IN THE CORONERS COURT OF THE NORTHERN TERRITORY

Rel No: A0009/2025

Police No: 25 17231

CORONERS FINDINGS

*Section 34 of the **Coroners Act 1993***

I, Elisabeth Armitage, Coroner, having investigated the death of **a 5 week old Aboriginal female infant** and without holding an inquest, find that she was born on **11 January 2025** and that her **death occurred on 16 February 2025, at Alice Springs Hospital in the Northern Territory.**

Cause of death:

1(a)	Disease or condition leading directly to death:	**Sudden unexpected death of an infant (SUDI) from viral pneumonitis (Rhinovirus and Enterovirus)**
2	Other significant conditions contributing to death but not related to the condition causing death:	**Intrauterine Growth Restriction**

Other conditions present but not regarded (or provable) as contributing to death were: Unsafe sleeping environment (co- sleeping arrangement)

Following an autopsy on 18 February 2025, Forensic Pathologist, Dr Salona Roopan commented:

Circumstances surrounding death

The decedent was a 5-week-old infant who was found unresponsive by her mother after both had fallen asleep on a single mattress and the infant was lying on her back. The infant was last seen responsive at 6:30am after the mother fed her formula milk and they both went to sleep. At 10:00am the infant was found to be unresponsive, and the family drove to Alice Springs Hospital where she was declared life extinct at 11:01am. The infant was in a co-sleeping arrangement with the mother on a single mattress. The mattress had a sheet which was shared by both. The infant had a blanket underneath and blankets on top of her. A doona cover was also shared by the mother with the infant.

Comments

- The opinion as to the cause of death is based on the available police and medical information, and a full post-mortem examination including ancillary investigations.
- This was a sudden death of a 5-week-old infant (ex-premature, intrauterine growth restricted infant) with all growth parameters below the 3rd centile for growth. The baby was reportedly found by mother on her back after they had both fallen asleep on a single mattress on the floor which had soft bedding ("blankets, doona"). No obvious evidence

of neglect or trauma was demonstrated.

- At autopsy, the lungs were heavy, and congested, with histological evidence of viral pneumonitis. There was appropriate proper intervention without evidence of airway trauma or misplacement. A pericardial effusion was present, likely secondary to systemic inflammation or congestive changes associated with the viral infection. No intrinsic structural cardiac abnormalities were noted. Focal subcapsular haemorrhage, attributed to resuscitation efforts, and congestion, consistent with impaired venous return or systemic illness whilst histology showed viral changes, supporting systemic infection. Histology showed features of a multi-organ viral response, including in the brain-suggesting early encephalitic involvement, which can occur with enterovirus infection. The umbilical artery clot may reflect a prior thrombotic event, possibly related to the intrauterine growth restriction (IUGR), but was not a direct cause of death. Bilateral ovarian cysts are incidental and benign neonatal findings. No external or internal injuries, congenital anomalies, or signs of trauma were observed. No alcohol or drugs detected on toxicology analysis. Detection of rhinovirus and enterovirus RNA in both upper and lower respiratory tract specimens supports a respiratory viral infection.
- IUGR is a known risk factor for perinatal morbidity and mortality, often associated with impaired immune function with an increased vulnerability to infections and poor physiological reserve in early infancy.[1]

Reference

1. Colella, M., Frerot, A., Novais, A. R. B., & Baud, 0. (2018). Neonatal and Long-Term Consequences of Fetal Growth Restriction. Current pediatric reviews, 14(4), 212-218. https://doi.org/10.2174/1573396314666180712114531

Past medical history

Review of the Northern Territory electronic clinical case record showed a medical history of symmetrical early-onset intrauterine growth restriction in an otherwise normal infant, born at 37 weeks at 1.9kg via emergency C-section for ante-partum haemorrhage, pre-eclampsia and non-assuring cardiotocography CTG. Born with Apgars of 9 at 1 minutes and 9 at 5 minutes.

Social context

The decedent was a 5 week old female infant. She was formula fed and co-sleeping with mother on a single mattress. There is no maternal history of alcohol or drugs.

Background:

On 11 July 2024, infants mother attended Central Australian Aboriginal Congress (CAAC) and underwent a pregnancy test which returned a positive result. Mother underwent pregnancy testing, scans and was referred to My Midwives for midwifery care.

Infant was born at Alice Springs Hospital on 11 January 2025, by way of emergency C-section at 37 weeks of age and she weighed 1.920gr. Her biological parents are 21-year-old mother and 19-year-old father. Infant was the couple's first child.

