



**CORONERS COURT
OF NEW SOUTH WALES**

Inquest: Inquest into the death of JB

Hearing dates: 10-12 August 2026

Date of Findings: 21 October 2026

Place of Inquest: Coroners Court of New South Wales, Lidcombe

Findings of: Judge Carmel Forbes, Deputy State Coroner

Catchwords: CORONIAL LAW – infant death – 8 weeks old - unascertained cause of death - unexplained injuries – insufficient evidence to make a finding on manner or cause of death

File number: 2022/00103756

Representation: Counsel assisting the Coroner: Mr C McGorey, instructed by Ms R Campbell, NSW Crown Solicitor's Office

Senior Next of Kin (Mother): Mr T Hackett, pro bono counsel (NSW Bar Association, Legal Assistance Referral Scheme)

Findings: JB [REDACTED] died on 8 April 2022. The place of his death was [REDACTED] [REDACTED] Eschol Park NSW. The manner and cause of his death are both unascertained.

Non-publication order: Non-publication orders made on 19 May 2026 prohibit the publication of the names, photographs or any other information that would identify the deceased and the mother of the deceased. Copies of the orders may be obtained on application to the Coroners Court Registry.

INTRODUCTION

1. This is an inquest into the sad death of JB j. JB was only 8 weeks old when he died at home. At autopsy the Forensic Pathologist could not ascertain the cause of JB's death.
2. The role of a Coroner is set out in Section 81 of the *Coroners Act 2009* (NSW) and requires a Coroner to make findings as to:
 - i. The identity of the deceased person;
 - ii. The date and place of the person's death; and
 - iii. The manner and cause of the person's death.
3. Section 27(1)(d) of the *Coroners Act 2009* (NSW) requires an inquest to be held if it appears that the manner and cause of death have not been sufficiently disclosed.
4. The primary role of this inquest is to try and uncover how and why JB died.

JB

5. JB was born on 11 February 2022 (weighing 2.9 kg) at Campbelltown Hospital to AB. AB was 18 years old at the time of his birth.
6. AB completed year 12 the year before his birth. She discovered that she was pregnant in late November 2021 at about 26 weeks' gestation.
7. JB's father, indicated before birth that he did not wish to be involved in raising JB or have any contact with him, after birth.
8. AB had accepted early entry to commence a Bachelor of Nursing in 2022 but deferred for a year after learning of her pregnancy.

JB's birth

9. JB was delivered by emergency caesarean section following a prolonged labour. He spent two weeks in the Special Care Nursery due to initial respiratory difficulties and unstable blood sugar and insulin levels.
10. Before JB's birth AB made some inquiries about adoption. Shortly after JB's birth AB indicated she did not want to proceed with adoption.
11. During JB's admission to hospital, AB was noted by nursing staff to show an appropriate attitude towards JB in their observed interactions (e.g. on 17 February 2022 it was noted "*Mother visited at 1200hours for cuddle. Mother appropriately attends to baby cares and cues in a loving manner*"). There were also notes to the effect that AB required help in "*mother craft*" and with reading baby cues (e.g. notes made on 24 February and 25 February 2022).
12. No concerns were noted at the hospital in relation to AB's bonding with JB or overall care of him.
13. JB was discharged from hospital on 25 February 2022 weighing 2.91kg.

Family Home

14. AB lived with her father and her older brother. Both worked fulltime. AB's mother lived separately and visited on weekends. Her father's partner stayed over on weekends.
15. AB's paternal aunts and cousins lived within about 10 to 20 minutes' drive of her home. She described receiving support from her aunts, cousins and friends. She was otherwise the sole carer for JB. That included caring for him overnight when he woke for feeds.

16. JB had his own nursery which was used for daytime sleeps. At night he slept in AB's bedroom. He usually slept in a freestanding bassinet positioned at the end of her bed. Sometimes, if he was harder to settle, AB placed him in a small portable memory-foam mattress with raised sides, referred to as a 'sleep lounge', on her bed beside her.

Medical Checks post birth

17. After discharge AB presented JB for scheduled medical checks. This included:
- (1) On 2 March 2022 he was seen at an outpatient consult with Dr Angela Tan (Consultant Paediatrician) at the Transitional Neonatal Clinic. His weight was recorded to be 3.05kg.
 - (2) Child, Youth and Family Nurse home visit on 11 March 2022. JB's weight was 3.54kg.
 - (3) A GP check-up on / about 21 March 2022 during which JB received his 6-week-old immunisation shot. JB weighed 4.04kg putting him in the 15-25th percentile for weight (generally considered healthy albeit on the smaller end of the weight range).
18. JB was gaining weight and presented in these checkups in good condition with no concerns noted as regards his care.

