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, Olivia McTaggart, Coroner, having investigated the death of baby MH.

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

a) The identity of the deceased is MH;
b) MH died suddenly in the circumstances set out in this finding;
c) The cause of death cannot be determined; and
d) MH died on 1 September 2016 in Southern Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into MH's death. The evidence comprises the police report of death; an opinion of the forensic pathologist who conducted the autopsy; affidavits from MH's parents; police and witness affidavits; medical records and reports; forensic evidence; child protection and child health records; and a comprehensive review document prepared by the Serious Events Review Team of Children and Youth Services.

MH was born in July 2016 and was 7 weeks old when she died. She was born to parents GH, then aged 22 years, and CH, then aged 20 years. MH was the third child of GH, and the first child of CH. GH's two other children are PH and FH.

At the time of MH's death, the family were living in Southern Tasmania. GH had a troubled background, suffered poor mental health and, during MH's life, she was medicated for depression and anxiety.

MH was born at the Royal Hobart Hospital ('RHH') at 37 weeks gestation by normal vaginal birth. Her birth-weight, length and head circumference were normal and she was a healthy baby. MH progressed well initially. Child Health and Parenting Service records indicate that, at her two-week and four-week health assessments, MH was healthy and gaining weight.

In August 2016 MH was taken to hospital on two occasions for episodes of vomiting after being fed. On the first occasion, MH was admitted on 15 August and discharged on 20 August. She had presented with fevers and dehydration, assessed as most likely being due to a viral infection. She was discharged with medication and a follow-up review for 23 August 2016. At this review, MH's condition had improved, although she was required to continue the medication for a period of two months.

On 29 August 2016 MH was also taken to the RHH with acute onset vomiting in the setting of reflux. She did not have a fever on this occasion. She was discharged with recommended general practitioner and specialist follow-up. MH's vomiting was diagnosed as likely being gastro-oesophageal reflux.

Circumstances of Death

The direct evidence surrounding MH's movements and condition before her death comes principally from the affidavits of GH and CH. As will be noted, I have particular concern about the accuracy of the account in the affidavit of GH. The accounts provided by GH and CH immediately after MH's death to attending paramedics and police officers were incorrect in critical respects. However, I am satisfied that CH's affidavits are, in general terms, an accurate account of events.

On 31 August 2016, GH described MH as being the happiest she had ever been. She said that she was not crying and went to sleep that evening without any trouble. She said that MH was generally a good sleeper and would wake once or sometimes twice a night to be fed. The arrangement between GH and CH was that when MH woke during the night, CH would get up and feed her a bottle.

GH stated in her affidavit that she and CH slept on a mattress on the floor of the lounge room and MH slept in a cot in the lounge room. They slept in the lounge room due to the other rooms in the house being cold. She said that her three-year-old daughter, PH, would usually come from her own bed in a separate room into their bed at night and sleep with them on their mattress during the night. She would sleep between GH and CH. I am doubtful that PH slept in her own bed at all, considering the photographs showing the state of the available bed and cot. Both GH and CH said in their affidavits that FH slept in his own bed in his room. I accept the evidence in this regard.

On 31 August, likely just before 9.00pm, MH was swaddled and put to bed in her cot by either GH or CH. CH stated in his affidavit, and I accept, that he and GH went to bed at 10.30pm. GH stated that PH came into their bed at about 11.00pm and slept between her and CH. As discussed, this may not be correct but does not need to be resolved. CH said that at approximately 1.30am (on 1

September) MH woke. CH got up and fed her a bottle. He said in his first and more detailed affidavit that he initially put her back in her cot, but she was crying and unsettled. He therefore put her in the bed with himself and GH.

CH said that he laid with MH until she settled and then fell asleep himself. He said that he placed MH on his left side (looking from the foot of the mattress), to the outside of the mattress. On his other side was PH. GH slept next to PH on the far right-hand side.

When CH woke at approximately 7.00am the next morning, he said that GH and PH were still asleep. He stated in his second affidavit, but not his first, that when he awoke MH was on the other side of him, between himself and PH. He did not know how she came to be in that position.

A different account was given by GH in her affidavit. GH stated that CH moved MH from her cot onto the mattress at about 7.00am and that she thought she saw MH move at that time. She said that when CH put MH on the mattress with her she (GH) rolled the other way from her. I do not accept that GH, who I find was asleep, could have been aware of when MH was moved into the bed. I do not accept that it was at 7.00am. I also do not accept that she saw MH move. MH had, unfortunately, been deceased for some time at that stage.