Following the birth, infant remained in Alice Springs Hospital for the first 19 days due to being underweight. She was discharged from Alice Springs Hospital Paediatrics ward on 24 January 2025 into the care of her parents.

Upon being discharged infant and her parents returned to their family residence at Charles Creek Camp. The family shared a bedroom, and infant slept in a crib.

On 25 January 2025, a midwife attended and conducted a sleep assessment and discussed safe sleeping, the importance of not co-sleeping, and maintaining a smoke free home and environment with the mother. This was documented in the contemporaneous notes of that visit, "Checked out home sleeping arrangements, in cot made up correctly next to bed. No smoking in the house by family members at [mother's] request."

The family stayed at this location for a few weeks before they decided to move to an Outstation. The mother said that the house at Charles Creek Camp had too many visitors and there was a lot of drinking and the combination was not a good environment for infant.

At the Outstation the young family shared a bedroom in a family house. Bedding consisted of two single mattresses. Mother and infant co-slept on one of the single mattresses and father slept on his own mattress.

Circumstances:

Sometime between 9:00pm and 10:00pm on the evening of Saturday 15 February 2025, mother prepared her infant for bed. Infant was placed on the mattress beside the bedroom wall and blankets were placed on top of her. During the night she was bottle fed, burped and had her nappy changed and she was put back down to sleep. Close to 7:00am mother gave her daughter another bottle and both went back to sleep.

At around 10:00am mother woke and checked on infant and noticed she was unresponsive and not breathing. Mother picked her infant up and told father, "[infant] is not breathing".

Another family member started to perform CPR on infant. When infant did not respond, the family drove approximately 25 kilometres to Alice Springs Hospital.

At approximately 10:15am while enroute to Alice Springs Hospital, mother phoned her midwife who was at the Alice Springs Hospital Maternity ward.

Mother was upset, crying and screaming down the phone "what happened to my baby, she is not breathing, you've got to help me". Mother said infant was yellow and white. The phone call then cut out after 43 seconds; an attempt was made to call back but was unsuccessful.

At 10:18am the Maternity Team Leader spoke to mother on the phone and was told they were in the car driving very fast and infant was not breathing.

The Emergency Department were informed and the emergency department staff made preparations for their arrival.

At approximately 10:28am the family arrived at the Alice Springs Hospital emergency department. A family member passed infant to waiting staff who rushed her into the resuscitation room.

30 minutes of attempts to resuscitate and medical intervention were unsuccessful, and infant was declared deceased at 11:01am.

A crime scene was established at the outstation and examined by a Principal Crime Scene Examiner and no suspicious circumstances were identified.

A Coroners Constable completed the sudden child or infant death checklist.

This was the sudden unexpected death of an infant (SUDI) and the cause was later identified at autopsy as viral pneumonitis. Infant's parents cherished their little girl and were good parents. They looked after her well and were doing all they could to keep her safe. Thay are devastated and crushed by her passing. Their lives will never be the same.

Co-sleeping risk factors:

Accepting that the cause of death was viral pneumonitis, the coronial investigation identified risk factors in the co-sleeping environment. However, it was not established that these risks contributed to this death.

It is clear from the investigation that the parents, particularly the mother, had received some education about co-sleeping risk factors and had taken steps to eliminate or minimise risks she was aware of. Specifically,

a) Mother ceased smoking when she learned of her pregnancy, did not smoke during infant's life, and encouraged others not to smoke in the homes where infant was staying,

b) Mother did not drink alcohol during the pregnancy or during infant's life, and took steps to ensure infant was not exposed to intoxicated persons,

c) Infant initially slept in a 'correctly made up' bassinette/cot when discharged from hospital,

d) Infant commenced co-sleeping when the family moved residence and could not take the bassinette/cot with them but steps were taken to improve the co-sleeping environment, including:

   (i) Only the mother and infant shared the co-sleeping surface, father slept on a separate mattress,

   (ii) There was no smoking or drinking in the bedroom and mother was sober when sleeping with infant,

   (iii) There were no animals in the bedroom,

   (iv) Mother created a separate space on the mattress delineated by a baby blanket where infant slept and mother slept on the side of the mattress to reduce the risk of suffocation and/or rolling on infant,

   (v) Infant was placed on her back to sleep.

However, other risks associated with co-sleeping remained, including:

a) The infant was born with a low birth weight and was small and young,

b) On the side where infant slept the mattress was pushed up next to a wall. The join between the mattress and the wall created an unsafe crevice (gap) of a kind known to create a suffocation risk for babies,

c) There was unsafe linen on the co-sleeping surface including doona, blankets and pillows,

d) The mattress was of single size when a double mattress or greater is recommended as being safer for co-sleeping,

e) The mattress appeared to be of soft construction when a firm mattress is recommended as being safer for co-sleeping.

These risks are discussed not to blame anyone but rather they are identified in an effort to educate, and to point out just how difficult it can be to create a safer co-sleeping environment. Because of these difficulties, it is recommended that babies, particularly small babies, sleep on their own, separate, clear, firm, sleep surface, in line with the recommendations of Red Nose.

Bottle feeding is another known risk factor for SUDI but it has not been considered in detail in any Northen Territory inquest.[1]

In the *Inquest into the deaths of Baby K, Baby B and Baby S* [2026] NTCC 06, the risks of co-sleeping and risk minimisation were considered. In particular, how education on risk and risk minimisation could be improved and on the potential value of safe sleep devices in a co-sleeping environment. The two main devices considered were the Pēpi-Pod® (left) or Coolamon (right).

When used in accordance with the education provided with distribution, both of these devices are designed to provide a safe sleep environment for co-sleeping babies. As infant's parents are young and are likely to have further children it is important that they understand the risks of co-sleeping and the steps they can take to ensure babies always sleep safely. I trust that this education and opportunities to access safe sleeping devices will be provided to them in any subsequent pregnancy by NT Health, local clinic staff, midwives or family support services, but infant's parents are also encouraged to actively seek-out this advice.

Communication with the family:

In the *Inquest into the deaths of Baby K, Baby B and Baby S* [2026] NTCC 06 concerns were raised about how and when information about SUDI deaths is explained to families. Similar concerns have been raised by this family.

Infant's parents were unhappy about delays in communication and they did not wish to attend the local clinic or see a General Practitioner in order to have the coronial findings explained to them. When the Coroner's Grief Counsellor tried to make arrangements to discuss the findings the mother became distressed. She said *"this is not helping ringing her up and telling her she can go to the doctors when that means she has to go to town. Does the Grief Counsellor understand about her life?. Has the Grief Counsellor had any baby's die? Why ring me up and talk rubbish to me. I am not going to the doctor. I will kill myself. Send me that report right now. I am going to sue that hospital."* As she was very distressed she hung up on the Grief Counsellor.

Although the mother was firm in her view that she did not wish to have assistance when receiving these findings, I was concerned that they were complex and sensitive. I do not consider that these

[1] Bottle fed babies are at greater risk when co-sleeping because mothers who bottle feed do not demonstrate the same responsiveness at night as breastfeeding mothers - see SAF,T, SUDI and the practice of Co Sleeping/Bed Sharing in the NT which references the research of Professor James J. McKenna

findings can be properly understood without the assistance of a medical professional. Accordingly, arrangements were made for the Katherine West Health Board General Manager to deliver the findings in person to the parents.

In *Inquest into the deaths of Baby K, Baby B and Baby S* I noted that:[2]

> Issues of informing families accurately, sensitively and in a timely way about the cause of their child's death were considered by NSW Coroner O'Sullivan in the *Inquest into the deaths of Kayla Ewin and Iziah O'Sullivan*.[3] To improve investigation practices and communication with families that inquest heard that NSW Health were implementing an early interagency clinical review meeting for every SUDI. The meeting was to: take place within one week of the death; include the forensic pathologist, the investigating police and a paediatrician or medical professional; identify what further investigation was required; progress identifying the cause of death; and address how the needs of the family were being met (including for accurate information).

This mother's distress and experience of 'not knowing' adds to the urgency of recommendation 10 in *Inquest into the deaths of baby K, Baby B and Baby S* [2026] NTCC 06 and I therefore reiterate that recommendation in these findings. I note that any such communication practice should accommodate an ongoing process of communication, from immediately after the death through to any coronial findings and should not be confined to a single communication event.

Recommendation:

1. Consistent with recommendation 10 in the *Inquest into the deaths of Baby K, Baby B and Baby S [2026] NTCC 06* I recommend to **NT Health** that the Territory forensic pathologists, in consultation with Northern Territory Police, the Coroner's Grief Counsellor, and a suitable representative from a Central Australian and/or Top End ACCHO and/or AMSANT, establish a process and practice for explaining SUDI, SIDS and/or unsafe sleeping infant deaths to a deceased infant's parents or caregivers, ensuring that Aboriginal cultural values, traditions and sensitivities are identified, respected and embedded in the process.

[2] *Inquest into the deaths of baby K, Baby B and Baby S* [2026] NTCC 06 at [205]
[3] *Inquest into the deaths of Kayla Ewin and Iziah O'Sullivan* 29 November 2019 State Coroner's Court of NSW