Triple 000 call at 12:38pm on 8 April 2022

19. At 12:38pm on 8 April 2022, AB made a triple zero call. That call lasted for 13 ½ minutes. During the call AB stated that it "doesn't look like" her baby was breathing and that she had tried CPR but it hadn't worked. The operator instructed AB to check his mouth was not obstructed and to check for signs of breathing, with subsequent instructions on the performance of CPR (which AB confirmed she was doing). The operator continued calling out compressions and breaths for AB to perform. At about 12 minutes 45 seconds, AB said, in effect, that she could hear knocking. The operator told her to "let them in" and go "straight back to bubby" and then "take baby straight to the paramedics" (AB said "okay").

20. No one else was home besides herself and JB when she made the triple zero call.
21. At 12:49pm, Ambulance NSW Paramedics Erin Birmingham and Kevin Lam arrived at the home in response to the triple zero call.¹ The paramedics knocked on the front door. Several minutes after their arrival AB opened the front door with JB in her right hand and her mobile in her left (still on the phone with the triple zero operator).²
22. The paramedics found JB was unresponsive, not breathing, blue and floppy. They began emergency treatment at the scene. Two other paramedics, NSW Paramedics Caitlin Redford and Matthew McGregor, arrived at the scene.
23. Paramedic McGregor later reported that he assisted with first aid inside the ambulance. JB had a low body temperature of around 34 degrees, his pupils fixated and no signs of cardiac activity measured on the ECG. Paramedic McGregor, in his subsequent statement to police, expressed his view that JB had been deceased for *“some time long enough that there was no reasonable chance of resuscitation”*.³
24. JB was taken by paramedics to Campbelltown Hospital. Efforts at resuscitation continued en route. JB did not exhibit signs of cardiac activity. The paramedics subsequently noted their understanding, based on their brief interactions with AB at the scene, that she had last seen JB well about 8am.⁴

Campbelltown Hospital

25. At 1:10pm, paramedics arrived with JB at Campbelltown Hospital. The medical team included the Emergency Department, Dr Laverne Lok and Paediatrician, Dr Sophie Paton. JB was noted to be in cardiac arrest with no pulse / cardiac activity and not to be breathing.⁵ The treating team continued cardiopulmonary resuscitation.

¹ Ex 1 Tab 9 Vol 1.

² Ex 1 Vol 1 Tab 9

³ Ex 1 Vol 1 Tab 11

⁴ Ex 1 Vol 1 Tab 9

⁵ Ex 1 Vol 1 Tab 15

AB arrived at the hospital soon after JB's arrival (driving herself). Dr Sophie Paton pronounced JB's life extinct at 1:30pm (after AB's arrival

26. A social worker at the hospital made a note on 8 April 2022 (3:38pm) about meeting with AB on her arrival at the hospital and supporting AB when she spoke to doctors in the Emergency Department. In her note the social worker recorded that AB said she had fed JB at 8am, put him to sleep in his bassinet which was lying on the bed next to her and set her alarm for 12pm to ensure JB was fed on time. She was woken by her alarm at 12pm. She saw JB on his side, his chest not moving, skin pale and lips blue. She began CPR and then called triple zero. The triple zero operator instructed her on the performance of CPR until the paramedics arrived.

27. Dr Angela Tan, Consultant Paediatrician, also spoke with AB in the Emergency Department. Her progress note records: *"fed well at 8am, well, nil concerns and put to bed in supine position. Mother put alarm for 12pm and woke to find JB unresponsive, pale, pupils fixated and dilated and called ambulance"*.⁶

28. Dr Lok issued the Coroner's Court a formal notification that same day of JB's death. That notification stated that the cause of death was unknown and referred to "SIDS" as a possibility.⁷

29. Police were notified of JB's passing. Leading Senior Constable (LSC) Osstendorp, Constable Harradence and LSC Gilarte attended the hospital. LSC Gilarte arrived at about 2:20pm.

30. LSC Gilarte recorded that AB had fed JB around 8am, put him to sleep on the bed next to her and had woken at 12pm to her alarm for his next feed. When she woke and turned, she saw JB had rolled over, so he was facing away from her"⁸

⁶ Ex 1 Vol 2 Tab 25A.

⁷ Ex 1 Vol 1 Tab 2.

⁸ Ex 1 Vol 1 Tab 6

Examination of JB's home

31. Police and scene examiners attended JB's home.
32. Photographs were taken of AB's bed which showed the 'sleep lounge' mattress in situ on the bed and photographs of the cot positioned at the end of the bed.
33. AB completed a written statement to police on 2 July 2022. In that statement AB said that she had put JB to bed with her, in the sleep lounge on her bed, overnight on 7 to 8 April 2022. JB had no issues with his health that evening. She woke and fed him a bottle of formula (80mls) at 8am on 8 April 2022 before JB and herself fell back to sleep (AB next to him on the bed). When she was woken by her alarm, set for 12pm for his next feed, JB was lying on his side with his left shoulder facing her, and he looked "*really pale*". She placed him on the floor, began CPR (having previously undertaken first aid training) and called triple zero for help. The triple zero operator talked her through continuing CPR which "*I continued as best I could*". When paramedics arrived, she carried JB *downstairs* and handed him to a paramedic at the door. Once paramedics left, she called her friends, her stepmother, and then drove to hospital.

Autopsy

34. On 12 April 2022, Dr Dianne Little completed an autopsy.⁹
35. An autopsy report was subsequently finalised by Dr Isabel Brouwer, Senior Staff Specialist Forensic Medicine, on 8 March 2023, based on the findings recorded by Dr Little at autopsy. Dr Little had drafted the report but retired before it could be finalised. Dr Brouwer completed a supplementary report on 7 February 2025 after receiving a report of the paediatric radiologist, Dr Kristina Prelog (dated 26 June 2022).

⁹ Ex 1 Vol 1 Tab 3

36. In preparing her report Dr Brouwer considered scene photographs taken of the home and JB's sleeping area.

37. Dr Brouwer was unable to ascertain a cause of death. Dr Brouwer noted in her report that JB presented as a well-nourished infant although slightly small for his age (4.3kg / 10th percentile for age). There was no macroscopic evidence of natural disease. A neuropathological examination of the brain and spinal cord showed appropriate development for his age and no significant pathological abnormality. There was no evidence of recent or remote haemorrhage or skull fractures (neuropathologist examination¹⁰). No signs of external trauma were present, including no petechial haemorrhages. Bacterial cultures revealed no pathogens. Viral PCR detected no viral DNA/RNA, and there was no evidence of pneumonia or infection in the lungs.

38. A CT scan, skeletal survey and microscopic examination were performed. Dr Prelog reviewed the radiological imaging. JB had a *healing* fracture of the medial (inner end of) the right clavicle (collarbone), which appeared many weeks old and which Dr Little considered to be consistent with birth trauma (that is, not suspicious). Dr Brouwer noted in her report that a “[c]lavicular fracture is a common birth injury – 0.2-4.5% of newborns, including those delivered by caesarean section”.¹¹ Dr Prelog similarly opined that this injury “is more often seen in prolonged labour as was noted in this case”.¹²

39. JB also had an *acute* fracture of the *distal right radius*. Dr Prelog, in stating it was acute, stated that this fracture did not demonstrate any radiological signs of healing and likely occurred within the last 7-10 days (estimated based solely on the face of the imaging). In oral evidence Dr Brouwer confirmed in evidence at the inquest that this

¹⁰ Ex 1 Vol 1 Tab 5

¹¹ Ex 1 Vol 1 Tab 3 p.4

¹² Ex 1 Vol 1 Tab 22 p.5.

estimate range was reasonable. She could not say when within that range when the fracture occurred.

40. Drs Brouwer and Prelog considered this fracture, in the absence of a reasonably credible explanation accounting for it, was concerning and a possible indication of “non-accidental injury”.¹³

41. Dr Brouwer also identified, through microscopic examination, the presence of three additional fractures, being a fracture to the right ulna and the *left radius and ulna*. Dr Prelog, in her review of the X-ray / CT images, could not confirm or deny the presence of these fractures. In a supplementary report, after considering Dr Prelog’s report, Dr Brouwer stated:

“The fractures of the right ulna, left radius, and left ulna seen on microscopic examination were not identified on the post-mortem images. Dr Prelog explains in her report that the fractures may be difficult to identify in the acute setting on images, especially if there is no displacement of the fragments or an identifiable fracture line, as in this case. For these more subtle fractures not visible on routine post-mortem CT and X-ray imaging, microscopic examination may be more accurate as this examines the bone on a cellular level. I have reviewed the tissue sections of the ulnae and radii and agree with the observations made by Dr Little in the post-mortem report.”

42. Dr Brouwer described them as classic metaphyseal fractures, or ‘micro fractures’, and said it is not unusual for such fractures to be seen on microscopy but not on imaging. As to the mechanism of such fractures in infants, Dr Brouwer said in evidence:¹⁴

“In general, the infant's bones are more elastic than that of an adult so it's more difficult to break a long bone, but these specific fractures occur around

¹³ Ex 1 Vol 1 Tab 22 p.5.

¹⁴ Transcript 17:31-46, 10.8.2026.

the growth plates where the bones are more sensitive, and it's like a shearing type of injury that occur around the growth plate area of the bone, which is - it's typical of infants. It usually occurs in infants less than two years of age, so it's not something one sees in an adult. Because of the anatomy of the bone and the fact that the growth plate is still open because of the - that's where the bone grows and that's sort of the sensitive area of the bone, that's specifically sensitive to the mechanism of injury that causes these fractures, that's usually a rotation and traction type of injury. [In adults] the growth plates are closed and adults can't have – sustain this sort of injury. It's usually caused by a type of rotation and traction injury around the growth plate that causes these micro fractures or just splitting off of a little part or corner of the bone at the growth plate.”

43. The ‘rotation and traction’ injury is understood to typically result from forces generated from twisting or pulling on the limb as compared to the type of force generated from a blunt force impact.¹⁵

44. Dr Brouwer confirmed that she observed no external markings or injuries on JB's forearm suggestive of force being applied to that area e.g. bruising from gripping a limb. As to the significance of that, Dr Brouwer said in evidence:¹⁶

“Q: would visible bruising or some marking be expected if the fractures arose from in the preceding 7 to 10 days before death?

A: It depends on the time frame because bruising again is one of those very difficult things to date. So, if it had occurred you know in a week or more, the chance is there that the bruising might have disappeared and might have not been visible at the post-mortem, but there were no other indications, any other injuries on the surface of the body or internally that is indicative that the child was inflicted any other injuries.”

¹⁵ Transcript 18, 10.8.2026.

¹⁶ Transcript 18-19, 10.8.2026.

45. Dr Brouwer added that she could not explain from the autopsy how the fractures were sustained. She said an accidental mechanism might be an infant being pulled up vigorously by the arms with some rotation. She said a deliberate mechanism would typically be twisting of the arm to inflict pain. She excluded the fractures being caused during resuscitation (CPR), because the cellular reaction seen at each fracture indicates a period of survival after injury and JB was already deceased when CPR began. She also excluded birth as a cause, because unlike the clavicle fracture the forearm fractures showed no established healing. There was no indication of any bone fragility.

AB's record of interview on 7 February 2025

46. AB participated in a record of interview on 7 February 2025 with Detective Senior Constable Penman.¹⁷

47. AB was asked if she could explain her earlier statements about waking at 12pm (when the alarm activated) to feed JB and the timing of the triple zero call (12:38pm). AB stated that after the alarm went off, she decided to let him sleep a bit longer in his sleep lounge on her bed and then she found him *"lying either on his side or face down. He was like, very, like not blue but pale. And that's when I checked his heart rate and I couldn't hear it. That's when I called triple zero obviously. Triple zero walked me through how to give CPR to a newborn."*

48. Asked about how JB might have suffered his forearm fractures, AB said:

"I can't really imagine anything that would hurt him to that extent. The only thing I can think is like I was at home a lot because I didn't really want to take a newborn out in the world until six months that was my plan. - - - Obviously I was a lot younger, 18 or 19 at the time. So, I had a lot of people around me all the time, like Mum, Dad, Step Mum, friend, everyone. So, I can just imagine

¹⁷ Ex1 Vol 1 Tab 18.

that like he was handed off to a lot of different people wanting to see him and wanting to spend time with him kind of thing. But like I can't even imagine how something would be so bad that it would cause a fracture. I don't see how that's happened."

49. During the coronial investigation paramedic and police witnesses noted concerns about the appropriateness of AB's demeanour at the hospital and in her home in the context of her baby having just died. They had never met AB before.

50. On the other hand, family and friends described her as distressed. Submissions on AB's behalf point out that the social worker at the hospital, Ms Stuart, noted that AB was distressed, crying and sobbing.

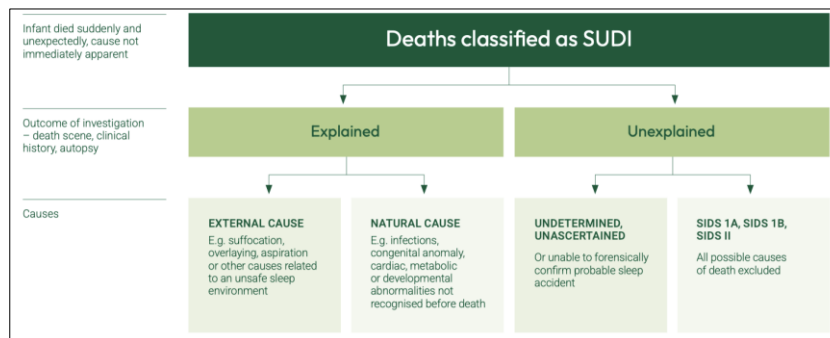
51. I am not persuaded that it would be safe for the Court to place weight on the observations relating to her demeanour when considering the cause of JB's death.

Sudi Classification

52. The NSW Child Death Review Team (CDRT) is a statutory body constituted under Part 5A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. The CDRT's functions include maintaining a register of child deaths in NSW; classifying those deaths according to cause, demographic criteria and other relevant factors; and making recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of child deaths: s 34D (1).

53. The CDRT, in its *Child Deaths in NSW 2022 and 2023 Biennial Report to Parliament* (2022-2023 Biennial Report), classifies infant and child deaths into three categories being (i) *natural causes of death*; (ii) *external causes of death* (transport, drowning, suicide and homicide) and (iii) SUDI.

54. The 2022-2023 Biennial Report depicts the SUDI classification as follows:



55. The report defines SUDI as:

“The death of an infant [child less than 12 months of age] that is sudden and unexpected, where the cause was not immediately apparent at the time of death.

SUDI is not a cause of death, but is a descriptive term applied at the point an infant is found deceased.

SUDI explained: where a definitive cause of death is found after investigation. These deaths may include death caused by infections, physiological or developmental abnormalities not recognised before death, accidental threats to breathing such as overlaying or suffocation in the context of an unsafe sleep environment. In rare cases, the cause may be identified as intentional injury.

SUDI unexplained: where no cause of death could be determined, despite investigation. Unexplained SUDI includes unascertained deaths and deaths classified as SIDS. In many cases, clinical findings or environmental risk factors are present but none can be identified as the definitive cause of death. These deaths are classified as ‘undetermined’, ‘unascertained’ or ‘unclassified sudden infant death’.”

56. The report defines the term SIDS as follows (citations omitted):¹⁸

“The sudden unexpected death of an infant [child less than 12 months of age], with onset of the fatal episode apparently occurring during sleep, that remains unexplained after an investigation, including performance of a complete autopsy and review of the circumstances of death and the clinical history. SIDS is coded to the ICD-10-AM as code R95 ‘sudden infant death syndrome (SIDS)’. This code also includes any mention of ‘sudden infant death’, ‘cot death’, ‘SIDS’, ‘crib death’ or other similar terms anywhere on the death certificate.”

57. The 2022-2023 Biennial Report specifies that the *SIDS* subgroup classification may only be applied when (i) a cause of death has not been identified and (ii) all requisite investigations have been undertaken to look for, and exclude, all known conditions that may lead to a sudden and unexpected death.¹⁹

58. The sub-group terms “SIDS IA”, “SIDS IB” and “SIDS II” are not defined in the 2022-2023 Biennial Report, however these terms have previously been defined by the CDRT in its 2010 Annual Report (Appendix 4)²⁰.

59. In the 2010 Annual Report the criteria for the SIDS IA category are defined to capture the death of:

- i. *Clinical*: the infant aged greater than 21 days but less than 9 months of age; he or she had a normal clinical history (including term pregnancy); normal growth and development; and no similar deaths among siblings, close genetic relatives or other infants
- ii. *Circumstances of death*: there has been an investigation of the scenes where incidents leading to death might have occurred, with a determination that they

¹⁸ See “SIDS” in the A1 Glossary, 2022-2023 Biennial Report, p.203.

¹⁹ 2022-2023 Biennial Report at [8.1] p.147 (footnote 129).

