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, Olivia McTaggart, Coroner, having investigated the death of BR

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

a) The identity of the deceased is BR;
b) BR died suddenly in the circumstances set out in this finding;
c) I cannot determine BR's cause of death; and
d) BR died on 12 February 2021 at Bridgewater, Tasmania.

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

- The Police Report of Death and Sudden Unexpected Death in Infancy Checklist;
- An opinion of the forensic pathologist who conducted the autopsy;
- Affidavits from family and friends
- Affidavits of attending and investigating police officers and body-worn camera footage;
- General practitioner, hospital, ambulance, nursing and child protection records; and
- Photographic and forensic evidence.

BR was born on 4 September 2020 and was aged 5 months and 8 days at her death. Her parents are DP (born 1998) and JK (born 1996). BR and JK were separated at the time of BR's death but had been in a relationship for about two and a half years. They have an older daughter, who was aged 3 years at the time of BR's death.

JK had an extensive record of family violence towards DP throughout their relationship, including during her early pregnancy with BR. He was incarcerated when BR was born and

did not have any involvement in her life. DP was actively involved with Child Safety Services until August 2020 just prior to BR's birth.

When DP was six months pregnant with BR, she began a relationship with LV whom she had known for a number of years. LV was a supportive partner and helped with the children.

Towards the end of her pregnancy, DP suffered from high blood pressure, resulting in BR being born four weeks early. Although there were no complications during the birth, BR initially had trouble feeding and regulating her body temperature and required a 10-day stay at the Neonatal Intensive Care Unit. Upon discharge from hospital and during her life at home, she was a healthy baby in all respects. BR was fed with formula and she had received her scheduled vaccinations and health checks. She was seen regularly by her doctor and the child health nurse.

The Child Health and Parenting Service records for BR show that DP had been advised on three separate occasions by the child health nurse (as per standard protocols) to provide a safe sleeping environment for BR both night and day. The advice included the recommendation that BR should sleep in a safe cot in her parents' room. I assume that DP had also previously been provided with the same advice after the birth of AE.

During her pregnancy and after BR's birth, DP smoked about 10 cigarettes per day. She did not smoke inside the house. The child health nurse had also spoken to DP about the importance of keeping BR "smoke-free" and provided advice on cessation of smoking because of the health risks to BR.

BR was a good sleeper and would wake two or three times a night. DP would habitually put AE to bed in her (AE's) own bedroom. She would put BR to bed in her cot, which was in the bedroom occupied by her and LV. DP and LV slept on a queen-sized bed, with a fitted sheet, double doona and adult pillows. After both AE and BR woke during the evening for their first feed, DP and LV would put both children into bed with them and sleep with them in the queen-sized bed until morning. In respect of BR, a young infant, this practice was contrary to safe sleeping recommendations and entailed a risk of death by suffocation in bedding or accidental overlaying by another occupant of the bed.

On the evening of 11 February 2021, DP gave BR a bath, fed her and put her to bed at 7.30pm. Before going to bed at about11.00pm, DP checked on BR. She saw that she was fine at the time, moving a little and sleeping on her back.

Both BR and AE woke between 12.30am and 1.00am on 12 February 2021. At that time, LV got up to feed BR. Once he had done so, he placed BR in the queen-sized bed between him

and DP in accordance with their usual practice. AE also came into the bed, lying on the outside.

At 6.00am LV awoke, had a shower and left for work at 6.30am. He saw that DP and the girls were still asleep and did not take any particular notice of BR.

When DP awoke at 7.10am, she found BR lying on her back next to her in the middle of the bed. She initially thought BR was asleep but soon realised that she was lifeless after picking her up. DP called the ambulance, and ran outside for help.

FG, a neighbour, immediately brought DP and BR to her own house. FG laid BR on the floor of her lounge room and started CPR. At that point, BR was quite stiff and had vomit in her mouth. IM, DP's stepfather, arrived soon after and took over the CPR.

Ambulance paramedics arrived shortly but could not resuscitate BR. They determined that she was deceased.

At 7.41am, police officers arrived at DP's address, were advised of BR's death and commenced an investigation. They noted that there was no sign of trauma or injury upon her body. Relevant items were seized for forensic examination. They noted that DP's home was clean and neat and no suspicious circumstances were identified. There were two infant bottles partially filled with milk on the queen-sized bed.

BR was conveyed to the Hobart mortuary, where the State Forensic Pathologist Dr Donald Ritchey, conducted an autopsy upon her. He was unable to positively determine a cause of BR's sudden death. However, in his report, he stated as follows:

> *The autopsy revealed a normally developed and nourished infant girl without apparent congenital abnormalities or injuries. Bacterial cultures of samples obtained at autopsy grew only normal oropharyngeal flora from the lungs and coagulase negative Staphylococci from the blood (both findings of doubtful clinical significance-probable post-mortem overgrowth or contamination). There was no active pneumonia but there were increased alveolar histiocytes in the lungs suggestive of chronic aspiration. Aspiration is common in infants and seldom is implicated as a cause of death. Rhinovirus was recovered from respiratory fluids using the PCR technique. Rhinovirus is the most common virus implicated in the common cold and can cause illness and death in vulnerable infants but there was no suggestion that rhinovirus caused such illness (pneumonia or other inflammation) in baby BR. In summary, these intrinsic factors (rhinovirus, aspiration) would not, be sufficient of themselves to cause death in my opinion.*

> *Several extrinsic factors were also identified. Co-sleeping with adults and a toddler is potentially dangerous because infants may be accidentally smothered by a sleeping adult or toddler leaving little or no evidence at autopsy. Toxicology testing of samples obtained at autopsy revealed the presence of nicotine and its metabolite cotinine that could be from tobacco smoking in the presence of the infant or possibly acquired from breast milk. A small amount of ibuprofen is non-contributory. Finally, the possibility of an unknown genetic factor cannot be excluded by autopsy criteria alone.*

I accept the opinions of Dr Ritchey. I find that BR did not die as a result of any inflicted violence or injury. Upon the evidence as a whole, I am also able to exclude a genetic factor as a cause of BR's death, as there is no evidence to support this. However, there is significant evidence that BR died in an unsafe sleeping environment involving the risk of suffocation by adult bedding or the bodies of others in the bed. I am satisfied that the sleeping environment did, at the very least, contribute to BR's death by restricting her breathing. I cannot determine, however, exactly how it contributed. It is possible that her breathing may also have been restricted by her rhinovirus (common cold) and that the nicotine in her lungs may have also contributed.

Comments and Recommendations

Over the years, coroners and health professionals have constantly stressed the fatal risks of co-sleeping with infants. Unfortunately, this practice continues and results in preventable death. In this case, it is likely that BR would not have died if she had been in her own cot with appropriate bedding.

I again emphasise the critical importance of putting babies to sleep in their own cot or safe sleep surface at all times in order to reduce the risk of sudden infant death.

I extend my appreciation to investigating officer Senior Constable Skye Carey for her investigation and report.

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

Dated: 23 February 2022 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner