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 I

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

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

Introduction

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

- An opinion of the forensic pathologist who conducted the autopsy;
- The results of toxicological analysis of samples taken at autopsy;
- Medical records from Tasmanian Health Service;
- Affidavit from Ms M – Baby I's mother;
- Affidavit from Mr F – Baby I's father;
- Relevant police, paramedic and other witness affidavits;
- Forensic and photographic evidence;
- Police Report of Death for the Coroner; and
- Sudden Unexpected Death in Infancy Checklist.

Background

Baby I was the daughter of Ms M, and Mr F. Ms M and Mr F had been together for four years at the time of her birth, and had two other children, aged three years and 18 months.

Baby I's parents and siblings moved to Tasmania in January 2018 from the mainland. The reasons for the move included a wish to escape the heat and the fact of a potential job offer for Mr F. The family moved into a home in Northern Tasmania.

Ms M enjoyed a typical uncomplicated pregnancy and was unaware of her pregnancy until late in the term. The birth was quick and without complication following a full term pregnancy September 2018 at the North West Private Hospital, Burnie.

Ms M took Baby I home later that same day.

Baby I was breast fed from birth, attended two out of three check-ups and was reportedly putting on weight. The evidence is she was a healthy little girl.

Baby I and her mother slept in the lounge room. Baby I had her own bassinet and her mother slept on the couch.

Despite putting Baby I into her bassinet after feeding, there were several occasions when Ms M fell asleep on the couch whilst Baby I was feeding.

Circumstances Surrounding the Death

In the early morning of 27 October 2018, Ms M fed Baby I while both of them were lying on the couch in the lounge room. Ms M was positioned at the front of the couch facing Baby I who was on her left side between her mother and the back of the couch. During the feeding Ms M fell asleep. Some hours later - the timeline is not clear - Ms M woke up. When she did, she saw Baby I was unresponsive and had blood around her nose and mouth.

Ms M called 000 (at 1.18pm) and requested an ambulance. While waiting for the ambulance Ms M performed CPR under the instruction of the 000 operator. Ambulance Tasmania records indicate that the ambulance arrived on the scene at 1.30pm.

It was apparent to paramedics that Baby I had been dead for some time. Ambulance Tasmania Paramedics contacted Tasmania Police and advised of the death.

Investigation

Consequently, Tasmania Police attended and began an investigation pursuant to the *Coroners Act* 1995. The first officers arrived shortly after notification by Ambulance Tasmania.

Both parents were interviewed; the premises was closely examined and photographed. Baby I's body was examined and photographed and various exhibits seized.

A specialist forensic officer Sergeant Katrina Chivers conducted a forensic examination of Ms M at the same. She also photographed her and her clothing. Notably some red brown staining, apparently blood, was seen and photographed by Sergeant Chivers on Ms M's bra.

After Baby I's body was formally identified by Ms M, it was taken by mortuary ambulance to the Royal Hobart Hospital (RHH). At the RHH, experienced forensic pathologist Dr Donald Ritchey performed an autopsy. His findings at autopsy included that Baby I was a normally developed and nourished baby with skin colouration (lividity) on her back, skin colour to her upper body, compression pallor to the bottom half of her body and bleeding from the nose and mouth. In addition, there were florid petechiae on the surfaces of the lungs – indicators of asphyxia.

Toxicological analysis of samples taken at autopsy indicated that Baby I had traces of nicotine in her blood at the time of her death. I note that the evidence is that both Ms M and Mr F smoke cigarettes and both told investigators they only smoke outside. I am however satisfied that Baby I's secondary exposure to cigarette smoke, possibly from her mother's breast milk, did not cause or contribute to her death.

The investigation by Tasmania Police indicated Baby I was not subject to any referrals or monitoring by Child and Family Services in Tasmania. In addition the family had not come to the attention of child protection authorities in any other jurisdiction.

I am satisfied viewing the evidence as a whole that there are no suspicious circumstances surrounding Baby I's death.

Conclusion

I am satisfied to the requisite legal degree that the cause of Baby I's death was suffocation. Her death was a direct result of co-sleeping with her mother.

I have recently dealt with another, very similar death, that of 5 month old Baby E in Launceston in May 2018. Like that death, Baby I'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 I's death is a stark and tragic illustration of what happens when those warnings are ignored.

When I made my findings in relation to Baby E's death, I said:

> *"I take this opportunity, as Coroner McTaggart recently did in the case of the death of 7 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 and Baby E, Baby I died as a result of co-sleeping.

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

Comments and Recommendations

Tragically, and completely avoidably, deaths of infants caused by co-sleeping keep happening. This is so, despite repeated warnings against the practice by organisations such as Red Nose as well as coroners.

I convey my sincere condolences to Baby I's family and loved ones.

Dated: 19 May 2020 at Hobart in the State of Tasmania.

Simon Cooper
Coroner