²⁰ CDRT Annual Report 2010 in Appendix 4 at p.131.

do not provide an explanation for the death. Found in a safe sleeping environment with no evidence of accidental death

- i. *Autopsy*: there is an absence of potentially fatal pathologic findings, with no evidence of “*unexplained trauma, abuse, neglect or unintentional injury*”, and negative results for toxicologic, microbiologic, radiologic, vitreous chemistry, and metabolic screening studies.

60. Unexplained trauma is excluded from the SIDS 1A subgroup as the unexplained SUDI group classification is arrived at by process of exclusion. The presence of trauma, in a case where no medical cause could be identified in autopsy, raises the potential that an external cause caused or materially contributed in some unknown way to death.

61. Category IB applies to infant deaths that meet the general definition of SIDS and all the criteria of category IA, except that there has not been an investigation of the scene where the death might have occurred and/or medical investigations were not performed (e.g. toxicological, microbiologic, radiologic, etc).

62. Category II SIDS applies to infant deaths that meet category IA or IB criteria other than for one or more specified factors; for instance (non-exhaustively) because of “*similar deaths among siblings or close relatives or infants in custody of same caregiver not considered suspect for infanticide or recognised genetic disorders*”.

63. The SUDI classification framework is intended to ensure greater consistency in the investigation, collection and reporting of data on SUDI. Amongst other matters the collected data on SUDI is analysed to identify recurring factors that have been correlated with increased incidences of SUDI (e.g. risk factors). That analysis informs public health recommendations as to policy and public awareness campaigns aimed at reducing risk factors particularly those identified as ‘modifiable’ (e.g. prone positioning, co-sleeping, exposure to smoking, etc). For instance, the NSW Health SUDI protocol states that most SUDI occurs in the first 3 months of life. Unsafe sleeping

practices are an identified risk factor associated with SUDI.²¹ It recommends using cots that meet the Australian safety standard and have a firm well-fitted mattress. It also recommends against the use of (i) other sleep environments such as makeshift beds, armchair, lounge, couch, sofa, bean bag or prams and (ii) cot bumpers, pillows, doonas, mattress padding, sheepskin or lamb's wool which might obstruct a baby's face.

Dr Brouwer's evidence

64. Dr Brouwer was unable to determine a medical cause for JB's death.

65. JB's case was considered by the Forensic Medicine Multidisciplinary Paediatric Review Panel, of which Dr Brouwer was a member. The panel agreed the cause of death should remain unascertained. JB's neonatal history (respiratory distress and unstable blood sugars) was not considered a SUDI risk factor.

66. Dr Brouwer, noted that JB was reportedly placed in an "unsafe sleeping environment", stating:²²

"The infant was placed in an unsafe sleeping environment. A history was given that he was put to sleep in a baby lounger on an adult bed with his mother next to him. Photographs of the bedroom taken by police show the lounger on the bed. This is considered to be an unsafe sleeping environment with the potential for decreasing adequate oxygenation of the blood due to rebreathing in a poorly ventilated area."

67. Dr Brouwer elaborated in her oral evidence that an unsafe sleep environment is not limited to instances where there is complete airway obstruction arising from bedding or a sheet, but may also arise where the positioning and bedding contribute to reduced oxygen intake, stating:²³

²¹ https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2021_013.pdf

²² Ex 1 Vol 1 Tab 3

²³ Transcript19-20, 10.8.2026.

"Q. You noted there it was agreed that the cause of death should remain unascertained and raised concerns about JB's sleeping environment. Could you just expand on what the concerns were with the sleeping environment and how that might be relevant?"

A. So, the sleeping environment would be described as an unsafe sleeping environment according to the recommendations from the New South Wales Child Death Review Team and organisations like for example Red Nose. So a safe sleeping environment of an infant is usually in a crib on its own on a firm mattress that's child safe without having any toys or any other potential objects in the crib that can cause any airway obstruction, and the position of the child should be placed on their back. So that's a safe sleeping environment. Anything other than that is considered to be unsafe.

Q. Yes

A. And unsafe in the context that we - that JB was found in would be being on an adult bed in a baby lounge that's soft, and a lot of these baby sleeping devices are sold as infant safe, but according to what we look at that is not a safe environment, and you know if there's other things with the baby in that lounge that could also have contributed to anything like airway obstruction or, yeah.

Q. In terms of the need for a firm surface, can you - to the extent you're able, what is the significance of a firm surface as a means of safety for a child sleeping on their back versus say in a softer mattress or on a bed, an adult bed?

A. These are all things that have been through research and through looking into sudden infant deaths has been identified as the best position or the best scenario for sleeping. There's a lot of research done around sudden unexpected death in infants and there's no real explanation as to why sleeping on the bed - on the back versus sleeping in a prone position. There's lots of theories around it, but research has shown since for example changing

the position of the infant's back to sleeping on their back, that it has impacted on the number of sudden infant deaths. So, a lot of it is experimental and a lot of it's around research and that's where these recommendations come from.

Q. When you speak of airway obstruction in this context for instance, one extreme example might be a blanket that's over the face of an infant, so it's directly covering the airway, is there other more nuanced sort of scenarios for airway obstruction in the context of unsafe sleep arrangements? Could it be that the setup reduces airflow or contributes to difficulties with breathing in other ways?

A. Yeah, so like I said a lot of research has been done around for example the impact on just low oxygen on the infant's brain because of the anatomy of the - and the - just the, the sensitivity of the brain around hypoxia for example. So, it doesn't necessarily have to be like complete airway obstruction, it's just a reduced intake of oxygen that can impact and lead to Sudden Infant Death Syndrome, but all of those - a lot of it is in theory, and a lot of it has been postulated through research, and there are certain anatomical abnormalities in the brain that can or has been associated with Sudden Infant Death Syndrome. [A neuropathological examination revealed] no anatomical structural abnormalities...that would have made JB more sensitive to sudden infant death syndrome. So, there's no real explanation as to why he died, and that's why the cause of death was given as unascertained."

Conclusion

68. JB's right collarbone fracture is reasonably attributable to birth trauma.

69. JB's acute distal right radius fracture and the fractures of the right ulna left radius and left ulna are not attributable to birth, to resuscitation efforts, or to any known natural cause or bone fragility. They were all acute, showing no established healing,

and the evidence is that they resulted from a traumatic event, or several traumatic events, sometime before death.

70. Their existence is of concern given that JB was only eight weeks old. He was not independently weight bearing or mobile, which excludes the possibility he might have accidentally caused these fractures to himself.
71. It is not possible to find when the fractures were suffered. Dr Prelog estimated the distal right radius fracture occurred within 7 to 10 days before death. All four forearm fractures showed only an early cellular reaction, with no established healing, and appeared similar in age. Dr Brouwer could not say whether they were sustained at the same time or within a short period of each other, but there was nothing to suggest they were sustained over an extended period.
72. The forearm fractures may well have been caused at the same time, or close in time, rather than by separate events. They may have been deliberate, or it is possible that they were accidentally inflicted when picking JB up by his arms as described by Dr Brouwer in her evidence.
73. The fractures were not directly causative of JB's death.
74. Submissions were made on behalf of AB that as JB was found in what is described as an unsafe sleep environment and as his injuries may have been caused accidentally, that a finding could be made that JB's death is consistent with SUDI unexplained. (No cause of death could be determined despite investigation, and environmental risk factors are present, but none can be identified as the definitive cause of death).
75. While there are no other injuries found on JB as might be expected if his injuries were deliberate, the available evidence does not permit a finding that they were accidentally caused. There is no evidence that at some point he was accidentally handled in such a way that he may have sustained the injuries.
76. JB's injuries remain unexplained.

77. Dr Brouwer emphasised that a SUDI classification is not itself a diagnosis or cause of death. Her evidence is that injuries at the time of death warrant further investigation and, because JB's fractures remain unexplained, she would not support any SUDI classification in his case.

78. I accept her evidence that the most appropriate finding for the cause and manner of JB's death is unascertained.

Concluding Remarks

79. I thank Mr. C McGorey, Counsel Assisting and his instructing solicitor Ms. R Campbell for the work they put into assisting me in this inquest.

80. I would also like to acknowledge the work of the Officer in Charge, Detective Sergeant Penman, who conducted the police investigation into this matter and compiled the police brief.

81. I express my sincere condolences to JB's family.

Findings pursuant to s 81(1), *Coroners Act 2009*

JB died on 8 April 2022. The place of his death was [REDACTED], Eschol Park NSW. The manner and cause of his death are both unascertained.

Judge Carmel Forbes

Deputy State Coroner NSW

21 October 2026

Coroners Court of NSW at Lidcombe