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, Robert Webster, Coroner, having investigated the death of baby MX

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

a) The identity of the deceased is MX;

b) MX died suddenly in the circumstances set out in this finding;

c) MX's cause of death was Undetermined Sudden Infant Death (USID); and

d) MX died on 24 February 2020 at Mornington, Tasmania.

Introduction

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

- The Police Report of Death and Sudden Unexpected Death in Infancy Checklist;
- Affidavits establishing identity and life extinct;
- Affidavit of the forensic pathologist Dr Andrew Reid;
- Forensic Science Service Tasmania – toxicological and analytical report;
- Affidavit of Ms RC;
- Affidavit of Mr LX;
- Affidavit of Ms RB;
- Affidavit of Ms Karyn Glover;
- Affidavit of Ms Maureen Hogan;
- Affidavit of Mr Jasper Ford;
- Information received from Denise Leonard, statewide coordinator CatholicCare Housing Connect Support;

- Affidavit of Daniel Richards (rank not stated), Tasmania police;
- Affidavit of Constable Petria Button;
- Affidavit of First-Class Constable Joshua Woods;
- Affidavit of Sally Swifte (rank not stated), Hobart Criminal Investigation Branch of Tasmania police;
- Affidavit of First-Class Constable Dean Walker and photographs;
- Documentation obtained from the Child health and parenting service and Child safety services;
- Records obtained from Ambulance Tasmania (AT); and
- Medical records obtained from the Amiens clinic, other reports and forensic evidence.

Background

MX was born at the Royal Hobart Hospital on 22 September 2019 to RC and LX who were both 20 years old at that time. MX had 2 older siblings: a sister and a brother. RC says when he was born MX weighed approximately 7 pounds. He was born on time and there were no complications with his birth and both he and his mother left hospital the next day. She says MX was a healthy baby who did not have any medical issues that she was aware of. She says he slept really well and had a good appetite.

RC and LX had been in a relationship for approximately 7 years when MX was born. It seems RC and LX had been living in New Town with some of LX's family support from around about 2017. In or about May 2019, a Police Family Violence Order was issued against LX protecting RC. That order was upgraded to an interim Family Violence Order on 4 July 2019. LX says because the order prevented him from going within 100 metres of the family home, he moved to Snug to live with his aunty. He says he remained living with his aunty for about 2½ months but returned to the New Town address after he *"got the order changed."* The order was not changed because at the date of MX's death LX was not permitted to enter any premises where RC or the older 2 Children were residing nor go within hundred metres of the boundary of any premises where the 3 of them may be staying or living from time to time. In any event, after LX returned to the New Town address all the others living at that address, apart from RC and the couple's 2 older children, moved out. LX says they were supporting themselves on Centrelink benefits and had very little family support from that point on. They continued to reside at New Town until about February 2020 when they had to move out as that home was being sold. Because of the difficult rental market in Hobart and its suburbs, the family could not find a place to live. RC therefore sought assistance from Housing Connect.

Individuals and families who present to Housing Connect are assessed and referred to a service provider who provides assistance. In February 2020 Colony 47 operated the Housing Connect program in southern Tasmania. That organisation conducts the initial assessment of the needs of a person before directing that person to the appropriate service provider.

After presenting to Housing Connect in 2019, RC presented for a second time on 11 February 2020 and was referred by Colony 47 to Catholic Care Housing Connect Support (CRCCS) for assistance. On both occasions RC sought assistance to obtain housing for herself and her children. She indicated to CRCCS she would be willing to accept a place in emergency accommodation as an interim measure while she waited for an offer of public housing. That interim accommodation was obtained at the Discovery Caravan Park at Mornington. RC paid a sum of money each week which contributed to the cost of that accommodation. CRCCS understood that RC and her 2 youngest children would be staying in this accommodation and that her eldest child was staying with a grandparent. As RC was exiting a private rental and as she told CRCCS she had social supports it was believed she had all the required items necessary to look after her family. Accordingly CRCCS did not supply beds or cots for the children. RC commenced her occupation of this accommodation on 13 February 2020.

CRCCS's assigned case officer met RC at the Discovery Caravan Park on 14 February 2020 in order to plan the acquiring of longer term housing. Also present were RC's 2 youngest children. During that meeting the case officer observed RC continually attended to her childrens' needs. CRCCS reports that RC *"was attentive, caring, and affectionate and displayed a multitude of protective factors towards her children."* In addition, CRCCS has an existing relationship with staff at the Discovery Caravan Park so that in the past if issues have arisen or the Park staff have concerns, they have contacted CRCCS. There was no such contact in this case; the inference being there were no issues or concerns.

