accidental child deaths in NSW.

I close this inquest.

Teresa O'Sullivan
NSW State Coroner
Lidcombe
29 November 2019