MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends and others by direction of the Coroner pursuant to s57(1)(c) of the *Coroners Act* 1995)

I, Simon Cooper, Coroner, having investigated the death of Baby E

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that:

a) The identity of the deceased is Baby E;
b) Baby E died as a result of co-sleeping (bed sharing);
c) The cause of Baby E's death was suffocation; and
d) Baby E died in May 2018 in Northern Tasmania.

Introduction

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Baby E's death. The evidence includes:

- Police Report of Death for the Coroner;
- Sudden Unexpected Death in Infancy Checklist;
- An opinion of the forensic pathologist who conducted the autopsy;
- The results of toxicological analysis of samples taken at autopsy;
- Ambulance Tasmania Records;
- Launceston Central Medical Centre Patient Health Summary;
- Affidavit of Ms M, Baby E's mother;
- Affidavit of Mr F, Baby E's father;
- Relevant police and witness affidavits; and
- Forensic and photographic evidence.

Background

Baby E was born in the Launceston General Hospital (LGH) in December 2017, the daughter of Ms M and Mr F. She had four older half-siblings. Baby E was just five months old when she died.

Her birth was by way of an emergency C-section and Baby E was, after her birth, admitted to the LGH's special care nursery because she was suffering respiratory distress. However, that issue resolved quickly and, at the time of her death, she was seemingly in good health.

Baby E was described by her mother as a "very happy baby who was always smiling and laughing".

Circumstances of Death

At about 10.30pm on Tuesday 15 May 2018, Ms M fed Baby E and put her to bed. It was the practice of Ms M and Mr F to 'co-sleep' with their infant daughter. According to Mr F they did this because Baby E "refuse[d] to sleep in the cot [her parents] bought for her". This night was no different. Mr F slept on one side of the bed, Ms M in the middle and Baby E next to her mother.

The evidence is that about 1.30am on Wednesday 16 May 2018, Baby E awoke. Ms M gave her a bottle of formula and she settled back to sleep. At some stage after this time, and before about 4.00am, one of the family's other children, four-year-old B, got into the bed. He was positioned next to Baby E, such that she was now sandwiched between her older brother and mother.

Mr F awoke after 4.00am. He noticed Baby E was not making any noise, which alarmed him. He became further alarmed when she did not stir when he picked her up. Mr F woke Ms M, who took Baby E in her arms and noticed she was not breathing and was non-responsive.

Ms M phoned 000. She commenced CPR under the instruction of the emergency telephone operator. Ambulance crews were also immediately dispatched. Ambulance Tasmania records indicate the 000 call was received at 4.25am and paramedics arrived at the family home, eight minutes later. Paramedics took over resuscitation efforts, which continued until 5.04am, when it was clear nothing further could be done for Baby E.

Police arrived shortly after the paramedics and assisted at the scene. Once paramedics advised police that Baby E was dead, an investigation was commenced. The scene, and her little body, were examined and photographed. Exhibits – including the bedding – were seized for subsequent forensic examination. Attending police (who included uniform, detectives and specialist forensic officers) describe the room in which Baby E and her parents slept in one bed, as untidy and cluttered. Photographs taken by investigators lend support to this description.

Nothing suspicious as such was identified at the scene.

After Mr F formally identified his daughter's body, it was transported by mortuary ambulance to the Royal Hobart Hospital (RHH). At the RHH, experienced Forensic Pathologist Dr Donald Ritchey, MD MSc FRCPA performed a post-mortem. He did not find any anatomical cause of death.

Dr Ritchey reported Baby E was:

- Anatomically normal for a girl of her age;
- Well nourished; and
- Normally developed.

He found significant petechiae in her thymus, heart and lungs – clear signs of suffocation.

The presence of nicotine was detected in samples taken at autopsy. No doubt this was the result of secondary exposure to cigarettes (both her parents were smokers), but I am satisfied that exposure to cigarette smoke did not cause or contribute to her death. The reasons for this conclusion are the amount of nicotine detected was extremely low and it is clear from the observations of the investigating officers that Baby E's parents did not smoke in the house.

Conclusion

I am satisfied to the requisite legal degree that the cause of Baby E's death was suffocation. Her death was a direct result of co-sleeping (or bed sharing) with her parents, the danger of which was exacerbated when her brother climbed into the bed. She was either suffocated by the body of her brother or mother or the bedding, or a combination of all or some of these factors.

Although not suspicious, Baby E's death was completely avoidable. Coroners and child health care professionals have warned, over and over again, of the danger to infants of co-sleeping.

Baby E's death is a stark and tragic illustration of what happens when those warnings are ignored.

I take this opportunity, as Coroner McTaggart recently did in the case of the death of seven week old Baby MH, to remind parents and carers of the "importance of ensuring that an infant sleeps safely by him / herself in a cot or bassinet, night and day, and does not sleep in an adult bed, with adult bedding, or next to other family members in the same bed".

Like Baby MH, Baby E died as a result of co-sleeping with two adults and a sibling in an adult bed, with an adult mattress and adult bedding.

Like Baby MH, Baby E would not have died if she had been placed on her back in her own cot to sleep.

Comments and Recommendations

The circumstances of Baby E's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Baby E.

Dated 18 May 2020 at Hobart in the State of Tasmania.

Simon Cooper
Coroner