MX's health records

MX had no identified health issues and no recorded medical history. He had no known allergies or adverse reactions. He last attended the Amiens Medical Clinic in Derwent Park on 5 January 2020 for his two-month immunisations. The notes record at that time MX was fit to receive the 3 vaccinations and they were administered.

Circumstances leading up to MX's death

A number of days[1] prior to MX's death he had partially swallowed a metal screw. RC says she tipped MX upside-down and removed the screw using her fingers. She says he vomited as a result of her actions but there were no ongoing issues. RB, who is the mother of LX, says this event occurred around about 13 February 2020 when the family were moving into the Discovery Caravan Park and one of MX's siblings put a shelf support screw in his mouth. RB, who cared for MX in the days prior to his death, said she was aware of the incident but had not noticed anything unusual in regards to MX's health in the ensuing days.

RC, LX and RB all say in the week or so proceeding MX's death he had cold like symptoms which were reported as consisting of a cough, a runny nose and he was phlegmy. The other children were suffering the same or similar symptoms. Neither parent held any genuine concern for the welfare of their children and did not seek any medical assistance.

Although the dates provided by each of the witnesses slightly differ it is clear in the days preceding MX's death he was in the care of RB at her residence in Moonah. LX says he had organised a break for he and RC and that is why RB was caring for MX. LX says he dropped MX off at his mother's home on 20 February and picked him up on the afternoon of 23 February 2020. During his stay with RB, RB says she did not notice anything unusual besides MX having a cough and a rasp in his throat.

RB fed MX his normal food of S26 Gold baby formula which had been supplied by LX. She also had fed him liquid beef and vegetables (baby/toddler food) from a squeeze pack which had been purchased from the supermarket. RB did change the teat on the baby bottle provided by LX to a smaller diameter to slow down MX's drinking. During his stay with RB, MX was cosleeping with RB.

LX says when he picked MX up and returned home via bus and taxi, he noticed MX was quiet and it appeared his cold had deteriorated. When he was breathing there was a barking sound, or a crackle and he still had a runny nose.

There is a discrepancy in the evidence with respect to the bedding that was used on the night of MX's death. RC says:

> *"[MX] wasn't under the blanket it was there as a barrier in case he rolled and fell out. There was also a pillow sideways next to him, to stop him rolling. [MX] was just starting to roll on his own."*

LX says:

[1] LX says this event occurred approximately 4 days prior to MX's death which means it occurred on or about 20 February 2020.

> *"[I]t was around 1:00am [MX] was the 2nd kid to go down to sleep. I was sitting on the bottom bunk area at the time, and [RC] put [MX] down to sleep on his back on the bottom bunk near my bunk, closer to the wall than the edge. There was a doona and second sheet, and a sheet on the mattress as well. [RC] pulled the doona up over his body but his arms were out. He was fully asleep. There was one pillow on the bed which was up against the wall to stop him rolling into the wall. The bunk bed ladder was on the other side to stop him rolling out of bed. He was at the age where he was just starting to roll himself over. Once he got onto his belly he couldn't roll back over."*

RC says MX woke up from a nap at around 11.00pm,[2] he was happy and was laying on the bed talking and kicking around. She changed his nappy before she fed him. She did not give him any Panadol or medication before bed. She had not given him any medication throughout that day. RC says MX was awake until about 3.00am. She gave him a bottle at about 2.00am which consisted of 180 mL of S26 Gold formula in a normal baby's bottle. He drank the whole bottle and she burped him after he finished. When he had the bottle he was laying on the bed on his back and she was holding the bottle for him. After he was burped and finished his bottle he went to sleep which would have been at about 3.00am. RC laid in bed with him and patted his back until he went to sleep. She then fell asleep with MX and she was woken by her daughter at about 5.00am. She left MX in bed and at that time he was sleeping on his right side. She pulled her arm out from under his head to get up to her daughter and she says he made a noise like she had disturbed him. She then went to sleep in a double bed with her daughter and her other son. LX was asleep in a single bed in the same room as MX. RC says she woke up at about lunch time on 24 February 2020 and she went to wake up LX. She did not disturb MX because it was not unusual for him to still be asleep. She looked at him and he looked fine. He was sleeping on his side. The blankets were still tucked up around him.

LX got up and had a shower and got the couple's older son dressed and took him to the playground. RC had a shower and looked after the couple's daughter. After her shower she went to the laundry to get some clothes and on the way there she passed LX and she told him she needed to get MX up. LX said that he would do that. It was then LX discovered MX had passed away. RC took MX from LX and ran to the reception area of the Park to obtain assistance. Ms Glover phoned 000 for an ambulance and then assisted RC administer CPR to MX.

Investigation

[2] On 23 February 2020.

(i) Police

At 3.48pm on 24 February 2020, Senior Constable Richards and Constable Button were tasked to attend the Discovery Caravan Park. On arrival it was ascertained from AT personnel that MX was deceased. The scene was secured[3] and examined and relevant witnesses were spoken to and statements taken. Forensics officer First Class Constable Walker attended[4] and examined the scene, collected a number of exhibits and took a number of photographs. As a result of his examination First-Class Constable Walker says there were no notable injuries to MX, there were no signs of a struggle or violence at the scene or anything of a suspicious nature.

At 4.00pm on 24 February 2020 Detective Senior Constable Craig and Detective Constable Swifte from the Hobart Criminal Investigation Branch (CIB) of Tasmania police were tasked to attend the Discovery Caravan Park at Mornington. On arrival they were briefed by Sergeant Connors and they inspected the cabin in which RC and her children were staying. Thereafter both detectives determined that there did not appear to be any suspicious circumstances surrounding MX's death.

The investigating officer, Senior Constable Richards, has highlighted that at the time of MX's death LX was breaching the Family Violence Order that was in place as he was living with his 3 Children and his partner at premises provided by CRCCS without that organisation's knowledge. It is clear to me that neither of these issues are in any way related to MX's death.

On his inspection of the cabin in which the family were housed on 24 February 2020, Senior Constable Richards says the bedroom where MX was located had purpose built bunk beds along one wall and MX was sleeping on the bottom bunk. A single bed ran along another wall and abutted one end of the bunk beds. The bedroom had one large window and the blind was closed. The beds each had an unmarked brand foam mattress which was covered in a brown water resistant vinyl. On the mattress used by MX there was a mattress protector on the mattress and a white sheet placed over the top. There was a further white sheet and doona and pillow on the bed. The bed sheets and mattress protector had a large fluid stain estimated to be a rough circular shape of about 15 cm in area where MX's face had been. Because the family had unstable accommodation, the cot which MX usually slept in was not taken by the family to the Discovery Caravan Park. Neither parent believed this to be an issue and had no concerns. In addition, Senior Constable Richards determined that both RC and LX were smokers but they tried not to smoke in the presence of the children.

[3] This was done by First-Class Constable Woods at about 3:50pm on 24 February 2020.
[4] First-Class Constable Walker arrived at 4:25pm on 24 February 2020.

They would smoke outside the cabin however the older 2 children may have on occasions gone outside and been in their presence while they were smoking. RC smoked an average of 5 cigarettes per day. LX says they never held MX while they smoked.

Senior Constable Richards concluded, after conducting his investigation, that both RC and LX came across to him as loving and caring parents who may lack some life skills but in his view they were trying their best in very difficult circumstances. He came to the conclusion that there were no suspicious circumstances with respect to MX's death.

Having considered all the material provided by Tasmania police I accept the views of the investigating officer, the forensics officer and the CIB officers that there were no suspicious circumstances surrounding MX's death.

(ii) Child safety issues

As part of this investigation, I obtained the records of Child Safety Services (CSS) (previously child Protection Services) relevant to the children of RC and LX. These records are voluminous. I also obtained the records from the Child Health and Parenting Service (CHaPS) which is a division of the Tasmanian Health Service. Both RC and LX were known to CSS because of the difficult upbringing that each of them endured. In so far as RC was concerned, a Care and Protection Order was made by a Magistrate pursuant to section 42 of the *Children, Young Persons and Their Families Act* 1997 on 8 February 2011. That order remained in force until RC was 18 years of age.

Despite these obvious difficulties, there was only one notification made to CSS with respect to MX and that was prior to his birth. That referral related to contact from the Royal Hobart Hospital ante-natal unit that RC had presented late in her pregnancy for out of home care. The main concerns were that RC had presented late, missed an appointment and the hospital were having difficulty contacting her. It was also noted there was a Police Family Violence Order in place which was later upgraded to an interim Family Violence Order, made on 4 July 2019, which protected RC and the 2 older children from LX. RC had demonstrated a similar pattern of not engaging with ante-natal care and being difficult to contact with respect to her 2 older children and therefore there was no significant concern with respect to the safety of MX. In addition there had been one prior notification with respect to MX's older sister and one with respect to MX's older brother prior to his birth. Since his birth there were 2 incidents which were investigated. In summary each of these matters was investigated and CSS was satisfied there were no demonstrable safety concerns and that none of the children were at risk.

Likewise the records from CHaPS demonstrate that RC was difficult to engage with. The family are described in correspondence between CHaPS and CSS as *"very disengaged"* with respect to all 3 children. There were many missed appointments. Prior to his death MX was seen twice for his 2 week and 4 week Child health assessment. The 2 week-assessment took place on 2 October and the four-week assessment took place on 16 October 2019. On both assessments RC demonstrated gentle, loving and caring handling of MX and an ability to respond to the needs of her older children. At the four-week assessment, steady growth and development with respect to MX is recorded. A home visit was scheduled for 8 October 2019 for a weight check however the nurse who attended was unable to get through a large gate at the family home which was chained and locked. At the four-week assessment safe sleep arrangements were discussed and RC reported that MX usually slept in a cot in a bedroom and that she ordinarily smoked outside. It was recommended an appointment be made with the GP for the six-week immunisations and a medical health check. An attempt to conduct an 8 week child assessment on 21 November 2019 was unsuccessful because RC could not be contacted on her mobile telephone and although the Child health nurse observed a male person standing outside the front door of the house, nobody answered the door when, on a number of occasions, the front door bell was pressed. It appears from the records the 2 older children had only ever been seen twice by the CHaPS service.

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 MX's birth. From the records I have examined however, I find that contact and information sharing between those organisations appears adequate. It goes without saying, given the services which those organisations provide, that those two organisations should ensure 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 those risks.

(iii) Post-Mortem examination

The forensic pathologist Dr Andrew Reid conducted an autopsy on 26 February 2020. That autopsy consisted of both an external and internal examination of MX, consideration of the results of both histology and toxicology together with a number of microbiological studies, consideration of photographs on the police forensic register and finally a consideration of a post-mortem CT scan. As a result Dr Reid determined MX's cause of death was USID. He also noted there were reactive splenic changes and that cosleeping or shared sleeping were significant contributory factors.

Dr Reid has arrived at his opinion because of the following which appears in his report:

"Sudden infant death syndrome (SIDS) is a term used to describe the sudden and unexpected death during sleep of an infant aged ***under 12 months*** *that is:* ***not explained*** *by the circumstances surrounding death including death scene examination; in which there is no unexplained trauma and there are no pathological or ancillary findings, after full external and internal post-mortem examination.*

The syndrome is a diagnosis of exclusion *for which the underlying cause is not known. It is probably multifactorial involving environmental, developmental and hereditary genetic aspects. A number of risk factors for SIDS have been identified.*

For epidemiological purposes the phrase "co – sleeping or shared sleeping" has been adopted for use in circumstances where there has been a shared sleeping arrangement as the circumstances appear to represent an important subpopulation in the spectrum of deaths associated with infant deaths.

The syndrome is further sub-classified into: SIDS type I for infants born (at full term) on or after 37 weeks gestation and aged between 21 days and 9 months old at the date of death; SIDS type II for full term born infants aged less than 21 days or between 9 months and a year old at the time of death. The third element of this classification is designated undetermined sudden infant death (USID) when the criteria for SIDS I or SIDS II cannot be satisfied.

Undetermined sudden infant death (USID) is the appropriate classification in this case. *There were positive findings which might explain a possible rather than a probable cause for this child's death. Therefore, the criteria for the SIDS diagnosis of exclusion cannot be satisfied.*

Although PMCT[5] scan and autopsy revealed no significant findings there were histological Changes of interstitial oedema, mild pneumocystis hyperplasia or desquamation with atypia and alveolar capillary congestion. The appearances are more consistent with agonal terminal changes rather than diagnostic of viral pneumonia. Histology also showed changes in the spleen of histiocytic hyperplasia and reactive changes with viral cytopathic effect and haemophagocytic lymphohistiocytosis (HLH).

Pathogenic viruses were not detected on PCR microbiology testing. Bacteria detected were caused by mild post-mortem contamination or represented normal bacterial flora. There was no evidence of pathogenic bacterial or viral infection on special and IHC testing for Epstein – Barr Virus (EBV) and cytomegalovirus (CMV) infection in the spleen. However, on balance the

[5] A PMCT scan is a post-mortem CT scan.

morphological appearances of reactive changes in the spleen are consistent with viral infection.

Haemophagocytic lymphohistiocytosis has a number of underlying differential diagnoses. The molecular karyotype in this child was normal therefore there was no evidence that this was arising from a genetic cause (primary HLH). Primary HLH is usually fatal within 2 months without treatment and therefore is not relevant in this child's case. Similarly, secondary HLH is most often seen in adult rather than paediatric patients.

The criteria for HLH diagnosis include haemophagocytosis in the bone marrow, spleen or lymph nodes and at least another 5 of 8 clinical criteria which cannot be determined in this sudden infant death case. Therefore, the changes of HLH seen in the spleen in absence of evidence of a viral infection on both IHC and microbiology and also in the absence of any evidence of immune suppression would suggest that the features/findings are idiopathic or unexplained. There is insufficient evidence upon which to suggest that secondary HLH was a primary cause of death in this case.

Similarly, there was no evidence of malignancy and in particular no evidence of lymphoma which is sometimes associated with HLH.

Secondary causes of HLH include viral infection and viral cytopathic effect was identified in this case. As discussed above there is insufficient evidence to satisfy the necessary clinical criteria for a diagnosis in this case.

Hepatic histology showed pale granular cytoplasmic cytology associated with glycogen deposition and distribution within normal limits. There was no evidence of abnormal histology associated with mitochondrial/fatty acid metabolic disorder. Neonatal metabolic screen test results were not available. The molecular karyotype showed no mutations which might be associated with an abnormal phenotype such as a metabolic disorder.

The descriptive term of co-sleeping/shared sleeping is included based on the evidence in this case. There was evidence of a tissue reaction to an undetermined infection or other primary pathology. This would likely have been associated with systemic response the nature and degree of which cannot be determined. However, adverse consequences of systemic inflammatory or immune responses are exacerbated by cosleeping/bed sharing.

The deceased's head circumference, length and weight were approximately at the 50th percentile at birth and were below this at the time of death (weight 15 – 50th percentile; crown – heel length and head circumference 3rd percentile for age).

Forensic toxicology was non-contributory. In particular there was no evidence of carboxyhaemoglobin which might have been relevant if the accommodation at the infant's usual address was subject to heating by a system in which there was incomplete combustion."

I accept Dr Reid's opinion. He has provided very comprehensive reasons for that opinion.

(iv) AT's records

These records disclose AT received the emergency call to attend the Discovery Caravan Park at 3.19pm on 24 February 2020. An ambulance was immediately dispatched and arrived at the scene and was with MX 8 minutes later. A backup ambulance crew arrived shortly thereafter. MX was treated but could not be revived. He was pronounced deceased.

The history taken by the ambulance officers from RC was consistent with the information she provided to Tasmania police; that being MX had had cold/flu like symptoms for the past week or so, that she put him down to sleep at 3.00am and checked on him just before lunch and thought he was sleeping so she left him alone. The history given by LX to the ambulance officers was also consistent with the information he provided to Tasmania police.

Comments and Recommendations

The cause of MX's death was USID. Reactive splenic changes and co-sleeping or shared sleeping were significant contributory factors. MX was placed to sleep on a single adult mattress with adult bedding and slept for at least 2 hours with his mother prior to his death. In fact the evidence discloses that co-sleeping between children and parents and between MX and his grandmother was not an uncommon occurrence.

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. The risk of death to MX would, given Dr Reid's opinion, have been reduced if he had been placed on his back in his own cot to sleep.

It is very important that the death of an infant is thoroughly investigated and to that end I extend my appreciation to the investigating officer Senior Constable Daniel Richards for his investigation and report.

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

Even though I have made comments in this finding about the parenting ability of RC and LX it is clear to me they loved their son and they did their best in very trying circumstances to

properly care for him. I convey my sincere condolences to them and the extended family and loved ones of MX for their loss.

Dated: 30 June 2022 at Hobart in the State of Tasmania.

Robert Webster
Coroner