Upon waking at 7.00am, CH then got out of bed to attend to FH.

When CH returned from FH's room, he noticed that MH, lying in the bed, had purple circles around her cheeks. He then woke GH, and they saw that MH was not breathing. CH called for an ambulance and was instructed by the operator to perform CPR upon MH.

Paramedics arrived at the scene at 7.40am. Intensive care paramedic, Mr Ky Wittich, stated in his affidavit that when he arrived, MH was clearly deceased. He said that she was stiff, with rigor mortis present. He formed the opinion, based upon his experience, that she had been deceased for some time. Mr Wittich spoke to CH and GH regarding the circumstances of MH's death whilst they were seated in the back of the ambulance with MH.

In his affidavit, Mr Wittich stated as follows:

"They outlined that CH had placed MH in her cot without any toys, on her back and CH woke her at about 7.00am that morning. This didn't sit right with me and I believed that this was not the case. CH said that he saw MH breathe and move when he got her up. I asked him if he was sure she breathed and moved and he said yes. He also said that she was warm. GH nodded. Both indicated that everything was fine with MH at 7.00am. GH said that she noticed that MH was blue and that was when they called 000."

Mr Wittich further stated:

"I went through risk factors with the parents. GH was a smoker and she said she only smoked outside. The smell of the house would suggest otherwise. The house was cold. The mattress on the floor didn't have sheets, I can't recall seeing a doona or blankets. The cot was filthy, bare and generally unclean. I recall seeing a full size pillow and couldn't understand why that would be there. GH had said that MH had reflux and in my mind that would be why the large pillow was in the cot, to raise her up a bit. I didn't clarify that with GH."

The other attending paramedic, Ms Aimee Turner, also stated in her affidavit that the house smelled of smoke. She was present when CH and GH told Mr Wittich that MH had slept through the night in her cot. It also appears that one or both of the parents told attending police officers that MH was only moved onto the mattress at 7.00am, still alive and healthy, and placed on her back. Shortly after being placed on the mattress, both CH and GH (who said she was awake) saw MH's face turning purple as if she was choking. They then said they started to pat her on the back.

I find, on the evidence, that CH and GH were not truthful in providing such accounts to Mr Wittich and attending police officers regarding MH sleeping in her cot during the night and experiencing a witnessed medical episode whereby she became purple and unresponsive before their eyes.

I am satisfied that CH brought MH into the bed with them at approximately 1.30am, and that she is likely to have died sometime between then and 7.00am. I am not satisfied that MH was breathing or at all responsive when CH first got up at 7.00am.

It should be noted that GH was invited to clarify her evidence and provide a subsequent affidavit in light of the anomalies in her affidavit. She declined to do so, stating that her recall had not changed.

Constable Stephen Bugg and Constable Rebecca Berriman, together with two other officers, arrived at the residence at approximately 8.20am. They noted in their affidavits for the investigation, as well as in the infant death checklist, that the house appeared dirty and untidy, with food, dirty dishes and nappies strewn around the house and on the floor. They stated that the bedrooms were in disarray. There were ash trays with used cigarette butts in the bedroom, dining room and bathroom. The inside of the house smelled of smoke. MH's cot mattress was stained and dirty, as was the bedding on the main bed in the lounge room.

An autopsy was conducted on 2 September 2016 by State Forensic Pathologist, Dr Christopher Lawrence. Dr Lawrence observed that there was no immediate cause of death apparent on autopsy. He found evidence of bronchopneumonia and concluded that MH died as a result of this condition.

At my request, Dr Lawrence subsequently reviewed the conclusions in his report with the benefit of all of the evidence gathered in the investigation obtained after he prepared his original report. In particular, he had regard to CH's affidavit which indicated that MH had slept for a lengthy period in her parents' bed at the time of her death. In his further report to me after reviewing the complete evidence, Dr Lawrence discussed the possibility of death occurring due to an unsafe sleeping environment.

In his further report, Dr Lawrence identified several possible causes of death but no definitive cause. He gave the possible causes as:

- Bronchopneumonia;
- Overlying by another occupant of the bed;
- Combined effects of bronchopneumonia (and/or prematurity and reflux) and unsafe sleeping environment;

Although Dr Lawrence found no clear indicators of overlying, he could not rule it out. Given CH's evidence that there were two adults and another child in the bed, and that MH was not in the same spot in the morning as where he had placed her, overlay is clearly a plausible cause of death. In this regard, CH is 190 centimetres tall and, at the time, weighed 138 kilograms.

GH was engaged with the Child Health and Parenting Service (CHaPs). CHaPs records indicate that GH participated in two assessments (two-week and four-week) for MH undertaken by a child health nurse. At both assessments, GH told the child health nurse, in response to standard questions, that she provided a safe sleeping environment for the baby night and day. Specifically, she acknowledged that she slept MH on her back from birth, kept her head and face uncovered, kept MH in a smoke free environment, and that MH slept in a safe cot in the same room. It also appears that advice regarding ceasing smoking may have been offered by the child health nurse at the four-week check.

I am fully satisfied that GH was aware of safe practices to adopt in order to ensure MH's risk of sudden infant death was minimised. Such advice would have been delivered in respect of PH and FH. From the statements initially made by CH to attending police officers, it is likely that he was also aware that MH should have slept at all times in her separate cot.

Contrary to widely promulgated advice, CH and GH exposed MH to an environment where at least one of them, GH, smoked cigarettes. In a premature baby with reflux and bronchopneumonia, this alone presents a risk for sudden, unexpected death in infancy. Significantly, CH placed MH to sleep next to him on a mattress where GH and PH were also sleeping. Apart from the risk of being

suffocated by the body of another person sleeping in the bed, there were also items of adult bedding, creating a risk of entanglement and suffocation. I am not able to determine whether GH was aware of MH's presence in the bed or not. I am also not able to determine the extent to which CH and GH took MH into bed to sleep with them on prior occasions, although it would seem unlikely that this was the first occasion.

I am satisfied, based upon all of the evidence in the investigation, that neither parent did any deliberate act with an intent to harm MH. Their untruths in their account reflect only knowledge that they subjected MH to a dangerous sleeping environment. On the evidence, it is very unlikely that MH died of purely natural causes. I am satisfied to the requisite standard that MH was restricted by the body of another person in the bed (most likely CH) or by bedding (the doona or pillows). It is possible that her prematurity, reflux and bronchopneumonia contributed to her inability to breathe.

Child Safety Issues

As part of this investigation, I obtained the records of Child Safety Services ('CSS') (previously Child Protection Services 'CPS') relevant to the children of GH. These records disclosed that CSS had involvement with MH's two older siblings, PH and FH from 2012 until 2014, ending two years before MH's birth. During this period four notifications were received regarding these two children which raised the issues of neglect, general parenting concerns and family violence. These notifications were investigated and dealt with in various ways by CSS, short of application to the court to remove them from the home. The final notification was closed on 17 April 2014. Because the notifications were closed, CSS had no further statutory function or power under the *Children Young Persons and Their Families Act 1997.* CSS therefore knew nothing of the family for a period of three years until a further notification was received on 31 July 2017 in relation to PH and FH. During this period of three years, MH was born and had died. No notification was made in respect of MH to CSS and CSS did not know of MH's existence.

Unfortunately, there have been delays in the finalisation of this matter due to investigation into the involvement of CSS with MH's family, factual conflicts surrounding the circumstances of MH's death and the workload of the Coronial Division generally. I am conscious that this lengthy period has impacted upon GH and MH's family. I had considered that a public inquest may have been desirable to resolve various issues, including to determine whether CSS responded sufficiently to the notifications in respect of PH and FH before MH's birth. Specifically, the question arose as to whether CSS should have had statutory oversight of this family in response to any of the previous notifications such that it would have been aware of MH's birth and the considerable risk factors associated with her living at home upon her birth.

I am now satisfied, for the following reasons, that there were no, or no significant, failings in the CSS responses to the notifications in respect of MH's siblings before her birth. In any event, the CSS actions and decisions in respect of them were not sufficiently connected, temporally or otherwise, to MH's death to require extended investigation. In coming to this view, I had regard to an extensive report ('the Review') dated 22 March 2018, compiled by the Serious Events Review team of Children and Youth Services ('the Reviewer').

The Review contained a comprehensive analysis of CPS decision-making and actions in response to notifications in respect of MH's siblings (both before and after her death). The Review has been of considerable assistance in considering the role of CSS in connection with MH's death. Although I am satisfied that an inquest is not desirable and that further scrutiny of CSS is not required, it is appropriate to briefly provide some details from CSS records to disclose my reasoning as the issue has occupied much of the investigation. The nature of the notifications also disclose the nature of the risks to the children of the household.

The first CSS notification in October 2012 and the second notification on 7 November 2013 were in relation to reported violence by two persons who were said to be PH's father and stepfather respectively, and the consequent risks to PH. Also in November 2013, CSS was contacted by a Department of Education employee advising it of concerns relating to PH's care. These reported concerns included GH needing to be reminded to change PH's nappy and feed her, and concerns that PH had blisters on her head from sunburn. One of GH's housing workers also advised CSS of concerns about the condition of GH's housing property, including unpacked belongings and food on the floor.

GH accepted, on a voluntary basis, Integrated Family Support Services' (IFSS) referral. The support needs identified were parenting skills, household management, counselling and support, and management of her mental health. GH also accepted a referral to Pregnant and Young Parent Support ('PYPS') which was thought to adequately address the issues raised. At that stage she was in the early weeks of pregnancy with FH. The notification was closed in February 2014, however, a further report was received by CSS shortly after that time from a housing service in relation to the condition of the property in which GH and PH were living. The house was reported to be cluttered and littered with dirty nappies, broken glass and sharp objects. GH was also reported to be unresponsive to hazards for PH, and it was reported that there was no food in the house. CSS then ascertained that GH was commencing to have significant contact with PYPS and beginning to address identified issues. The notification was then closed by CSS, noting that future harm to the children was unlikely, given GH's willing engagement with PYPS.

On 5 April 2014, a notification was received in relation to a reported family violence incident, where a Mr Hill allegedly threatened to punch GH, and so she allegedly punched Mr Hill. CSS contacted PYPS who confirmed active involvement with GH. She had already contacted that organisation after the incident, and counselling was being facilitated. CSS also received information about other interventions which had occurred, including increased childcare, preparation for the new baby and participation in Circle of Safety. The notification was then closed by CSS and no further notifications were received until July 2017, a period of over three years.

The notifications in July and September 2017 primarily concerned parental neglect and inappropriate discipline in respect of PH and FH. The review identified that there were deficits in the assessment of the July notification, particularly because CSS did not seek information about MH's death and did not adequately assess the concerns of inappropriate physical discipline by CH.

The Review found that the actions taken by CSS in relation to the notifications prior to MH's death were appropriate. I do not find otherwise.

The records demonstrate that the required and appropriate history checks were carried out. The information obtained was integrated into the analysis of risk. The notifications were appropriately allocated and closed at an appropriate level. There was significant involvement with community organisations, and the case notes demonstrate discussion and shared understanding of the risk factor between CSS and those organisations.

It is not clear whether CHaPs (including the child health nurses) harboured any concerns that the safety or well-being of the children in this family was at risk because of lack of adequate parenting. The CHaPs notes obtained for this investigation were limited to those relating to MH. Whilst those notes do not describe concerns that might have prompted staff to notify CSS, they do indicate some difficulty in contacting GH. MH's two-week assessment occurred on 25 July 2016 at the child health clinic. This assessment had been scheduled by the service for a home visit, although before the scheduled visit, GH telephoned the service and said that she wanted to come to the clinic because they were "moving soon and were in between homes". It appears that the four-week assessment on 8 August 2016 also took place at the clinic and was not a home visit.

These matters, in themselves, may not have caused concern. If CHaPs had ready access to CSS information, which I assume it did not at that time, then CHaPs may have been alert to whether previous risk factors were still present which may impact upon the safety of a newborn infant born into the family. Armed with this knowledge, the child health nurse may have made further enquiries with GH and, if necessary, contacted CSS with any concerns.

From the hindsight perspective of the coronial investigation, it is apparent that the risks to GH's children did not diminish to any significant degree after CSS ceased involvement two years before MH died. Those risks included poor parenting skills of CH and GH, GH's worsening mental health issues, dirty and unhygienic home conditions and smoking within the house.

I have not extended this investigation to receive evidence concerning the adequacy of the information-sharing processes between CSS and CHaPs at the time of MH's birth. I comment, however, that those two organisations should ensure that optimal methods of information-sharing are in place so as to identify infants whose safety is at risk, and upon identifying those infants, to take action in response to the risks.

Conclusion

MH died of suffocation because she was placed to sleep on an adult mattress with adult bedding, and with three other people in the bed.

I take this opportunity to reinforce to parents and carers 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. MH would not have died if she had been placed on her back in her own cot to sleep.

I extend my appreciation to investigating officer Detective Sergeant Michael Foster for his investigation and report and also to Constable Kathryn Luck, Coroner's Associate, for her valuable assistance.

Even though I have made comments in this finding about the parenting ability of GH and CH, they loved their daughter and I extend my sympathy to them for their loss.

Dated: 9 March 2020 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner