FINDINGS, COMMENTS and RECOMMENDATIONS of Coroner McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the deaths of:

Infant W and Infant P

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the deaths of Infant W and Infant P, with an inquest held at Hobart in Tasmania make the following findings.

Hearing Dates

18,19, 20, 21, 22 and 25 September 2023, submissions received by 12 December 2023; and additional submissions at the request of the Coroner received on 12 June 2025.

Representation

Counsel Assisting: L Sundram

Counsel for the Department for Education, Children and Young People and the Department of Health: E Lim

Counsel for the Roman Catholic Church Trust Corporation of the Archdiocese of Hobart, trading as CatholicCare Tasmania: J Mullavey

Introduction

1. Two infants, aged 4 months and 2 months respectively, died suddenly and unexpectedly whilst sleeping next to their parents in an adult bed with adult bedding. Both infants were known to the child protection system. Their deaths were not related, except that they occurred within about two months of each other. Further, each infant was one of a set of twins.

2. I decided to hold an inquest into both infant deaths jointly due to the commonality of issues surrounding the circumstances of their deaths. A public inquest was not mandatory for either death under the *Coroners Act* 1995 (*Act*). However, I determined that an inquest was desirable as these cases raised the issue of whether Child Safety Services had adequately performed its statutory function in assessing and responding to the respective child protection notifications for each infant and their twin. Each notification was made before birth, and each raised the issue of whether the infants were at risk in the care of their parents following their birth.

3. Within the Coroner's functions under section 28 of the *Act,* the inquest examined how each death occurred and focussed both upon the immediate circumstances surrounding each death as well as those significant persons and organisations responsible for the care and safety of the infants whose decisions and actions may be connected or contributory to each death.

4. Therefore, the following issues were examined at inquest:

   a. The safety of the infants with their parents and in the home environment.

   b. The involvement of Child Safety Service in its decision-making in relation to care and protection of the infants; the adequacy of risk assessments relating to the infants; the adequacy of safe sleeping communication and education (both in respect of the parents and other organisations); the adequacy of communication with CatholicCare (for Infant W only) and the Child Health and Parenting Service regarding the safety and care of the infants; and procedures and delays in case allocation and intervention; and adequacy of case review.

   c. The scope of duties of the Child Health and Parenting Service in relation to the infants and their families; including communication of safe-sleeping practices; its knowledge and assessment of risk to the infants; the adequacy of communication with Child Safety Service and CatholicCare (in respect of Infant W only) regarding risk, safety and care of the infants.

   d. The scope of the duties of CatholicCare in relation to Infant W and her family, including communication of safe-sleeping practices; its knowledge and assessment of risk to Infant W; the adequacy of communication with Child Safety Service and Child Health and Parenting Service regarding risk, safety and care of Infant W.

Evidence at inquest

5. I am satisfied that a thorough investigation has taken place into the deaths of both infants. The documentary evidence at inquest comprised three groups of exhibits: A1-A13, being exhibits relating to both investigations; B1 to B36, being exhibits relating only to Infant P; and C1 to C30, being exhibits relating only to Infant W. The three exhibit lists are annexed to this finding.

6. Additionally, evidence was called from the following witnesses in this order:

   - **Dr Andrew Garrett:** Senior Research Officer within the Coroner's Office and author of the research study *Sleep related infant death in Tasmania 2000-2021*;
   - **ZA:** Father of Infant W;
   - **XB:** Grandmother of Infant W;
   - **Dr Donald Ritchey:** Forensic pathologist who performed the autopsy upon Infant W;
   - **Dr Michael Burke:** Forensic pathologist who performed the autopsy upon Infant P;
   - **Veronica Burton:** former Senior Quality Practice Advisor within the Department of Children and Youth Services and author of the SERT report in relation to Infant P;
   - **Claire Gray:** former reviewer with the Serious Event Review team within the Department of Children and Youth Services, and author of the SERT report in relation to Infant W;

- **Professor Robert Lonne:** Independent expert in social work and child protection systems, who reviewed the child protection response in respect of both infants;
- **Sue McBeath:** Director of Nursing and Midwifery Women's and Children's Services at the Royal Hobart Hospital;
- **Nicole Kinghorn:** Acting Nursing Director Child Health and Parenting Services;
- **Rachael Bresnehan:** Team Leader with CatholicCare Tasmania and involved in the provision of the Intensive Family Preservation Program to Infant W's family;
- **Andrea Witt:** Executive Manager of Family and Community Programs for CatholicCare Tasmania;
- **Margaret Polascka:** Director Prevention, Education and Research, Red Nose;
- **Dr Michelle Williams:** Consultant paediatrician and Chair of the Paediatric Sub-Committee of COPMM.

Abbreviations and acronyms

7. In this finding, the following acronyms and abbreviations are used:

ARL – Advice and Referral Line;

SERT – Serious Event Review Report;

CHaPS – Child Health and Parenting Service;

CSS – Child Safety Service;

CSO – Child Safety Officer;

CPIS – Child Protection Information System;

CSLO – Child Safety Liaison Officer;

CHN – Child Health Nurse;

COPPM - The Tasmanian Council of Obstetric and Paediatric Mortality and Morbidity established under the *Obstetric and Paediatric Mortality and Morbidity Act* 1994;

CYS – Child and Youth Services;

ED – Emergency Department;

RHH – Royal Hobart Hospital;

SUDI – Sudden Unexpected Death in Infancy;

TRF – Tasmanian Risk Framework;

UBA – Unborn Baby Alert; and

CYPF Act - Children, Young Persons and Their Families Act (Tas) 1997, which governs the powers and functions of CSS in protecting children upon the receipt of a notification.

Intake – A CSS service which receives notifications concerning the wellbeing of children and unborn infants and provides advice and referrals relating to these notifications. An initial risk assessment is carried out by Intake staff following a notification, and, depending upon the extent of the assessed risk, referrals may follow to other CSS services, including Response. Intake is now known as the Advice and Referral Line (ARL).

Response – The process carried out following Intake or referral from ARL to comprehensively assess risk, safety and judgements about harm, future harm and persons responsible for harm in relation to a child or unborn infant and involves a Child Safety Assessment usually conducted by the Response Team.

Child Safety Assessment – The process of CSS conducting an assessment of a notification in accordance with required procedures to determine whether a child or young person has been abused or neglected or is at risk of abuse and neglect; and then to determine what response is needed for the child's immediate and long-term safety and wellbeing.

Court Application Advisory Group (CAAG) – A specialised body within CSS established to advise CSS case workers upon court applications.

Unchallenged factual and expert evidence

8. Prior to inquest, CSS acknowledged that aspects of its own decision-making surrounding the infants were inconsistent with proper policy and procedure. In each case, CYS authorised a review of the decision-making by its Serious Events Review Team (SERT). The review culminated in a lengthy document (SERT report) setting out the manner in which risk assessment in respect of each infant was absent, incomplete or inconsistent throughout the relevant time period, contributing to poor decision-making and safety planning, which was inadequate to address the risks. In each SERT report, there were also findings relating to the absence of safe sleeping information provided to the parents by CSS. At inquest, CSS, by its counsel, did not challenge the factual chronologies, findings and recommendations contained in either SERT report.

9. In the investigations and at inquest, I have placed significant reliance upon the contents of the SERT reports as accurately recording the facts of CSS involvement and providing a frank and thorough analysis of CSS practice. The reports employ clear language and helpful explanations, have a logical structure, are detailed in content and contain carefully reasoned opinions.

10. I also sought for this inquest an independent expert in child protection to provide an opinion of relevant aspects of CSS action and decision making within the scope of the inquest. The opinion also dealt with suggested recommendations for improvement in practice.

11. The expert, Professor Robert Lonne (PhD) is a Professor of Social Work and child protection consultant.

12. Professor Lonne's fields of expertise include systemic reform in child protection systems, community services workforce development, ethical practice in child protection and family support, policy formulation and development, and service and program evaluation. He is the author of a significant body of work, including four books, 14 book chapters, 53 refereed journal articles and six government reports. He has also held national leadership roles and many other positions in his field of expertise. He has been engaged as an expert witness in child protection systems in several jurisdictions, including the Carmody Commission of Inquiry involving reforms to Queensland's child protection system.

13. Professor Lonne's detailed report was tendered at inquest, and he also provided oral evidence. His report and oral evidence were not challenged by counsel for CSS and I discuss his opinions further on in this finding.

Factual Findings Infant W

Background

14. Infant W ("Infant W") was born a twin with brother TG on 9 December 2018. The twins were born prematurely at 26 weeks. Their parents are VP and ZA. VP and ZA had another eight children between them. Of these eight children, VP is the mother of five children born to previous relationships. These children are YN (born 2002), RW (born 2004), WG (born 2005), QE (born 2009), and WL (born 2011). As a result of a child protection notification, QE was placed into foster care immediately following birth.

15. At the time of the birth of the twins, all of VP's children resided in foster care and were subject to child protection orders under the *CYPF Act*. The removal of the children from her care related to their exposure to a very high level of risk. These included VP's drug use, exposure to family violence, inability to cope with the children and poor engagement with CSS. There had been numerous attempts by CSS to reunify VP with her other children, but they were unsuccessful.

16. VP was raised by her grandparents and commenced drug use whilst at school. She had a history of behavioural issues necessitating police intervention. At the time of Infant W's death, she was under the care of the Alcohol and Drug Service. She was prescribed methadone, as opioid replacement therapy, and had been on that program for 8 years. She was prescribed 100ml once a day, which included whilst she was pregnant with the twins and following their birth.

17. ZA has three children from a previous relationship with UH - NS (born 2004), LM (2006) and KJ (born 2009). ZA's relationship with UH involved family violence by both parties.

18. In 2010, CSS received a notification about risk to ZA's children. All three children then became subject to 12-month orders and were placed with other family members during this period. After the order expired, the children were returned to ZA and UH on the basis that they had engaged with services in respect of

family violence and drug use, and their housing situation was stable. Subsequently, further notifications were received, further notifications were received in 2015, 2016, 2017 and 2018. These involved violence and breach of orders by ZA towards UH as well as behavioural issues in the children and alleged parental neglect.

19. Ultimately, no further orders were sought by CSS in respect of ZA's children. In about 2017, ZA and UH separated. The evidence indicates that subsequently the children resided primarily with their mother or paternal grandmother, XB and not ZA.

20. ZA and VP commenced their relationship in early 2018 and moved in together shortly after the relationship began. At the beginning of the relationship, ZA was incarcerated for 4 months, having been sentenced by a magistrate for numerous family violence offences. Following his release, he returned to live with VP.

21. ZA expressed unhappiness about the pregnancy and wanted VP to undergo a termination. It would seem, based upon the evidence of XB, that ZA remained with this attitude throughout the entire pregnancy.

22. On 31 August 2018, VP failed to attend an arranged termination procedure. When contacted, she indicated that she no longer wanted the termination. A male voice, assumed to be ZA, was heard in the background saying that she needed to have the procedure.

23. XB said that at the time of the 20-week scan, identifying the existence of twins, ZA was particularly unhappy, telling his mother that VP had ruined his life.

24. On 28 September 2018 CSS received an unborn child notification concerning alleged family violence between ZA and VP and failure of VP, 19 weeks pregnant with twins, to attend ante-natal care.

25. In October 2018 VP declined to receive perinatal infant mental health support and also tested positive for cannabis.

26. On 23 October 2018 RHH advised CSS that VP had not attended the antenatal clinic and was no longer able to be contacted by phone. The UBA was completed that day with a decision made not to alert VP to its existence, as it was believed that the prospect of removal of the infants at birth would negatively impact her.

27. On 28 November 2018, CSS notified RHH of the existence of the UBA. The following day, the hospital held a UBA meeting. The CSLO requested CSS complete the Initial Assessment and refer it to the CSS Response team for a full assessment.

28. On 9 December 2018 the twins, Infant W and TG were born at nearly 27 weeks gestation. During VP's labour, ZA did not travel in the ambulance with VP. He attended the hospital but was not present for the

birth of the twins. Although he gave evidence at inquest that he was present, the evidence is not credible and does not accord with the credible evidence of his mother.

29. The CSLO and CSS were advised of the birth, with the CSLO alerting the CSS Team Leader that *"Response Assessment will still be needed*". The risk assessment was completed and the matter was sent to CSS Response for further assessment, assigned as a Priority 2 (the second of three categories specifying assessment times).

30. Given their extreme prematurity at birth (Infant W weighing 917 grams), the twins were treated and carefully nursed in the Neonatal and Paediatric Intensive Care Unit.

31. VP attended the hospital every day and, on occasions, more than once a day. ZA, on the other hand, attended less regularly and for shorter periods of time. On occasions, ZA would try to get VP to leave with him. In making such finding, I accept the evidence of ZA's mother, XB.

32. On 11 December 2018 the CSS assessment case was opened. This required CSS to make a thorough assessment in accordance with established practice and procedures regarding the extent of the risk to the twins in the care of their parents and the recommended protective response. In commencing a assessment, a CSS worker is allocated to undertake the assessment.

33. However, the assessment in relation to the twins remained "unallocated" until 22 January 2019, six weeks later. This means that a CSS worker had not been allocated to the case and consequently the required information-gathering and assessment did not occur.

34. On 3 January 2019 the RHH advised the CSLO (and hence CSS) that a family member had expressed concern about the parental mental health, cannabis use and family violence posing risks to the twins' safety and wellbeing should they be discharged home to their parent's care. No RHH discharge planning had been commenced by that time.

35. On 22 January 2019 CSS allocated the case to a staff member for assistance, although that worker did not commence the assessment as should have occurred.

36. On 29 January 2019, a new CSS worker was allocated to the case for assessment. On that day, the CSLO contacted CSS regarding advising the parents about the UBA and CSS concerns about risk to the twins. As at that date, ZA and VP had still not been advised of the notification. Plans were put in place for CSS to discuss the notification with the parents.

37. On 7 February 2019 CSS contacted VP by phone and requested a meeting for the following day. In the call, VP was advised of the child protection notification in respect of the twins (the UBA). VP became angry and upset, and ZA was heard shouting in the background of the call.

38. On 8 February 2019, the CSLO met with VP and ZA and advised that no CSS decision-making had yet occurred. VP and ZA provided reasons to the CSLO for why the twins should not be removed from their care. They said that VP was stable on the methadone program and was under a mental health plan from her general practitioner. They said that they had arranged suitable accommodation for the twins and ZA's two children who visited on alternate weekends. They said that ZA was in employment. ZA denied any family violence in the relationship with VP. He said he had attended CatholicCare for family violence counselling.

39. On 18 February 2019, a new (third) CSO was allocated and commenced work on the case. It is to be noted that this was almost five months after CSS had received the unborn child notification, and over two months since the birth of the twins and the opening of the assessment.

40. On that day, the allocated CSO responsible for the risk assessment, made contact with the Alcohol and Drug Service and XB. XB raised concerns about her son being controlling and emotionally abusive, and the coping skills of VP. XB also agreed to visit once a week for a few hours as part of the safety planning.

41. On 19 February 2019, CSS was advised that the twins had some feeding difficulties and would not be discharged for another 1-2 weeks. The CSO conducted a home visit that day as part of the assessment. The CSO recorded in correspondence to the CLSO following that visit that VP and ZA "*presented rather well*" but tended to minimise or dismiss past concerns. For example, the CSO recorded that VP commented that *"CSS are liars and that people can just ring up and make accusations up and it's not fair".* In response the CSO noted *"I had to point out to her the extensive FV history that was documented and asked her if she thought that would be a suitable environment for children and she said 'no'. She also denied previous drug use, but I see on the files there was positive (sic) for cannabis and opioids".*

42. Further, the CSO recorded in the correspondence:

> *"In regards to the future, my gut instinct is to send the children home and try to work intensively with the family. I would need to have a safety meeting beforehand and pull everyone in together where we set down clear boundaries i.e. – Family preservation worker to go in, Mum addresses mental health concerns, continued engagement with ADS, Dad to continue working with parole, Dad to do anger management/FV course etc".*

43. On the same day, being 19 February 2019, there was a *"quick consult*" by the CSO, the Team Leader (TL) and the Child Safety Manager (CSM) where multiple factors were described as working well, including the willingness of the parents to work with CSS and other services, apparent abstinence from drug use and lack of family violence reports. Risk factors discussed included VP's social isolation, the report of ZA being controlling, VP's minimising of previous concerns and family violence.

44. The decision by CSS to allow the twins to live with VP and ZA was documented as follows:

"Insufficient evidence with concerns currently to proceed with legal orders/remove children from the home. Much of the concerns are historical currently. Close assessment is required to monitor parents and babies. Mandatory that Family Preservation be engaged with. Mandatory that CSS be permitted to do assessment. Clearly outline to parents consequences of no engagement".

45. Concerningly, a later audit of the CSS system (CPIS) revealed that this case note was created on 17 April 2019 (after the death of Infant W) and backdated to 19 February 2019.

46. On 20 February 2019, CSS emailed a referral to CatholicCare and included the history of family violence of both parents with different partners. The decision to allow the twins to return home with the parents was communicated by CSS to RHH and ADS, advising those organisations that CSS would remain involved with a "*very robust safety plan and strict 'conditions'"*. The referral also referenced an incident of ZA and VP arguing outside the RHH following the birth of the twins and noted that pushing was involved but the incident did not escalate.

47. The next day, 21 February 2019, there was an *"impromptu"* consultation between the CSO, CSLO and CSM where the case direction was described as *"children to return with parents, CSS continue with assessment with no order as parents agree, CatholicCare to support"*. The concerns were noted as historical. On that day, a Court Application Advisory Group discussion regarding the twins was cancelled because the decision had been made not to pursue court orders.

48. On 22 February 2019 the CSM contacted a Clinical Practice Consultant and Educator (CPCE). A CPCE is a senior consultant in child safety within CSS. The CSM requested the involvement of the CPCE in safety planning if CSS agreed to the twins being in parental care. I note that that this decision, apparently not conveyed to the CPCE, had already been made.

49. The CPCE reviewed the available material and noted there was not a documented Safety Network and Safety Plan. The CPCE, in responding to the CSO and TL, stated:

"I would not be supportive of the babies being discharged from hospital to their parents care at this time. It would seem very timely to slow things down, ensure we have all the information that we need to make a well informed decision for the babies' best interests and make sure that everything is in place so that the babies can be as safe as they need to be in their parents care".

50. The CPCE also raised numerous questions for CSS consideration to assist their assessment and confirmed prioritisation of the matter for further CPCE consultation.

51. On 25 February 2019, the CSM emailed the CSO and TL and requested to meet with them before their meeting with the parents, and also requested their inclusion for a meeting with the CPCE the following day. CatholicCare advised CSS that they had capacity to allocate the family under the Intensive Family

Preservation Program, this being a service providing up to 20 hours of intensive outreach per week for 12 weeks while families are engaged with CSS during the initial investigation phase.

52. That day, a meeting occurred involving the CSM, TL, CSO and CPCE. It does not appear that the decision to place the twins at home with the parents was reconsidered at this meeting, although the need for a Safety Network and Safety Plan was acknowledged to be necessary before the twins were to be discharged from hospital.

53. Immediately following this consultation, CSS and CatholicCare met with the parents at the RHH, where VP was agreeable to a range of referrals and ZA advised his mental health was good and he was confident caring for the twins, and that he would not complete the family violence training that was part of his probation order because there was insufficient time in the remaining fortnight of the order. The CPIS case note contained planning for the twins' discharge, visits and expectations for CatholicCare and CSS, and the need for ongoing discussion with CHaPS, Probation and the ADS.

54. Significantly, a CSS file note outlined a discussion with ZA's probation officer who "*advised the CSS that ZA was court directed to complete a family violence course as a 'medium risk offender'. However, an internal review found him to be a 'high risk offender'. This made him ineligible for the court ordered family violence course, and he would not be completing any work in this area*".

55. The probation officer also told CSS that ZA had been seen giving VP a *"hard time"*, including grabbing her arm, in the waiting area of Community Corrections in July 2018, with staff intervening. It also appears that CSS received information that ZA engaged in conduct towards VP involving yelling at her, picking on her, and grabbing her arm, occurring on that day.

56. On 27 February 2019, Infant W and TG were discharged from hospital in the care of VP and ZA.

57. On 28 February 2019, CSS spoke with XB to confirm her safety plan arrangements and she was pleased help was being offered to the parents but she was feeling stressed as a result of CSS relying on her and "*she felt under too much pressure*". Further, she expressed distrust of CSS from prior experiences with ZA's other children and said that whilst it was *'good the parents were having a go … [she] didn't think that it would work in the long run".*

58. On the same day, CSS completed its first home visit post-discharge, with both infants seen, positive interaction with the parents, with the home in good condition and clean. No reference to the infants sleeping arrangements or discussion of safe sleeping was recorded in the notes.

59. On 6 March 2019 ZA's probation order concluded and he was no longer under the supervision of Community Corrections.

60. From 7 March 2019 until 28 March 2019 various arrangements were made to progress the case plan with CatholicCare. CatholicCare commenced home visits as per a weekly schedule and reporting to CSS. Two visits were made by the CHaPS nurse with no issues noted. No concerns were noted on 15 March 2019 by CSS at a home visit.

61. However, it was recorded by CSS that by 26 March 2019 the parents had not undertaken the required actions of ZA making contact with the Men's Shed and VP to secure a regular general practitioner. These requirements were part of a "scaled back" plan, consented to by CSS. The parents had not taken the twins to the CHaPS clinic on 25 March 2019 as required. CSS noted concern that VP and ZA had not engaged well with services. They were also not answering calls from CatholicCare. An unannounced visit by CSS on 28 March 2019 was unsuccessful.

62. Records indicate that, by 29 March 2019, CSS and CatholicCare were concerned about parental disengagement. On that day, CSS conducted another unannounced home visit. During the visit, VP explained she had been ill and had been admitted to hospital the previous week. This fact explained the lack of response to calls from CatholicCare the previous week.

63. On 1 April 2019, the six-weekly review meeting occurred involving Catholic Care, CSS and VP. However, the CSS notes of the meeting were not entered into the system until 8 April 2019, two days after Infant W's death. The notes documented that there was positive mother-children interaction but ZA had not commenced counselling. VP had also still not made contact with a general practitioner. VP denied any family violence in her relationship with ZA. CatholicCare reinforced to CSS that the objectives contemplated by the original case plan could not be achieved, and the obligations of the parents were limited to the two matters stated.

64. On 2 April 2019, the CHaPS notes state that the twins were growing well and developing, and that safe-sleeping information was provided to parents. The corrected age for the twins at this time (taking into account their prematurity) was 24 days. VP described CHaPS involvement in positive terms and wanted to continue contact even after the CatholicCare program had concluded. On this date, there was email communication between CSS, CatholicCare and CHaPS about holding a multi-team meeting to *"ensure understanding of the roles and goals of services working with the family"*. The request for a meeting was initiated by CHaPS.

65. On 3 April 2019, CatholicCare made a home visit to VP and helped her book a general practitioner appointment. VP was observed to be connected to both babies, and to have the twins laying on either side of her on the couch going to sleep. The note did not provide details about further actions concerning the sleeping environment for the twins.

66. On 4 April 2019, CSS noted that the baby monitor had been purchased, and would be delivered the following week, at which time a home visit would also be conducted.

67. On 5 April 2019, the CatholicCare caseworker took VP to her general practitioner and there was nothing else untoward observed.

68. There was no further contact by CSS, CatholicCare or CHaPS with the family until after the death of Infant W.

Circumstances surrounding Infant W's death

69. On Friday 5 April 2019, Infant W and TG woke as normal early that morning. At about midday, VP took the twins for a walk in the stroller around the streets close by their residence. She then returned home and caught a bus with the twins to the Priceline Pharmacy at Bridgewater where her methadone prescription was dispensed.

70. VP returned home that afternoon and fed both infants. Their feed comprised bottles containing S26 Original Newborn formula. VP spent the afternoon at home with them by herself, spending a majority of her time on the couch in the lounge room. Both infants were laying on the couch with their heads propped on the armrest. In his inquest evidence, ZA said that he had previously seen VP asleep on the couch in the presence of the twins. I accept that this is correct.

71. At 4.30pm ZA arrived home and made arrangements for his son, KJ, to stay for the weekend. KJ arrived at the house at approximately 5.15pm that evening. The family had dinner together.

72. During the evening, VP and KJ bathed TG in a portable bath in the lounge room under the heat pump. ZA watched on from the armchair and consumed Jim Beam alcohol mix cans. At this time, Infant W had been placed on the couch with her head propped up on the armrest. After bathing TG, VP fed him and put him to sleep in his own bassinet.

73. The twins had separate bassinets in their parents' bedroom. VP and ZA slept in a double bed. The double bed was situated hard in one corner of the room placed hard against the wall.

74. Between 10.00pm and 10.30pm, ZA went to bed having consumed approximately six cans of Jim Beam over the course of the evening. It appears from VP's evidence that, at about this time, she or ZA placed Infant W to sleep in the double bed with ZA. By then, JK had fallen asleep on the couch.

75. Infant W awoke subsequently and VP took her from the double bed and bathed her in the same manner as she had for TG. The bathing process was uneventful. JK and ZA remained asleep at this time.

76. After the bath, VP fed Infant W her bottle and then took her back to the double bed without making any attempt to place her in her bassinet. It is apparent from VP's interview with police that she and ZA had formed the habit, at least over previous days, of placing Infant W to sleep with them in their double bed. ZA corroborated this fact in his affidavit. VP explained that Infant W was unsettled and liked VP to lay down with her and hold her. ZA said that sometimes VP would fall asleep trying to settle Infant W in their bed.

77. At this time, Infant W was wearing a jumpsuit and was swaddled tightly in a blanket. VP placed Infant W next to her, between her and the wall. She placed her arm around Infant W. ZA was on the other side of the bed next to VP. There was a full-size doona on the bed as well as at least two other blankets. In her interview with police, VP said that *"the doona was over us as well"*. I find that VP placed the doona over Infant W's body. Her face was likely uncovered.

78. At about 1.30am TG woke for a feed. VP told interviewing officers that she got up and fed TG in the loungeroom. I accept this event occurred. VP said that when she got up out of bed, she could see Infant W's chest going up and down and could feel her breath. In light of the subsequent findings of asphyxia by the forensic pathologist, I do not accept at face value that VP is correct in her account that Infant W was breathing at this time. It is likely that she was deceased as a result of accidental asphyxiation caused by VP having previously rolled onto her accidentally whilst asleep. It is also possible that ZA may have accidentally rolled onto Infant W whilst VP was out of bed and feeding TG.

79. After placing TG in his bassinet, VP returned to the bed. She noted that Infant W had not woken for her feed as expected. VP attempted to wake Infant W but noticed that Infant W's face was all white and that her eyes were shut closed. She noted that there was white stuff coming out of her nose and looked like milk. VP tried to wake Infant W by calling her name and touching her face and noted that she was warm to touch. VP then tried to wake ZA.

80. In his evidence at inquest, ZA said that he was asleep during this whole period and the first thing he knew upon being woken was seeing VP with Infant W in her arms. ZA noted that Infant W was pale and that her hands were cold but the rest of her was warm and her lips were tinged blue. ZA stated in his affidavit that VP told him that there was "*shit covering her (Infant W's) face.*" In evidence at inquest, ZA could not further explain what he understood by this comment. However, XB gave evidence that VP told her at the scene that Infant W had blankets and doonas over her face.

81. ZA gave evidence at inquest reiterating that he was unaware that Infant W was in their bed at any time that evening. I do not accept his evidence at face value. He may well have placed her in the bed earlier in the evening before she was taken by VP for a bath. He also assented generally to the unsafe practice of placing Infant W to sleep in the double bed. It is not unreasonable to assume that the alcohol consumed by ZA

contributed to a lack of awareness or vigilance regarding Infant W's sleeping location during the night of her death.

82. Upon the evidence, including the account of VP of the events, it is reasonable to find that ZA was not conscious of Infant W's presence or location in the bed after he fell asleep.

83. At approximately 2.00am, upon discovering Infant W unresponsive, ZA called his mother and she attended their residence straight away.

84. At 2.16am, VP called 000. At 2.18am an ambulance was dispatched, arriving at the scene at 2.21am.

85. The 000 operator provided instruction to VP on how to conduct CPR on Infant W. When the CPR was being conducted VP reports that when she breathed into Infant W's mouth white stuff came out of her nose, and was like a milky substance

86. When the paramedics arrived, they noted that VP was conducting ineffective CPR, and it was obvious to them that Infant W was dead at the scene. They conducted 2 minutes of CPR on Infant W before discontinuing resuscitation efforts.

87. On 8 April 2019, CSS was advised that Infant W had died and took steps to notify CatholicCare and CHaPS. That afternoon, CSS delivered the baby monitor for TG and made a decision that TG would remain with XB until further notice.

Investigation

88. At 2.21am on 6 April 2019, police officers from Bridgewater Uniform attended the scene and commenced an investigation. They obtained an affidavit from ZA. They also obtained details for the completion of the report of death for the Coroner and for the Sudden Unexpected Death in Infancy (SUDI) checklist. Detectives from Glenorchy CIB and officers from Forensic Services attended the scene.

89. Attending officers observed the house to be in a tidy state with numerous blankets, nappies, bottles, clothing items and toys throughout the house. The house was noted to be very warm with the heat pump in the lounge room indicating a temperature of 28 degrees. The examination of both bassinets in the main bedroom indicated that they had been used at some stage for the infants to sleep in. The detectives saw no signs of injury or trauma on Infant W's body. Attending officers saw no obvious signs of drug use, excessive consumption of alcohol and it did not appear that persons smoked inside the residence. The officers also observed a portable plastic baby bath filled with water on the lounge floor.

90. On 8 April 2019, the detectives who attended the scene interviewed VP, and video recorded the interview. The detectives did not consider that the circumstances indicated that Infant W had been intentionally

harmed. VP was requested to give evidence at inquest but her poor state of mental health prevented this from occurring.

91. The autopsy upon Infant W was conducted on 8 April 2019 by Dr Donald Ritchey. In performing the autopsy, Dr Ritchey had regard to the circumstances of death (as stated in the Police Report of Death and the SUDI checklist completed by attending officers). He also had regard to scene photographs.

92. Dr Ritchey found that Infant W was a normally developed and well-nourished infant who was hydrated and appeared well cared for. At the time of death, she weighed 4.89 kilograms and had a head circumference of 35 centimetres. He saw no evidence of injury, trauma or other suspicious findings. There was also no natural disease or medical condition to account for death.

93. Dr Ritchey summarised the following relevant findings after autopsy and toxicological testing of Infant W's blood:
    a. Co-sleeping with parents;
    b. Marked lividity of left side of face and chest;
    c. No traumatic injuries;
    d. Pulmonary congestion and oedema; and
    e. The presence of cotinine (metabolite of nicotine from parental smoking).

94. Dr Ritchey concluded that Infant W died of asphyxia caused by accidental overlay by a sleeping parent.

95. In coming to this conclusion, Dr Ritchey placed particular reliance upon the lividity (pooling of blood) present on the left side of Infant W's chest and left side of face (surrounded by an area of pallor) suggesting that Infant W was unable to breathe after accidental overlay (smothering) by a sleeping parent. Dr Ritchey's conclusion accords with all the evidence in the investigation.

96. I accept Dr Ritchey's conclusion as to cause of death. I find that Infant W died of asphyxia caused by being accidentally overlain by the body of either VP or ZA whilst she slept with them in their bed. It is most likely that, at the time of death, Infant W was lying on her left side amongst adult bedding and pressed into VP's body. It is likely that she was positioned between VP and the wall as VP described, rather than between VP and ZA. However, as discussed, I cannot rule out that Infant W was accidentally suffocated by ZA, perhaps rolling over in his sleep, whilst VP was absent from the bed feeding TG.

97. The quantity of adult bedding on the double bed represented a very unsafe environment for a sleeping infant. It is possible that bedding covered Infant W's face, also contributing to her inability to breathe. Infant W was exposed to cigarette smoke from her parents which increased her risk of sudden death but did not directly cause it.

SERT Review

98. The report relating to CSS decision-making was completed on 26 August 2019 by the Serious Events Review Team and an addendum report was prepared following interview with child protection employees and was completed by 29 June 2020. I have relied heavily in this finding upon the excellent chronology and analysis in these reports.

99. In summary, the SERT reviewer formed the view that the decision that the twins be discharged into the parents care without orders was not based on an adequate assessment and was incongruent with the known child protection history relating to the children of both parents. The report summarised the issues of risk resulting in VP's other children being placed in care. These included her alcohol and drug use, significant mental health concerns (including trauma, anxiety and depression), anger management issues, pattern of relationships characterised by family violence, a pattern of failing to engage with CSS, transience, failing to engage in reunification, and disengagement with her children.

100. The SERT review also found that there were deficiencies in the allocation of the notification, compliance with time conditions, and recording of case notes. There was also found to be a lack of safe-sleeping education imparted to the parents by CSS. Given the depth of the report, and the fact that it is unchallenged, I do not repeat its contents and analysis in detail. However, some of the main findings made were as follows:

- The case remained with Intake for an extended period (two months) without proceeding to Response. This was partly due to perceived stress on the system but is poor practice.
- Arbitrary timeframes and decision-making delegations in respect of unborn infant processes.
- Allocation to three CSOs during 10 weeks in Response and only one meeting with the family prior to the final allocation (and this was by the CSLO). This also resulted in pressured decisions once allocated and a failure to provide the parents with timely information and make contact in a timely way.
- Low staff numbers were partly responsible, staff having been taken to work in the ARL and staff resigning with the positions not being filled. There was 25 cases awaiting allocation from January to March 2019. There were also line management issues, with team leader position is being unfilled or filled only in a temporary capacity.
- There was overreliance by CSS upon the parents self-reports without seeking verification from objective sources.
- Safe-sleeping discussions were not initiated by CSS to the parents, despite this being a requirement pursuant to CSS written procedure since 2013.
- There was the need for a more formalised and thorough gathering of information and analysis. Family violence was a valid and current issue in respect of both parents, including the reports of incidents

between them. Yet, it was not considered significant or investigated thoroughly. There needed to be comprehensive and separate interviews with the parents, a full analysis of the child protection history relating to the other children, information from VP's health providers (particularly regarding the effect of her sedating medication), and a cognitive assessment of VP. Importantly, a specific assessment did not occur as to whether the parents had capacity to properly care for infants in light of complex issues such as trauma, intergenerational abuse, substance use mental health and family violence.

- The decision to invoke the Intensive Family Preservation Program was based on insufficient evidence and was incongruent with the level of risk and pattern of risk over many years.
- The child safety assessment remained open following discharge from hospital, when it should have been completed and there was ample time to do so.
- CSS was not clear with CHaPS regarding its request to provide an intensive service to the family and did not include CHaPS in the six-week review.

101. Relevantly, The SERT review was particularly critical of the decision not to seek protective orders given the very high-risk level of the case. This criticism is completely warranted in this case. I agree with the reviewer's criticism that initial views about case direction were not based upon comprehensive assessment; and that therefore those views became embedded, did not change, and contributed to CSS not adverting to the need for more thorough assessment. This view persisted, even despite the recommendation of the CPCE, and despite new information about family violence concerns reported on 25 February 2019.

102. Additionally, and importantly in my view, the SERT reviewer emphasised the fact of inaction by CSS when CatholicCare's intervention plan had to be scaled back due to the parents being unable to adhere to the agreed obligations. The obligations were realistic and achievable and considered by CSS to be bottom line requirements. The relaxing of the parents' requirements under the program should have caused CSS to question whether they were genuinely committed to addressing the risks and to achieve safe parenting. Urgent and robust re-assessment of risk by CSS needed to take place, including whether court orders should be sought to protect the twins. CSS instead did not respond in this way, despite the open child protection notification which imposed a statutory duty under the *CYPF Act.*

103. The issue relating to non-delivery of safe sleeping messages to the parents by CSS is concerning. The SERT review analysed thoroughly the reasons why this may have been the case. They reviewer found, following comprehensive investigations, that CSOs in the south of the State did not follow procedure and did not provide safe sleeping instruction or education to parents of infants. It appears that the CSOs interviewed for the review felt that they were not trained to have such conversations with parents, and that this messaging was provided by CHaPs in any event.

104. The recommendations made in the SERT review are sound and appropriate, as will be discussed.

Professor Lonne's opinion of CSS deficits

105. Consistently with the findings in the SERT report, Professor Lonne explained his opinion on the five most significant issues with the child protection practice in respect of Infant W. He summarised these in his report and they are set out *verbatim* below:

> (a) Delay in CSS interventions: There were two significant delays in attending to this case in a timely manner, and these were approximately four months of the total of six months from the notification received on 28 September 2018, prior to the birth of the twins on 9 December 2018, until Infant W's death on 6 April 2019. There was a delay of around two months in the time taken at Intake to do an Initial Assessment and then another delay of approximately two months for the matter to be allocated to a Response Team staff member who actioned the assessment. I am aware of the staffing shortages that appeared to play a part in the non-allocation of the case at the Response Team. These delays contributed to further issues outlined below.
>
> (b) Flawed Assessment and Decision Making: the assessment undertaken at the Response team was, in my view flawed and inadequate for the required task of determining the level of safety and risk to the twins should they reside with their parents. Specifically, the assessment was not holistic and was inadequate because it failed to give sufficient weight to the prior history of both parents regarding care of their other children, nor critically examine the contemporary incidents and risks of family violence. Decisions to allow the parents to take home the twins when they were discharged from RHH were unsound because they did not accurately determine the probability of ongoing family violence, and the level of the parents' engagement and commitment to disclosing contemporary incidents to the CSS and undertaking appropriate professional interventions to ameliorate the risk of ongoing family violence. I concurred with the SERT Report author's conclusion that the CSS staff were overly reliant upon the self-reporting of the parents, including their denials of contemporary family violence in their relationship. I have not had access to the completed Tasmanian Risk Framework (TRF) tool. According to the SERT Report there was no evidence of a completed safety plan or safety network documentation. Taken overall, the assessment process was, in my view, a significant failing and contributed to other issues in the management of the case by CSS staff.
>
> (c) Rushed Intervention Led to Issues: Following the flawed Initial Assessment process was the discharge of the twins by RHH, which found the CSS Response staff caught under-prepared for this, and 'chasing their tails' to get an adequate support network quickly into place. The SERT Report depicts a rushed process of intervention and coordination with other agencies, including the probation office staff. As the support plan formed it became clearer that there was more to the picture than the verbal assurances by the parents that there were no issues of concern. Rather, it became apparent that, despite their denials, there was ongoing family violence by ZA upon VP. This did not appear to alter the CSS approach to the intervention.

Other shortcomings were apparent with the CSS assessment and decision making and I concurred with the author of the SERT Report's conclusions about the nature of concerns that were evident, including that "*the substantial history known to the CSS warranted a careful and more formalised gathering of information and analysis*". Because the assessment was inadequate, in my opinion, the subsequent case decision making was flawed and risky.

(d) Case Review Delayed: Compounding this was the lack of a proper review as the weeks of parental care following the twin's discharge from RHH provided further information, albeit being somewhat inconsistent with some information indicating that the care of Infant W and TG by VP (primary caregiver) was appropriate and the twins were gaining weight and looking good, and also that there were stresses in the family household and ZA was proving to be angry and over-bearing of VP on occasions and that both parents sought to hide the incidents of family violence that were occurring. Moreover, there was evidence that the parents were not properly engaged in the intervention and were minimising the risks and issues, and then delaying taking the required actions to ensure that they were committed to addressing the relevant issues through undertaking professional help and support measures. Whilst the death of Infant W led to a change in direction of the case management and decision making by CSS staff there were, in my opinion, enough indicators that the parental behaviour would lead to a situation whereupon the twins would be removed from their care due to ongoing violence in the relationship perpetuated by ZA. A timely case review can assist in helping staff to get clear eyed about what is occurring, assess the progress in reaching chosen goals, and to re-calibrate the interventions and processes being used. That this did not occur in this case was a significant failure in my view.

(e) Safe Sleeping Procedure Not Undertaken by CSS: There was evidence in the SERT Report that the CSS staff did not recognise nor understand the policy requirement that they undertake action to ensure they delivered safe sleeping information and guidance to the parents. Whilst the CHaPS staff did this, it was apparent that the CSS did not see this as being part of their role. I concluded that this was a significant practice failure within CSS more broadly as in a previous report I had identified that CSS staff did not undertake safe sleeping procedures with the parents of infants that they were working with in 5 of 9 cases, and only partially did so in another 2 cases. I had at the time of my January 2020 Report concluded that there was evidence of slow improvement in this area of the CSS practice. This case has caused me to re-consider my earlier assessment and to identify this as one area where a much more forthright approach is needed by CSS to ensure that its staff are fully aware of the *Infant Safe Sleeping Practices Policy and associated Procedure (both effective 15 November 2013)* and their responsibilities to undertake the procedure of sharing information and guidance with all parents of infants that they work with. The provision of such information and guidance does not guarantee that parents will adopt the safe sleeping practices, but it nevertheless remains an important preventative strategy.

106. Professor Lonne went on to state:

> "These failures are, in my opinion, connected within an overall process of the CSS undertaking its statutory duties and responsibilities under the legislation, the *Children, Young Persons and Their Families Act* 1997, including Sections 10B and 18, and those Sections within Division 2. That is, the failures have occurred within staff's legislative remit but are events where their practice falls outside of the expected practice approaches. There is a need to see them as connected, with prior events playing a part in how subsequent actions and events transpire."

107. In his helpful and clear evidence at inquest, Professor Lonne confirmed his opinions of the significant failings in CSS practice, emphasising the lack of proper risk assessment, lengthy delays, the risk posed by the family violence in the relationship, the lack of engagement by the parents, the lack of assertive action by CSS, and failure to deliver safe sleeping messages as per the policy requirements. He also highlighted an obvious point relating to the history of the parents' involvement with CSS over a period of years and noted that the behaviour responses of the parents with respect to the inadequate care of their children had not changed. Professor Lonne said in evidence *"… and that in itself for me is a sort of prima facie case of well, ah if this – if the sort of corrective changes of behaviour by the parents had not occurred with previous work the department done, why should we expect it to change now?".*

108. Professor Lonne also agreed with a question from counsel assisting that there were enough indicators in this case for statutory intervention to be occurring with regards to the twins being removed from the home. His opinion, having regard to all of the evidence, is unassailable.

109. Professor Lonne also discussed in his evidence at inquest evidence the possible reasons for CSS not delivering safe-sleeping advice to the parents in this case and systemically in relation to other cases, despite the clear procedural requirement to do so. He recommended further review into this important and concerning issue.

110. I am satisfied that the applicable policy at the time, dated November 2013, was reasonable and adequate for its purpose and was consistent with the national safe- sleeping messages given by the *SIDS and Kids* organisation (now *Red Nose*). The policy is easy to read and provides good instruction to CSS caseworkers as to the content of discussions with parents.

111. The policy requires that advice on the following topics are to be discussed with parents, expectant mothers and other caregivers in relation to safety and well-being for young infants as appropriate:

- Sleep baby on the back from birth, not on the tummy or side.
- Sleep baby with head and face uncovered.
- Keep baby smoke free before birth and after.
- Provide a safe sleeping environment night and day.

- Sleep baby in their own safe sleeping place in the same room as an adult caregiver for the first six to twelve months.
- Breastfeed baby if you can.

112. The policy emphasises communication regarding the risks of suffocation of an infant sharing a bed with an adult and amongst adult bedding. Subject to adequate training, delivery of these critical messages by a CSO to parents should not be a difficult task.

113. In his evidence at inquest, Professor Lonne emphasised the importance of repetition of these messages and the CSS role in this process. The fact that CSS workers did not discuss safe sleeping with parents when a policy existed was described by Professor Lonne as not being a small issue. I agree with his view. CSS must take steps to understand and effectively resolve this issue.

114. It was critical in this case that CSS engaged with VP and ZA to impart and reinforce safe-sleeping information so that the messages became entrenched and acted as a strong deterrent to unsafe sleeping practices.

115. It is foreseeable that vulnerable newborn infants in a high-risk household may well be placed in unsafe sleeping situations, such as in the parental bed, by parents who are under the influence of alcohol or drugs and/or not able to cope. The responsibility of parenting newborn twins only magnifies this foreseeable risk. The need for safe-sleeping communication to parents whose infants are at risk and are the subject of a notification falls squarely within the remit of CSS.s

Factors in the circumstances surrounding Infant W's death

116. The evidence allows me to conclude that VP and ZA were not able to safely parent a single newborn infant. It is difficult to understand how CSS, even at the time, considered that they were capable of safely parenting prematurely born twins. The safety of the twins was in jeopardy upon being discharged home under the care of their parents.

117. Obviously, one of the risks of newborn twins being vulnerable to parents who are unable to cope is that a fatal sleep accident will occur. In this case, VP was sedated by the effects of methadone and other substances and ZA was sedated by significant quantities of alcohol. They were aware that Infant W should have been put to sleep on her own safe sleeping surface and should not sleep with them in their bed. The CHaPS nurse conveyed to them this information. Further, they almost certainly had this knowledge following the birth of their older children. Yet, they were ill-equipped to consistently provide a safe sleeping environment for the infant twins.

118. Professor Lonne provided an opinion that he considered that the CSS failures to convey to the parents safe-sleeping messages were connected to Infant W's death but he did not consider them causative. He said

that he reached this opinion because he could not conclude that the parents would have followed the CSS advice and guidance regarding safe sleeping even if it had been provided.

119. The issue of causation in any coronial investigation is one for determination by the Coroner, having regard to all of the evidence.

120. Nevertheless, I agree with Professor Lonne that it was unlikely that VP and ZA would have followed safe sleeping practices for the reasons he indicated in his report. However, there is always the possibility that repeated instruction may have deterred them from placing Infant W to sleep with them in their bed. CSS also had the power to convey to the parents that their failure to adhere to safe sleeping practices would be a significant factor in CSS deciding to apply for care and protection orders.

121. Within the scope of the inquest, I am required to consider the relationship between Infant W's death and the significant failings of CSS. I have received detailed submissions from counsel for CSS, who submitted that CSS could not have taken action to *ensure* that the twins were not placed at home after their birth.

122. Professor Lonne did not directly deal with whether or not the infants should have been in the home environment with their parents from the outset. He also did not venture an opinion upon what a court might do faced with an application which, if granted, would have the effect of the children being removed from the home.

123. It is quite correct to submit that CSS, in performing its statutory functions, is not able to ensure that children the subject of notifications are not placed at home with their parents. Counsel provided detailed submissions that the evidence did not reach the point of allowing a finding that CSS should have applied for court orders to remove the infants from their parents. Further, it was submitted that *"it is unknown what a thorough and proper assessment would have found. Even if a CAAG response had been recommended it is impossible to know what that response would have been."*

124. I reject that submission. There is abundant evidence in this case that a full and proper assessment would have highlighted the risk to the twins, including the ongoing pattern of family violence by ZA, the severe mental health issues of VP, the extent of their drug and alcohol use, and their demonstrated inability to parent their other eight children.

125. I have no hesitation, upon consideration of the abundant evidence, in finding that the case should have been properly and fully presented to CAAG before the birth of the twins or during their hospitalisation for consideration of the need for protective court orders under the *CYPF Act.* This course of action was considered at the time but, for ill-considered reasons, was aborted.

126. As discussed, CSS also had a stark opportunity towards the end of March 2019, at least a week before Infant W's death, to urgently reassess risk and to apply for assessment orders under the *CYPF Act* involving

removing the twins from the home. It was at this time that it should have been apparent to CSS that both parents were rapidly disengaging from the Family Preservation program. They were well aware of the consequences of disengagement. Again, the statutory function of CSS required there be a reassessment of risk, given the already precarious nature of the parenting capacity.

127. At that point, a proper assessment of risk would likely have resulted in further action by CSS to apply for orders. I am careful to take into consideration the benefit of hindsight in making these comments. However, in this case, the extent of the risk to the infants should have been obvious at the time, even despite investigative and assessment processes.

128. The use of statutory powers and court processes was not utilised. It is difficult to think that a magistrate hearing an application by CSS would have declined to make an order for the protection of the infants if full evidence of the extent of the risk was before the magistrate. Any order may have involved allowing custody to the Secretary and the twins being removed from the home.

129. Such an outcome is not a foregone conclusion and, in most cases, it is not helpful for a coroner to speculate on hypothetical court outcomes in finding causal factors in a death.

130. Despite the very significant failures by CSS, it is therefore not appropriate in this case to find that CSS played a direct causal role in Infant W's death. However, these failures represented factors within the circumstances surrounding her death occurring at a time when CSS was required to exercise its statutory duty.

131. The failure of CSS to recognise the risk and take appropriate action, together with other deficits in practice, represented missed opportunities to protect Infant W. The outcome for Infant W may well have been different if the failures had not happened.

132. The fact remains that, the parents were responsible for their infants' safety and care. Despite their violent relationship, substance use and mental health issues, VP and ZA insisted that they were able to provide a safe environment for their infant twins. They were provided with intensive support and were given professional and clear advice, including advice applicable to twins, through the CHaPS nurse about critical safe sleeping practices.

133. Being responsible for Infant W's safety, their actions in placing her in an unsafe sleeping environment was the direct and overwhelming causal factor in her death.

134. In relation to CatholicCare, counsel assisting submitted that I should find that it ought to have recognised from 10 March 2019 the early disengagement of the parents in its program. I fully accept the sound evidence of Andrea Witt that, in delivering the Intensive Family Preservation Program to the family for up

to 20 hours each week for 12 weeks, she did not consider that this family were disengaging as compared to her long experience with other families in similar programs.

135. I note the evidence that CatholicCare regularly sees inconsistent levels of engagement, particularly in the first six weeks of a program of this type where short periods of unresponsiveness or non-engagement are a common feature for most families. The evidence of Ms Witt and Ms Bresnehan that the degree of engagement and participation in this program was not out of the ordinary in the context of families engaged with CSS.

136. CatholicCare maintained that, during the whole IFPP period, both parents appeared to be doing their utmost to provide appropriate care for the twins and expressed the wish to engage in the program. I accept the evidence of Ms Bresnehan that her phone conversation with ZA did not necessarily signal a categorical refusal on his part to further engage in the program. As she said in evidence, ZA appeared to be showing signs of general stress associated with his return to work rather than disengagement with the program. ZA's, evidence, also denied an actual intention to disengage despite the language he may have used to Ms Bresnehan.

137. It is apparent that CatholicCare was aware of a lack of progress shortly before Infant W's death. The factors demonstrating this problem included ZA returning to work on 27 March 2019, both parents not being in regular contact with the program or with required services, the need for further modification of the case plan to decrease requirements, and ZA not attending the six-week review on 1 April 2019. It appears that VP's reluctance to attend a new parents group (apparently due to her anxiety levels) and general practitioner were clear impediments to progress. CatholicCare also noted that VP's tiredness following her recent hospitalisation for pleurisy was affecting her ability to engage.

138. However, I note that CatholicCare had home visits with VP on 3 April 2019 and 4 April 2019 and organised for VP to attend a general practitioner. At these visits, nothing untoward was observed. VP continued to express a wish to engage with services and learn how to parent the infants.

139. VP did, in fact, visit the general practitioner on 5 April 2019, but needed her CatholicCare worker to accompany her home from Glenorchy as she did not feel safe.

140. From the point of view of CatholicCare, I do not consider that there was anything in these last days of the program which should have prompted particular correspondence to CSS. In fact, VP had finally complied with her obligation to go to the doctor, albeit with difficulty.

141. At all material times, CatholicCare was reporting to CSS on visits and program development. The reports were delivered to CSS in a comprehensive and timely manner. There is no suggestion in the evidence that CatholicCare delivered the IFPP in a manner that was unacceptable to CSS. In fact, the evidence indicates

that CSS was simultaneously monitoring the progress of the family in the IFPP, including conducting home visits, as would be expected for the purpose of assessing an open notification.

142. It might be thought that CatholicCare, with its employees being experienced social workers, was insufficiently aware of the high risk to the twins and not sufficiently forceful in articulating to CSS the failures of the parents to comply with obligations.

143. Such a criticism cannot be sustained. The sole responsibility of CatholicCare was to deliver the IFPP as required and as overseen by CSS. It was not responsible for any high-level assessment of risk to the twins but to assist the parents, link them to services and undertake work to help preserve the family unit. That is not to say that a non-government organisation involved with CSS-referred families in other circumstances are not obliged to initiate risk assessments or make notifications to CSS; but this was not such a situation.

144. CatholicCare, in accepting the contract for delivery of the program, was entitled to rely upon the fact that CSS had conducted a full and proper risk assessment in supporting the twins being at home, albeit subject to their parents requiring significant assistance and support. It was also entitled to assume on an ongoing basis that CSS was monitoring risk to the twins pursuant to an open notification.

145. In hindsight, the IFPP program in the form delivered was an insufficient risk mitigation strategy for protection of the infants and could never have achieved the level of safe parenting required. Again, this is not the fault of CatholicCare. Even if a more intensive program had been available at the time, the problem was the assumption by CSS that the safety of the twins could be achieved by referral to such a program rather than applying for court orders.

146. I also accept that CatholicCare was not tasked to deliver safe sleeping education or messages. It was aware during the program that such discussions had occurred between VP and the CHaPS nurse. In my view, such a service delivering intensive support to newborn infants and their families should be contractually mandated to discuss safe sleeping practices with parents and caregivers.

147. I do not criticise CatholicCare in this finding. It delivered for CSS the IFPP service as required and did so in a professional manner.

Factual Findings for Infant P

Background

148. Infant P was born a twin with brother FG on 22 April 2019. They were born prematurely by emergency caesarean at 35 weeks gestation.

149. His parents were PT and AQ. They had commenced a relationship in 2017, although it had been marked by instability. PT and AQ finally separated just before the birth of the twins when PT was 34 weeks pregnant. At this time, AQ went to Melbourne and they had little contact thereafter.

150. AQ did not engage in the inquest process. An affidavit was also not able to be obtained from him.

151. Based upon the available information from the SERT report, AQ grew up in Victoria in a family involved in criminal activity. He was reported to have a history of mental health issues. These included suicidal ideation and attempts resulting in psychiatric admissions whilst residing interstate. He was also reported to have a history of illicit drug use (ice and cocaine) and criminal behaviour while residing interstate.

152. PT participated fully in the inquest, helpfully providing an affidavit and oral evidence. She was assisted throughout the process by the Coronial Liaison Officer.

153. PT had a long-standing history of poor mental health, principally anxiety and depression. These issues, including superficial self-harm by cutting, manifested in her teenage years and may have been exacerbated by trauma within her family and separation of her parents. She was treated by various mental health services.

154. At the age of 15 years, PT finished school and worked in various jobs, finding an interest in photography. She developed a relationship with BV, who she would later marry.

155. At the age of 18 years, PT's grandfather died and left her the residence in Taroona where she subsequently lived. PT's mother said in her affidavit that, for a period of time, her daughter developed an extreme fear of leaving the house, where she lived with BV.

156. At the age of about 20 years, PT married BV. She trained as a hairdresser and had her own salon, which was operating successfully for a period of time.

157. On 21 December 2015, at the age of 25 years, PT contacted her husband to collect her car from the Tasman Bridge as she said she was going to jump from it. Police attended, located her on the bridge and transported her to hospital in mental health crisis. She was prescribed a high dose of anti-depressant but it appears that her mental health nevertheless declined.

158. In about 2016, PT's marriage to BV broke down. After the separation, PT assaulted him on two occasions, in October 2016 and in January 2017. On the latter occasion, she attended BV's workplace and punched him several times when he refused to reconcile with her. PT's general practitioner, in referring her for further psychiatric assessment, recorded that PT had no recollection of perpetrating the assault and it appeared to be a "fugue-like episode".

159. In 2017 PT was given the provisional diagnosis of borderline personality disorder and later in July 2017, her general practitioner wrote to MHS with concerns that PT's presentation was worsening.

160. A short time after her separation from BV, PT met and formed a relationship with AQ and started travelling to Melbourne to see him.

161. PT had always been a cigarette smoker and would smoke up to 10 cigarettes a day. She continued smoking at the start of her pregnancy but gave evidence that when she started to attend pre-natal care she weaned off the cigarettes and only smoked when she was stressed. I do not accept this evidence at face value. PT's mother, SW, said in her affidavit that PT continued to smoke after the twins were born and she had observed her smoking outside the house.

162. PT's uncle, EZ, said in his affidavit that he observed cigarettes butts both inside and outside of PT's home. PT said in evidence that she never smoked in the house following the birth of the twins, except on the night of Infant P's death. I find that PT did, at times, smoke cigarettes inside the house after the twins were born.

163. On 15 April 2019, police were called to an incident by a member of the public where it appeared that PT was trying to jump in front of cars and was in a highly emotional state with AQ trying to calm her down. Police reports note that AQ was in the process of leaving the relationship with PT observed as having a packed a bag. A Family Violence Management System (FVMS) report was completed by attending police officers and noted the matter as a family argument.

164. Due to the FVMS entry, a notification was sent to CSS from Tasmania Police to the Advice and Referral Line (ARL). This report was also entered into Childrens Advice and Referral Digital Interface (CARDI) on 17 April 2019.

165. On the same day, 17 April 2019, another child protection notification was received by an anonymous person indicating their concern for the safety of the unborn babies, including concerns around PT hurting the babies either on purpose or accidentally.

166. The notifier reported that PT attempted to commit suicide by jumping out of a moving vehicle in February 2019 and stated that she did it impulsively and was feeling overwhelmed about the pregnancy. The notifier said that PT had made comments on multiple occasions that she wanted to end her life once the babies arrived. The notifier expressed multiple concerns about PT's ability to care for the infants, including her history of self-harm, her sedating medication, her emotional dysregulation, AQ' criminal history and drug use, and her apparent lack of connection to her unborn twins.

167. On 18 April 2019, the CSO at the ARL completed a thorough analysis utilising the Tasmanian Risk Framework tool. The resultant classification for the harm consequence was "extreme", the harm probability as "highly likely" and the future risk as "very high". Appropriately, the notification was determined as requiring transfer to the Response Team for assessment in light of the vulnerability of the infants and the high risk to them. This referral was sent and marked as Priority 2 requiring a five-day

response. However, the matter remained unallocated for two weeks. No adequate reason was provided for this delay.

168. On 22 April 2019, while the matter was awaiting allocation at Response, Infant P and FG were born five weeks premature. CSS was not notified of the birth of the twins at the time and was only notified on the 29 April 2019 because the prenatal service nurse contacted the CSLO.

169. On 1 May 2019, CSS allocated the case for assessment by a CSO. The SERT reviewer was unable to locate any records relating to discussions around case direction at the point of allocation on this date.

170. On 2 May 2019, the CSO requested an update from CSLO and was advised that the twins would be in hospital for another three weeks.

171. On 6 May 2019, CSS made an unannounced home visit, although PT was not present.

172. On 8 May 2019, CSS met PTat the RHH, being the first face-to-face meeting. Records of this meeting note that PT appeared to have self-inflicted cuts to her arms. It is likely that no further investigation into this was made by CSS.

173. On 9 May 2019, the twins were discharged from the RHH. At the time of his discharge, Infant P weighed 2560 grams, was 46 centimetres in length and had a head circumference of 32 centimetres.

174. Upon being discharged, PT took the twins to her residence. PT's grandmother, URR, stayed with her and the twins for the first two weeks. PT agreed to visit every second night to help.

175. On the same day, 9 May 2019, the CHaPS nurse received a referral from the RHH about the twins and the nurse made a call to PT. In addition, the CSO was notified by the CSLO that the twins have been "unexpectedly" discharged from the RHH without adequate safety planning.

176. On 13 May 2019, another visit was noted in the "blue book" (a child's personal health record kept by the parent), and an appointment was made for Infant P to see the CHaPS nurse on the 17 May 2019.

177. On 17 May 2019, the CHaPS nurse visited the house. In the family assessment, the nurse indicated that PT did not have mental health concerns. The next visit was scheduled for two weeks' time.

178. On 20 May 2019 CSS sent a request to mental health services for records about PT. CSS also conducted a home visit where PT told the CSO that she had no suicidal ideation or attempts whilst carrying the twins.

179. On 23 May 2019, information was provided to CSS by CHaPS nurse that PT was a heavy smoker. The nurse indicated no concerns about the health and development of the twins.

180. On 24 May 2019, CSS contacted the CHaPS nurse and outlined to her the fact of PT's history of self-harm, suspected borderline personality disorder and attempted suicide attempt when PT was about 16 years old.

181. On 31 May 2019, CSS conducted an unannounced home visit to PT. The CSO had no concerns about the twins or PT's parenting or support systems. There was extensive discussion about a safety plan for PT to manage AQ's possible return to Tasmania.

182. On the same day, a CHaPS nurse check-up occurred for both twins and records made in their blue books. The nurse noted that they were making healthy progress and another appointment was made for the 21 June 2019.

183. On 7 June 2019, CSS had its first safety planning meeting with PT. At the meeting were URR and two friends. A safety plan was developed which considered AQ's access to the infants, PT's mental health, her capacity to care for the babies and her support system. At this time, PT's mother who lived in Richmond was unable to be of great assistance due to being treated for ovarian cancer. UR herself was being treated with chemotherapy for lung cancer during this period.

184. PT noted that in early June 2019, Infant P demanded feeds more often and was crying more. PT said that she consulted with the district nurse who gave the advice to feed Infant P more and not stick to a feeding schedule as with FG.

185. For the long weekend prior to Infant P's death, PT stayed at her mother's house. During this time, she co-slept with both infants. SW said in her affidavit that the infants were sleeping in the queen bed next to PT, and she (SW) removed them and placed them back in their individual travel bassinets she kept at her house.

Circumstances surrounding Infant P's death

186. At 6.00pm on 14 June 2019, PT took the twins for dinner at Frank Restaurant. Present were SW, EZ as well as other family members. Guests at the dinner noted that both boys were good and were cuddled by the dinner guests. Infant P had a "projectile vomit" after feeding, which PT had not previously seen. However, SW said in her affidavit that Infant P vomited after feeding as a matter of course. There is no evidence at all that Infant P was exhibiting signs of illness or discomfort.

187. At 8.00pm PT and the twins arrived home and were the only ones present in the house. Her grandmother, UR, had stayed the previous night and was due to stay the following night. During the evening, the heat pump was on in the loungeroom, which she stated was always set to 27 degrees celsius. However, police attending the scene observed that the heat pump was set to 30 degrees. It is more likely that it was set at 30 degrees. In PT's bedroom, she had a "fan tower heater" that sat on her dresser opposite the bed, which OPT set between 30 and 32 degrees. This heater continued to operate all night. PT said that the windows were closed, and curtains drawn in her bedroom.

188. PT described in her affidavit her movements and events after arriving home at 8.00pm:

> *"I fed both the twins and let them have a little nap while I did some chores. About an hour later I change them and put them into their pyjamas which were onesies with singlets and a nappy, I then swaddled them and put them in their bassinets in the Lounge room… It was probably around 10pm by this stage. As soon as the twins were asleep I went to bed in my bedroom. I had been sleeping in the Lounge room on the couch with them but that night I couldn't sleep there as it was playing havoc on my back, so I went back to my bed for the first time. I had a baby monitor so could hear the twins.*
>
> *Around 3am on Saturday 15 June 2019 Infant P woke for a feed crying. I went out to the Lounge room and fed him 120mls of S26 Gold formula with water which I made up and heated in the microwave. Infant P fed fine and once I fed and burped him he settled. I changed him before I fed him which was just wet. I changed and fed FG about an hour later after I had finished with Infant P. I put the twins back to bed in the bassinets and went back to bed.*
>
> *At around 5am to 5:30am Infant P woke again crying. I gave him another 120 mil bottle of S26 Gold formula which I prepared and heated in the microwave. I checked his nappy and noticed that it was wet but not soiled so I didn't change it as I was so tired and knew that I would be up soon. I burped him. Infant P was wearing a (sic) his onesie which was white with yellow trimming and little whales on it.*
>
> *I then put the twins into my queen bed. The bed has an underlay, electric blanket and sheet on it, in that order. I also have a feather doona on the bed which was covered by a cotton cover. I put Infant P on his back next to me in my bed. There was a pillow behind him which was already there. I put a blue stripe pillow between myself and Infant P. I put FG next to Infant P on his back with no pillow between them. I then put a pillow down on the outer side of FG but away from him, to prevent him falling out of the bed and then I threw a pillow on the floor in case that didn't work then there would be a pillow to catch him as well. Infant P pretty much went straight to sleep. The twins were not swaddled in my bed and I had the doona pulled up to around their waist level.*
>
> …….
>
> *I was watching Forensic Files a TV show on my lap in the bed. I was laying on my side watching the laptop on my bedside table with the twins behind me. I remember staying awake until 6.25am and turning the laptop off. I did not check the twins at that time, I'd just turned the laptop off and laid there. I must have fallen asleep I'm not sure how long I was asleep but I remember waking up with a jolt around 7am. I was still facing the bedside table when I woke up.*
>
> *I turned to look at Infant P who was still on his back and noticed a pinky white froth coming out of his nose. I remember thinking "what's that". I then realised that the bubble was foamed blood and I wiped it with my*

hand thinking he may have scratched himself with his little finger nail. Once I did this no more came out. The phone was coming out of both his nostrils and was sitting above his top lip.

I picked Infant P up and kind of said Infant P are you awake, Infant P wake up, Infant P please wake up. Infant P was doing nothing. I then called the ambulance. I have no idea what I was thinking at the time. I believed he was still alive although he wasn't moving or making any sounds. FG was still in the bed asleep."

189. The evidence indicates that PT called 000 at 7.45am. She performed CPR upon Infant P in accordance with the ambulance operator's instructions. Infant P remained unresponsive. Ambulance Tasmania paramedics arrived at 7.55am.

190. Whilst I do not necessarily accept all of PT's evidence, I have no reason to disbelieve her account. I find that it accurately represents the circumstances leading to Infant P's death. I do not accept at face value her evidence that this event of co-sleeping before Infant P's death was only the second time this occurred, the first occasion being the event at her mother's house as described. However, it is unnecessary to make further findings on this point.

191. Following resuscitation attempts by the paramedics, Infant P was transported to the RHH. Nothing further could be done to revive him and, very sadly, he was pronounced deceased at 9.10am.

Investigation

192. At 8.05am on 15 June 2019, police became aware of Infant P's death. Police officers, including forensics officers and detectives, attended the residence.

193. The attending officers at the scene noted that PT's bedroom, where Infant P had been sleeping, was cluttered with clothes, rubbish and other items lying around the room. A number of used cigarette butts were lying on the floor and a packet of cigarettes was on the bedside table ashtray. In the ashtray, there appeared to be approximately a 10 cigarette butts. A number of blister packets of medication were over the floor and on the bedside table.

194. The attending officers also inspected the ensuite that connected to PT's bedroom. They observed that the ensuite was also in a dirty state, the sink being full of water with a white film on top, and cigarette butts on the sink. One police officer noted the strong smell of cigarettes from the bedroom. The bedroom was very warm because of the freestanding heater. In contrast to the bedroom and ensuite, the other rooms in the house, including the room containing the infants bassinets, were not dirty or cluttered. The house was very warm because of the heat pump.

195. An autopsy upon Infant P was conducted on 17 June 2019 by forensic pathologist, Dr Michael Burke.

196. Observations of Infant P's body indicated that he was a normally formed male infant a weighing 4.5 kilograms and 48 centimetres in length. There was no evidence of trauma on his body and no abnormalities detected. There was no evidence of inflicted injury or natural disease.

197. Dr Burke recorded the presence of anterior lividity (pooling of blood). This provides some evidence that Infant P died in a face down position. Toxicology examination noted cotinine and nicotine detected, and carboxyhaemoglobin was detected at 4% saturation. These results indicate that Infant P had in his system the products of his mother's cigarette smoke.

198. Dr Burke concluded that Infant P died of sudden unexpected death in infancy (SUDI). By giving the cause of death as SUDI, Dr Burke was indicating that a cause of death could not be ascertained at autopsy.

199. However, I must have regard to the circumstances of death in such a case. The totality of the evidence points to a very unsafe sleeping environment for an infant.

200. The bedroom was likely excessively warm and Infant P was inhaling his mother's cigarette smoke. He was lying next to his sleeping, and exhausted, mother in the dangerous environment of adult pillows and bedding. Infant P had an adult doona pulled up to his waist when he went to sleep on this back.

201. I am satisfied that Infant P did not die of natural causes but of causes relating to his sleeping environment. There is no evidence that Infant P was able to roll onto his stomach, and yet it appears that somehow he died in a prone position on the bed.

202. I cannot find exactly how he died but it is apparent that restriction of his breathing is likely to have occurred through accidental overlay by PT or by being covered in bedding.

203. PT told the court that it was only after Infant P's death that CPS spoke to her about safe sleeping and that she received a pamphlet via the post following that visit. I accept this is the case.

204. However, safe sleeping practices were discussed with PT at the hospital by the nursing staff and she also watched a video prior to discharge that provided information on CPR and safe sleeping. She also received two home visits from the CHaPS Nurse who raised the topic of safe sleeping. I am satisfied that PT was aware of the risks of having the infants sleeping with her in bed.

SERT Review

205. Again, the SERT review in respect of Infant P's death is a detailed and analytical document which has been very helpful in this inquest. The experienced reviewer in this case, Veronica Burton, is a former Senior Quality practice Advisor for CSS and registered psychologist.

206. In the review, Ms Burton identified the major issues as including the fact that a UBA was not generated as part of the assessment; that the ARL (intake) assessed the notification as a Priority 2, despite the infants being accurately classified as "very high risk"; and that after the notification was sent to Response it remained unallocated for two weeks, during which time the twins were born prematurely.

207. The review determined that the effects of these significant issues included: (a) that the notification was not treated with sufficient priority and so the opportunity was lost for a more thorough and correct assessment of risk and response to protect the infants; (b) CSS was not alerted to the birth of the twins until a week after they were born, resulting in a lack of important information from the hospital to CSS and; (c) PT did not receive the required support to alleviate the risk to the infants upon bringing them home.

208. Ms Burton also concluded that CSS staff were unaware of, and not compliant with, required procedures regarding safe sleeping risks and responsibilities and were unaware of the many associated risks that were present in this case.

209. Ms Burton concluded that there were positive aspects of CSS practice, particularly the quality of the initial assessment at ARL and aspects of the safety planning for the twins at home.

210. In the SERT report as well as in her evidence at inquest, Ms Burton emphasised the role played by CSS staff shortages at Response, resulting in high case loads and a high number of unallocated cases. She also referred to issues with CSS staff not having completed the available online training. She made recommendations relating to training in risk assessment (including for infants), monitoring of training and workforce development and updating relevant policies to include the compulsory provision of safe-sleeping information.

Professor Lonne's opinion of CSS deficits

211. I set out below, verbatim from his report, Professor Lonne's summary of the three main child protection issues relating to Infant P:

> (a) Failure to Complete an Unborn Baby Alert (UBA):
>
> Despite the sound practice at the ARL in communicating speedily with the relevant sources of information, undertaking the initial assessment, and collating this into an accurate picture of the context of these unborn twins, that identified harm consequences as 'extreme', the harm probability as 'highly likely' and 'very high risk', there was not any action taken in accordance with the CSS UBA policy that had been in existence since 2013 (6 years). I remain puzzled by this as it seems to be a case of 'missing the bleeding obvious'. The SERT Report highlights in its findings that this led to missed opportunities to provide early support and preventive strategies, and *"to strengthen the P2 assessment that was sent to Response. This also impacted upon the communication between the RHH and the CSS in that the CSS were not informed when the*

babies were born". From my perspective this particular case looked like the sort of case for which the UBA was designed as a policy and procedure, because unborn infants can be at serious risk by parental behaviours and after they are born infants are completely dependent and vulnerable and require a far higher level of vigilance lest something bad occur for them. The threats by a heavily pregnant PT to jump in front of a car posed a real risk of harm to the unborn twins. I find the non-use of the UBA procedure in this case to be inexplicable. Yet its importance is underscored by the Garrett report on Sleep-related infant deaths in Tasmania (2000-2021) which identified, for example, a number of associations involving higher probability of deaths including involvement with the child protection system, co-sleeping, being premature babies and having low birth weight, and no provision of safe sleeping messaging provided to caregivers.

(b) Delay at Response Allocation:

After the matter was sent to Response, it remained unallocated until 1 May 2019, two weeks after it was received. Yet, it had been given an initial ARL assessment of 'very high risk'. Given the facts outlined above, this sort of delay could have, in different circumstances, proved to be tragic. As it was, opportunities were missed to provide earlier support. As in the earlier case of Infant W, there were significant staffing issues evident in the Response Team, and at the time only Priority 1 matters were being actioned and assessed. This makes it more evident that not making a UBA earlier did have consequences down the line with the passage of time. This was a theme evident in both these cases, and both SERT Reports highlighted in detail the flow on effects of delays in the Response Team allocation of staff to undertake the critical, time-dependent tasks of completing a more thorough assessment of the risk and safety of these infant children. A system that leaves the most vulnerable and dependent children in these sorts of circumstances for these sorts of time periods has some very serious and potentially fatal issues on its hands, and there is a responsibility to deal with them in timely ways.

(c) Safe Sleeping Procedure Not Undertaken by CSS:

This is also a recurring theme in both these cases. The reason for the CSS policy and procedures around this is self-evident, and I have outlined them in my response to this term of reference with respect to Infant W. In the matter of Infant P, it remains unclear to me whether or not any agency involved with him and his twin brother actually discussed the information and guidance with their mother PT, although based on the SERT Report I am prepared to assume that CHaPS staff did so. That CSS and its staff have a responsibility and obligation to do so as part of an evidence-based policy and practice framework appears to be, in my opinion, self-evident. I noted that the SERT report outlined some real difficulties CSS staff had in locating the policy and procedures on the CYS Practice Manual, and that *"training records indicate that the involved staff had not completed the available training at the time of the assessment.*" This would have placed them in a very tenuous situation as their job roles and tasks has them in the front line to implement these requirements. Had CSS staff had this sort of training and easier access to the Safe

Sleeping policy and Infant Safe Sleeping procedure, this would hopefully have led to them also passing this information on to PT, and thereby, could have potentially resulted in her adopting these practices. I recognise that this is speculation, but the stakes are quite high in these circumstances.

212. Professor Lonne further stated:

> "Similar to the failings I identified with the Infant W matter, these failings are also, in my opinion, connected within an overall process of the CSS undertaking its statutory duties and responsibilities under the legislation, the *Children, Young Persons and Their Families Act* 1997, including Sections 10B and 18, and those Sections within Division 2. There is a need to see them as connected, with prior events playing a part in how subsequent actions and events transpired. The decision to not make a UBA for the twins was clearly impactful on the significance of the delays in actioning matters at Response, and in turn this was connected to a view by CSS Response staff to see external agencies as holding the responsibility for advising departmental service users of the safe sleeping information and guidance."

Factors in the circumstances surrounding Infant P's death

213. Although I cannot determine upon the evidence exactly how Infant P died, I am satisfied that factors relating to his unsafe sleep environment were either the cause or major contributor to his death, by compromising his airway. I am satisfied that he would not have died if he had been placed in his bassinet on his back in a smoke-free room and with no loose bedding.

214. In relation to the role of CSS, again there were missed opportunities to respond to the risk. I do not suggest in this case that a proper assessment of risk at Response would inevitably have led to the twins being removed from PT's care or even that a court application should necessarily have been in serious contemplation.

215. However, a more thorough assessment based upon comprehensive information, should have occurred. This may well have led to a stronger intervention to ensure their safety at home. The view of CSS concerning risk to the infants could also have been more clearly conveyed to PT.

216. The evidence indicates a lack of appreciation on the part of CSS regarding the inability of PT to cope as a single mother with newborn twins, in circumstances of her poor mental health, a recent separation and lack of support. As the notification remained open at the time of Infant P's death, relevant information was still being gathered in respect of the notification. However, by this time, it was too late.

Tasmanian rates of sudden infant sleep-related death

217. For these investigations, I requested a coronial research study on sleep-related infant deaths in Tasmania since the year 2000. This was completed by the then Senior Coronial Research Officer, Dr Andrew Garrett.

218. In compiling the statistics and research, Dr Garrett also created the Tasmanian Sudden Infant Death Register (TSIDR), a password protected database that stores data on sleep-related infant deaths in Tasmania since 2000. The TSIDR is current for this category of death until 1 January 2022. Dr Garrett devised rules and instructions allow for future database coding and analysis.

219. The TSIDR contains both general socio-demographic factors and a comprehensive set of rationally derived risk-factors including (but not limited to):

(1) Infant-related factors (low-birthweight, prematurity);
(2) Care-giver related factors (young maternal age, maternal parity);
(3) Sleeping environment factors (sleeping surface, co-sleeping exposure); and
(4) Miscellaneous risk factors (toxicology, reduced arousal).

The study is annexed to this finding and marked "B".

220. Dr Garrett summarised the main findings of the study as follows:

- There were 80 infant sleep-related deaths (0-12months of age) in the period of 22 years.
- Of the total deaths, 46 (58%) deaths were male, 34 (42%) were female.
- 47 of the total of 80 infant sleep-related deaths had evidence of co-sleeping, noting that co-sleeping could be with caregiver or sibling or another family member and includes mechanical overlay and bed-sharing during non-sleeping activities.
- 79% of infants who died while co-sleeping were equal to or younger than 4 months of age, indicating that younger infants may be more susceptible to sleep-related risks such as exposure to unsafe sleeping environments or sleeping practices, as compared to 69% of deaths occurring in the absence of co-sleeping.
- Of the total of 80 sleep-related deaths, 48.8% occurred where the sleep surface was an adult bed; a further 18.8 % occurred where the sleep surface was a couch, mattress on the floor or sofa bed. Therefore, of the total deaths, 67.6% of infants died on sleep surfaces that are known to correlate to SUDI. Only 7.5% of the total deaths involved an infant sleeping in a bassinet, being recommended as a safe sleep surface.
- In terms of caregiver-related risk factors, 63.8% of the total sleep-related deaths involved maternal smoking during pregnancy.
- 31.3% of the total sleep-related deaths involved maternal drug or alcohol use during pregnancy.

- 50% of the total sleep-related deaths involved the infant being exposed to a smoking party in the period proximate to death.
- 16.3% of the total sleep-related deaths were noted to have exposure to domestic violence.
- 25% of the total sleep-related deaths had toxicology findings at autopsy.
- 25% of the total sleep-related deaths were of infants known to child protection, again a significantly a overrepresented cohort as compared to the general population.

221. The study has determined that 62.5% of the total deaths did not involve the parents being provided with safe sleeping messages. There are reasons why this statistic should be treated cautiously. The study data utilised by Dr Garrett has necessarily been based only upon the documents in the individual coronial investigations. For the most part, the information in the investigations is thorough. However, the investigating police officers (acting as coroner's officers under the Act) in charge of individual investigations have historically been reluctant to obtain details from parents or caregivers about their knowledge of correct safe sleeping practices. This is understandable. At a time when parents are grieving the unexpected death of their infant, raising such a topic may appear to place blame on the parents.

222. I am also aware that over many years, particularly in the latter half of the study, hospitals and visiting child health nurses consistently impart safe sleeping messages to parents on several occasions in the period immediately following birth.

223. Further, it is often the case that parents in these cases provide evidence that they did not receive safe-sleeping information, when agency records indicate this is not the case. Again, it is understandable that parents may provide this account in their time of grief.

224. Therefore, in making further comments in this finding, I should not rely upon this statistic alone to find deficiencies in safe sleeping education to parents and caregivers.

225. In fact, the study highlights that the average three-year death counts of infant sleep-related deaths have substantially declined to a minimum of 1.3 per year over the 2020-2022 period. It is quite plausible that the decline may partly be attributable to better and more repetitive safe sleeping messages to parents relating specifically to co-sleeping and other risk factors.

226. I recently requested from the current Senior Coronial Research Officer, Runi Larasati, an updated memorandum regarding sleep-related infant deaths in Tasmania between 1 January 2022 and 31 May 2025 following on from the study by Dr Garrett. In this period of 3 ½ years, 5 sleep-related infant deaths were reported to the coroner. The three-year average for 2022-2024, like the preceding three-year period, is 1.3 deaths.

227. The evidence regarding these further 5 sleep-related infant deaths indicates that three deaths, and possibly four, were associated with circumstances of parental cigarette smoking. Additionally, at least three of these deaths were caused by or associated with or caused by an unsafe sleeping environment (including co-sleeping with adults). The average for this period remains consistent with the previous similar period.

228. Unfortunately, the Coronial Division is not yet resourced to code these more recent deaths in accordance with the detailed criteria required by the TSIDR. However, in my view, it is critical that a Coronial Court has access to detailed analysis in order to understand the complexities of causative factors and to make valuable, evidence-based recommendations for the purpose of further preventing these tragic deaths.

Council of Obstetric and Paediatric Mortality and Morbidity (COPPM)

229. Dr Michelle Williams provided an affidavit and evidence at inquest. She is an experienced consultant paediatrician. She is a council member of COPMM, constituted under the *Obstetric and Paediatric Mortality and Morbidity Act* 1994. One of the primary functions of COPMM is to review and classify all maternal, paediatric and perinatal deaths in Tasmania.

230. Dr Williams is the current Chair of the Paediatric Subcommittee of COPPM and is the previous Council Chair. Over many years, COPMM has reviewed cases of SUDI and has made comments and recommendations regarding education to minimise preventable risk factors for SUDI for many years.

231. Dr Williams highlighted in her evidence that most SUDI cases have occurred in families with socio-economic disadvantage. This is because many of the risk factors for SUDI are more common in disadvantaged families: smoking, premature birth, drug and alcohol issues, poverty and unstable housing situations.

232. Dr Williams commented that it may be appropriate to re-visit the criteria used in the TSIDR regarding socio-economic disadvantage to ensure that it is sufficiently expansive if it assists future education and other strategies. I agree that resourcing permitting, such an exercise would be of assistance in more fully understanding the role of socio-economic disadvantage in SUDI so as to inform prevention strategies.

233. The 2021 COPMM report contains the following recommendation regarding SUDI:

> *That a clear consistent message is used as part of the universal distribution of educational material concerning safe sleeping practices to all new parents. It is also recommended that further education packages are provided to parents highlighting the risks associated with parental use of illegal and prescribed drugs and co-sleeping. As highlighted in previous reports, it is also recommended that more effective forensic death scene examinations be undertaken to establish whether the cause of death is due to overlying.*

234. Dr Williams, in her affidavit for the inquest, stated that many parents do co-sleep with their babies, either by choice or accidentally. She emphasised that this practice is not recommended.

235. She outlined that the safe sleeping practices promulgated by Red Nose (and as previously outlined in this finding) should be adhered to. She said that safe-sleeping guidelines are widely distributed at antenatal visits, during the birth admission, in the parent held infant record book, via CHaPs and during any subsequent admission to hospital. Further, she expressed the opinion that the information provided through THS is concordant with information available through most community resources.

236. Dr Williams confirmed that the risks of co-sleeping are further increased if the infant is premature or small for age, the parents smoke, or are affected by drugs or alcohol. Infants with these risk factors should not co-sleep. Infants should never be placed to sleep on a sofa or chair, with or without a parent.

237. Dr Williams concluded her affidavit as follows:

> *"Both Infant P and Infant W had an increased risk for sudden infant death and sharing a bed with an adult increased these risks further. Both infants were twins, and parenting twin babies is a greater load than parenting one infant.*
> *Neither infant should have shared a bed surface- being in a separate appropriate crib in the same room would have been the safest sleeping option."*

CHaPS and THS

238. At inquest, I heard evidence from Nicole Kinghorn, Director of Nursing, CHaPS, who confirmed the important role of CHaPS in delivering safe-sleeping education to parents of infants.

239. Ms Kinghorn's evidence was impressive. She outlined the mandatory and thorough training undergone by CHaPS nurses, including in safe sleeping education, and said that safe sleeping is raised with parents at every visit.

240. Ms Kinghorn gave evidence that a clinical nurse educator is responsible for ensuring that the CHaPS safe sleep information is current and that educator is also responsible for checking content. Time is provided to CHaPS staff to complete training courses and Ms Kinghorn emphasised the importance of recruitment and succession planning in the organisation to ensure that skilled staff are filling these critical positions.

241. I am satisfied that CHaPS' delivery of safe sleeping information and education are of a very good standard.

242. Similarly, I heard evidence from Susan McBeath, Women's and Children's Nursing and Midwifery Director at the RHH. Ms McBeath also provided a helpful affidavit regarding the safe sleeping education and messages provided to parents before and after birth by the three main public hospitals in Tasmania.

243. As submitted by counsel assisting, Ms McBeath provided knowledgeable and credible evidence that indicated, in general, that THS safe sleeping procedures and education were of a good standard. Her evidence was that the messages regarding safe sleeping are provided in several ways, including by video, and it is inevitable that parents to be and parents of newborns will receive safe sleeping information on more than one occasion if they attend these hospitals.

244. In her affidavit, Ms McBeath also described the 2020 pilot program of Pepi-Pods, whereby 100 small, purpose-built portable tubs (including bedding) were provided by CHaPS nurses to high-risk women before the birth of their babies. It appears that this pilot program has still not been evaluated.

245. In a report for a previous inquest, Dr Williams, referred to the Pepi-Pod pilot program and stated "*The provision of an evidence-based safe, portable sleeping equipment (such as a Pepi-Pod) to "at risk" families would allow them to move the baby to a warm room or to a safe house and still sleep safely, decreasing the risk of sudden unexpected death in infancy (SUDI).*"

Conclusion

246. The sudden and preventable deaths of Infant W and Infant P highlight that there can be tragic consequences of placing an infant in an unsafe sleeping environment. In both cases, the infants were loved but the ability of their parents to keep them safe was limited.

247. In each case, there was an open CSS notification at the Response stage, but deficiencies in CSS practice meant that there were missed opportunities to protect the infants. The common failures involved delay in allocation of the cases, inadequate recognition and assessment of risk, and failure to discuss safe sleeping practices with the parents as required by CSS policies.

248. I received a comprehensive affidavit from Kai Kitchin, Principal Practice Manager of CSS, regarding the significant changes to the organisation and the response to Professor Lonne's recommendations in his report.

249. Of particular relevance, CSS has implemented a Practice Leadership Redesign which aims to provide a leadership structure that increases staff access to practice leadership and enables practice leaders to engage in mentoring, coaching and role modelling practice in the day-to-day delivery of services. As part of this change, the CPCE role (now called Practice Manager) includes practice delegation and decision-making.

250. I also received evidence that the *Bringing Baby Home* residential program is in operation and includes requirements for the very close monitoring of sleeping practices 24-hours per day. Each family participating in the program must sign an agreement to abide by individualised house rules. These include rules about visitors, drug and alcohol restrictions, and sleeping arrangements. The rules may be as prescriptive as requiring bedroom doors to remain open at all times to enable monitoring. In this program, infants must

sleep safely according to *Red Nose* advice. Any attempted or actual deviation from these requirements will be reported to CSS.

251. Apart from the families and loved ones, the sudden death of an infant in these circumstances also has significant impact upon CSS and all those who are doing their best to assist and support the families.

252. For the large part, CSS staff conscientiously perform their roles to the best of their ability. In many instances, child protection practice is of high quality. As Coroner, my role necessarily involves identifying deficits and issues that may impact negatively upon an outcome, as I have done in this finding. I am also conscious that CSS staff are often required to make decisions and take action in an environment where staffing and resourcing are inadequate.

253. It appears from the statistics, that the rates of SUDI have been lower in recent years. This coincides with strong, consistent messages provided by health organisations, which must continue. Unfortunately, deaths of infants, particularly in higher risk households, continue to occur.

Findings Required by s28(1) of the *Coroners Act 1995* in relation to the death of Infant W

a) The identity of the deceased is Infant W, date of birth 9 December 2018;
b) Infant W died in the circumstances set out in this finding;
c) Infant W's cause of death was asphyxia due to accidental overlay by a parent in an unsafe sleeping environment; and
d) Infant W died on 6 April 2019 at Bridgewater in Tasmania.

Findings Required by s28(1) of the *Coroners Act 1995* in relation to the death of Infant P

e) The identity of the deceased is Infant P, born 22 April 2019;
f) Infant P died in the circumstances set out in this finding;
g) Infant P's cause of death cannot be fully determined but an unsafe sleeping environment was a causative factor; and
h) Infant P died on 15 June 2019 at Taroona in Tasmania.

Recommendations

I **recommend** that CSS, at regular intervals, revisit the unborn baby procedures and processes to ensure clarity of purpose, role and function, and to promote the administration of the procedures in a consistent manner state-wide and ensure that there is evaluation of the delivery of these in staff training programs.

I **recommend** that CSS, at regular intervals, revisit the infant safe sleeping procedures and processes to ensure clarity of purpose, role and function, and to promote the administration of the procedures in a consistent manner state-wide and ensure that there is evaluation of the delivery of these in staff training programs.

I **recommend** that CSS, at appropriate intervals, undertake an audit process to determine whether safe-sleeping messages and instructions have been delivered to families by CSS in accordance with required procedure; and, depending on the audit outcome, implement any further training or other measure to ensure consistent adherence to the requirements of the procedure.

I **recommend** that CSS require contracted community sector organisations to deliver safe sleeping information to CSS-referred families, and to notify CSS of any observed unsafe sleeping practices.

I **recommend** that CSS ensure that, in engaging community sector organisations to deliver a service in cases where a CSS notification is open, the roles and responsibilities of both parties are clearly specified, including critical timeframes for decision-making or other action.

I **recommend** that CSS and CHaPS implement a plan to jointly consult and share information in cases where infants are subject to CSS involvement, in order to maximise the safety of the infants in their sleep environment.

I **recommend** that community sector organisations engaged in delivering intensive programs to high-risk families with infants establish a training module for staff regarding infant safe-sleeping which includes training in the delivery of safe-sleeping messages to families.

I **recommend** that the Serious Event Review Team be re-established or, alternatively, that another body be established comprising persons appropriately qualified to review relevant aspects of CSS practice in cases involving deaths of children involved with CSS.

I **recommend** that the Tasmanian Health Service completes the evaluation of the 2020 Pepi-Pods trial and, if indicated by the evaluation, implement a statewide rollout of Pepi-Pods to parents or caregivers whose infants may be at risk from unsafe sleeping practices.

I **recommend** that, where appropriate, safe-sleeping education to parents, should incorporate information about the narrow size of an infant's airway; and also information about the high correlation between SUDI and cigarette smoking, including the risk posed by smoke transference from adult clothing to an infant's airways.

I convey my condolences to the families and loved ones of Infant W and Infant P.

Dated: 24th day of June 2025 at Hobart in the State of Tasmania

Olivia McTaggart
Coroner

Annexure A

LIST OF EXHIBITS

Record of investigation into the death of

INFANT W and INFANT P

Tab No.	TYPE OF EXHIBIT	NAME OF WITNESS
A1	Report to the Coroner - Regarding Infants Deaths	Professor Robert Lonne
A2	Affidavit – 30/5/2023	Nicole Kinghorn Acting Nursing Director – Child Health and Parenting Services
A2a	Infant W - CHaPS Records	CHaPS
A2b	Infant P - CHaPS Records	CHaPS
A2c	CHaPS SUDI online education package	CHaPS
A3a-t	a – Brochure Safe Sleeping 2017 to 2019 b – Info Statement - Sharing sleep surface with baby – Dec 2019 c – Red Nose Safe Sleep Recommendations d – What is sudden unexpected death in infancy e – Co-Sleeping With Your Baby f – Bedsharing and Co-Sleeping With Older Siblings g – Does sleeping with baby on a sofa or couch increase risk of sudden unexpected death in infancy h – Is it safe to sleep with my baby i – Accidental co-sleeping – How to reduce your risk j – Red Nose advise to parents following recent co-sleeping accident in Perth k – Sharing a sleep surface with your baby (archived version) l – Co-Sleeping with your baby (archived version) m – Mother – Infant bed sharing in clinical settings (archived version)	Margaret Polascka Director, Education and Research - Red Nose

	n – What is a safe sleeping environment (archived version) **o – Is it safe to sleep with my baby (archived version)** **p – Does sleeping with baby on a sofa or couch increase the risk of sudden unexpected death in infancy (archived version)** **q – What steps can i take to sleep my baby safely (archived version)** **r - Red Nose co-sleeping information 2019-2023** **s – Information Statement Sharing a Sleep Surface with Baby** **t – Statutory Declaration – Margaret Polascka**	
A4	**a – Letter to Coroner** **b – 2012-2013 Infant Safe Sleeping Practice – DHHS Wide Procedure** **c – 2019 – Infant Safe Sleeping Practice – THS Statewide Protocol** **d – 2019 – Infant Safe Sleeping in Hospital and In the Home – THS South Protocol** **e – 2018 – Old Version of CHaPS Screening and Surveillance Protocol** **f – 2018 – Old Version of CHaPS Child Health Assessment (Two Weeks)** **g – 2022 – Co-bedding of multiples in the neonatal and paediatric intensive care unit** **h – 2022 – CHaPS Screening and Surveillance Protocol** **i – 2022 – CHaPS Child health assessment (two weeks) Guideline** **j – 2022 – CHaPS Child Health Assessment (Four Weeks) Guideline** **k – 2022 – ChaPS Child Health Assessment (Eight Weeks) Guideline** **l – 2022 - CHaPS Child Health Assessment (Six Months) Guideline** **m – 2022 – ChaPS Child Health Assessment (Twelve Months) Guideline** **n – No Year – WACS Post Development of Family Information APP**	**Department of Health**

	o – Document List Sleep Safe Documents	
A5	**Affidavit – 6/6/2023**	**Kai Kitchin** **Principal Practice Manager - Child Safety Service**
A6	**Sleep Related Infant Deaths in Tasmania (2000 – 2021)**	**Andrew Garrett**
A7	**Affidavit – 15.9.23**	**Nicole Kinghorn**
A8	**Affidavit & Annexures**	**Sue McBeath**
A9	**Affidavit**	**Dr Michelle Williams**
A10	**CHaPS 2018-19 Welcome Pack**	**CHaPS**
A11	**Personal Health Record (2018/19)**	**CHaPS**
A12	**Personal Health Record (Current Version)**	**CHaPS**
A13	**Safe Sleeping (Video)**	**CHaPS**

LIST OF EXHIBITS

Record of investigation into the death of

INFANT P

No.	TYPE OF EXHIBIT	NAME OF WITNESS
B1	REPORT OF DEATH	CONSTABLE MUNRO
B2	DEATH REPORT TO CORONER	DR JOSEPH POWER
B3	LIFE EXTINCT AFFIDAVIT	DR NICHOLAS WATKINS
B4	AFFIDAVIT OF IDENTIFICATION	D/CONSTABLE SHAREE MAKSIMOVIC
B5	POST- MORTEM	DR MICHAEL BURKE
B6a	TOXICOLOGY REPORT	FORENSIC SCIENCE SERVICE TASMANIA
B6b	CONTININE FACT SHEET	CENTERS FOR DISEASE CONTROL AND PREVENTION
B7	MEDICAL REPORT	INFANT P
B8	AFFIDAVIT – 31.7.19	PT (MOTHER /SNOK)
B9	AFFIDAVIT – 6.8.19	SW
B10	AFFIDAVIT – 14.2.20	EZ
B11	AFFIDAVIT – 17.2.20	UR
B12	AFFIDAVIT – 14.2.20	D/SENIOR CONSTABLE SHAREE MAKSIMOVIC
B13	AFFIDAVIT – 14.2.20	CONSTABLE MATTHEW ANDREW BURLEIGH
B14	AFFIDAVIT – 15.02.20	S/CONSTABLE STEVEN ANTHONY BOMFORD
B15	AFFIDAVIT – 22.2.20	1yepC/CONSTABLE ANDREW DAVID LEWIS
B16	AFFIDAVIT – 28.2.20	D/CONSTABLE REBECCA TAWS
B17	AFFIDAVIT – 17.02.20	D/SENIOR CONSTABLE NICOLETTE MUNRO

B18	**AFFIDAVIT AND SCENE PHOTOGRAPHS (CAUTION) -24.2.20**	**CONSTABLE TANIA MAREE CURTIS**
B19	**ADDITIONAL SCENE PHOTOGRAPHS (CAUTION)**	**CONSTABLE TANIA MAREE CURTIS**
B20	**PROPERTY RECEIPT**	**TASMANIA POLICE**
B21	**PROPERTY RECEIPT**	**RHH DEPT OF ANATOMICAL & FORENSIC PATHOLOGY**
B22	**PERSONAL HEALTH REPORT BOOK**	**INFANT P (PHOTOCOPIES)**
B23	**CHILD HEALTH NURSE NOTE**	**KAREN GRUBB**
B24	**MEDICAL REPORTS**	**ROSNY PARK FAMILY PRACTICE**
B25	**MEDICAL REPORTS**	**AUGUSTA ROAD MEDICAL CENTRE**
B26a-b	**MEDICAL REPORTS**	**DHHS MENTAL HEALTH SERVICES (CLARE HOUSE AND STATEWIDE)**
B27a	**MEDICAL RECORD (USB)**	**RHH RECORDS PT**
B27b	**MEDICAL RECORDS (USB)**	**RHH RECORDS FG**
B27c	**MEDICAL RECORDS (USB)**	**RHH RECORDS INFANT P**
B28a	**MEDICAL IMAGING – INFANT P**	**RHH DEPT OF IMAGING**
B28b	**MEDICAL IMAGING – PT**	**RHH DEPT OF IMAGING**
B29a	**EMAIL FROM CSS TO CORONERS OFFICE**	**DEPT OF CHILDREN AND YOUTH SERVICES**
B29b	**LETTER SERT REVIEW**	**DEPT OF CHILDREN AND YOUTH SERVICES**
B29c	**SERIOUS EVENT REVIEW REPORT**	**DEPT OF CHILDREN AND YOUTH SERVICES**
B30	**FVMS HISTORY**	**BV (82254, 80541 AND 80518)**
B31	**FVMS HISTORY**	**AQ (96418)**
B32a	**OFFENCE REPORT NO. 615417**	**TASMANIA POLICE**
B32b	**INCIDENT LOG (ESCAD 000062-15062019)**	**TASMANIA POLICE**
B32c	**INCIDENT REPORT**	**TASMANIA POLICE**

B33	**SUDI CHECKLIST**	**D/CONSTABLE SHAREE MAKSIMOVIC**
B34	**SAFE SLEEPING INFORMATION**	**TASMANIAN HEALTH SERVICE**
B35ai-ii	**CYS RECORDS – PT**	**CHILDREN AND YOUTH SERVICES**
B35bi-xxxii	**CYS RECORDS – INFANT P**	**CHILDREN AND YOUTH SERVICES**
B36	**ADDITIONAL CONSULTATION – INFANT P**	**CHaPS**

LIST OF EXHIBITS

Record of investigation into the death of

INFANT W

No.	TYPE OF EXHIBIT	NAME OF WITNESS
C1	TASMANIA POLICE REPORT OF DEATH	CONSTABLE CARLY MEDHURST
C2	SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI) CHECKLIST	DET. CONSTABLE CROWTHER
C3	LIFE EXTINCT AFFIDAVIT– signed 6.4.19	DR VIET TRAN
C4	AFFIDAVIT OF IDENTIFICATION – signed 6.4.19	DET. CONSTABLE REBECCA NORQUAY
C5	POST MORTEM REPORT – signed 8.4.19	DR DONALD MACGILLIVRAY RITCHEY
C6	TOXICOLOGY REPORT – signed 14.6.19	MR NEIL MCLACHLAN TROUP
C7	AMBULANCE TASMANIA REPORT	AMBULANCE TASMANIA
C7a	000 CALL	AMBULANCE TASMANIA
C8	AFFIDAVIT – ELECTRONIC DVD DISK & TRANSCRIPT	VP (MOTHER)
C9	AFFIDAVIT – signed 6.4.19	ZA (FATHER)
C10	AFFIDAVIT – signed 3.5.19	XB (GRANDMOTHER)
C11	AFFIDAVIT – signed 1.8.19	PAUL STEPHENSON (AMBULANCE TASMANIA)
C12	AFFIDAVIT – signed 24.5.19	CONSTABLE CARLY MEDHURST
C13	AFFIDAVIT – signed no date	CONSTABLE DION MENZIE
C14	AFFIDAVIT – signed 11.11.19	DET. CONSTABLE IAN CROWTHER
C15	AFFIDAVIT – signed 30.10.19	DET. CONSTABLE REBECCA NORQUAY
C16	AFFIDAVIT & FORENSIC PHOTOGRAPHS – signed 9.6.19	CONSTABLE NICHOLAS MONK

C17	**ROYAL HOBART HOSPITAL PROPERTY RECEIPT**	**DEPTARTMENT OF ANATOMICAL & FORENSIC PATHOLOGY (#2723)**
C18	**PRIOR CRIMINAL HISTORY**	**VP**
C19	**PRIOR CRIMINAL HISTORY**	**ZA**
C20	**ROYAL HOBART HOSPITAL NOTES – 2 X CD**	**TASMANIAN HEALTH SERVICE**
C21a	**AMIENS CLINIC RECORDS**	**Infant W**
C21	**ALL ROUND HEALTH AND COMMUNITY CARE MEDICAL RECORDS**	**VP**
C22a	**CHAPS CASE NOTES**	**CATHRYN COLLINS**
C22b	**UNBORN BABY ALERT**	**CHILDREN AND YOUTH SERVICES: CHILD SAFETY SERVICES**
C22ci	**CASE NOTES REPORT – Infant W**	**CHILDREN AND YOUTH SERVICES: CHILD PROTECTION SERVICES**
C22cii	**NOTIFICATION RECORDS – Infant W**	**CHIDLREN AND YOUTH SERVICES: CHILD SAFETY SERVICE**
C22di	**SIGNS OF SAFETY ASSESSMENT**	**SARAH DAYTON-O'NEILL**
C22dii	**SUMMARY OF CCS OLDER CHILDREN – ZA AND VP**	**CHILDREN AND YOUTH SERVICES**
C22e	**EMAIL 1 – SENT 8.4.19 BY CATHRYN COLLINS (THS)** **EMAIL 2 AND ATTACHMENT – SENT 8.4.19 BY JUDY AUSTEN (THS)** **EMAIL 3 – SENT 28.3.19 BY CATHRYN COLLINS (THS)** **EMAIL 4 – SENT 26.3.19 BY TONI FSP** **EMAIL 5 – SENT 28.3.19 BY CATHRYN COLLINS (THS)** **EMAIL 6 – SENT 26.3.19 BY SARAH DAYTON-O'NEILL (COMMUNITIES)**	**VARIOUS CORRESPONDENCE SENT BY THS AND COMMUNITIES STAFF**

	EMAIL 7 – SENT 25.3.19 BY CATHRYN COLLINS (THS) **EMAIL 8 – SENT 7.3.19 BY CATHRYN COLLINS (THS)** **EMAIL 9 – SENT 7.3.19 BY CATHRYN COLLINS (THS)** **EMAIL 10 – SENT 5.3.19 BY RHH NICU DISCHARGE CO-ORDINATOR (THS)** **EMAIL 11 – SENT 1.3.19 BY JUDY AUSTEN (THS)** **EMAIL 12 – SENT 28.2.19 BY JUDY AUSTEN (THS)** **EMAIL 13 – SENT 27.2.19 BY JUDY AUSTEN (THS)** **EMAIL 14 – SENT 20.2.19 BY SARAH DAYTON-O'NEILL (COMMUNITIES)** **EMAIL 15 AND ATTACHMENT – SENT 13.12.18 BY JUDY AUSTEN**	
C22ei	**INFORMATION UPDATE**	**CHILD HEALTH AND PARENTING SERVICES**
C22f	**MEETING NOTES – 25.2.19**	**TO BE IDENTIFIED**
C22g	**PURCHASE ORDER**	**CHILDREN AND YOUTH SERVICES**
C22h	**LIST OF CHILDREN OF VP AND ZA**	**CHILDREN AND YOUTH SERVICES**
C22i	**MEDICAL RECORDS**	**MENTAL HEALTH SERVICES**
C23	**DHHS RECORDS**	**CHIEF PHARMACIST PETER BOYLES**
C24	**SERIOUS EVENT REVIEW REPORT**	**CHILD SAFETY SERVICES**
C24a	**ADDENDUM TO SERIOUS EVENT REVIEW REPORT**	**CHILD SAFETY SERVICES**
C25	**FORENSIC EXHIBIT LIST**	**DEPARTMENT OF POLICE FIRE AND EMERGENCY MANAGEMENT FORENSIC REGISTER #FR108142#**
C26	**OFFENCE REPORT 610760**	**TASMANIA POLICE**
C27	**DUPLICATE OF C23**	**CHIEF PHARMACIST PETER BOYLES**

C28	**TASMANIAN HEALTH SERVICE RECORDS AND SIDS & CO-SLEEPING INFORMATION/BOOKLETS/DVD**	**TASMANIAN HEALTH SERVICE (FOLDER 3)**
C29	**AFFIDAVIT – 29.5.23**	**ANDREA WITT – CATHOLIC CARE**
C30	**AFFIDAVIT – 15.9.23**	**RACHAEL BRESNEHAN – CATHOLIC CARE**

Annexure B

TITLE:	SLEEP-RELATED INFANT DEATHS IN TASMANIA (2000-2021)
FOR:	Coroner O. McTAGGART
PREPARED BY:	Andrew GARRETT
DATE	**20 October 2022**

SUMMARY of FINDINGS

80 infant sleep-related deaths (0-12months of age)
46 (58%) deaths were male, 34 (42%) were female
47 infant deaths had evidence of co-sleeping.
79% of infants who died while co-sleeping were ≤ 4 months of age

INFANT RISK FACTORS (evidence of co-sleeping, N= 47)

13 (28%) involved low birthweight infants
9 (19%) involved premature infants
17 (36%) infants had a physical illness 2 weeks prior to death 12 (26%) infants were first-born
22 (47%) infants were breast feeding at time of death

CARE-GIVER (Inc. MATERNAL) RISK FACTORS (evidence of co-sleeping, N= 47)

7 (15%) infants were born to mothers < 20 years of age 10 (21%) mothers were not in a relationship
37 (79%) mothers consumed cigarettes (including during pregnancy) 29 (62%) infants were exposed to a smoking party

ENVIRONMENT RISK FACTORS (evidence of co-sleeping, N= 47)

36 (77%) infant deaths involved co-sleeping on an adult bed 20 (43%) infants died while co-sleeping with mothers
25 (53%) infants were placed on their back to sleep
26 (55%) infants were found lying on their back when found 35 (74%) infants were sleeping with improper bedding

MISCELLANOUS RISK FACTORS (evidence of co-sleeping, N= 47)

30 (64%) involved no evidence of safe-sleeping messaging provided to caregivers 30 (64%) involved a feeding episode prior to sleep
20 (43%) had evidence of reduced arousal (of either parent or infant)
18 (38%) had evidence of family (and/or infant) being known to child services

DEFINITIONS

Since 1969 the term Sudden Infant Death Syndrome (SIDS) has been used to describe unexpected deaths of infants where subsequent "*investigations did not demonstrate a definitive cause of death*" (Willinger et al., 1991; Krous et al., 2004). In 1989 an expert panel convened by the National Institute of Child Health and Human Development (US) updated the definition by clarifying the set of investigations that must, upon completion, fail to establish the aetiology of death. Subsequently, the definition was updated to the following:

> "*The sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history" (Willinger et al., (1991), p681)*

Although this definition of SIDS has remained in use as recently as 2015 by Fleming et al.,[1] the failure of the 1991 definition to include pathognomonic features of SIDS deaths such as sleep-relatedness, led the American Academy of Paediatrics to further redefine SIDS in 2004 to:

> "*SIDS is defined as the sudden unexpected death of an infant < 1 year of age, with onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation including performance of a complete autopsy and review of the circumstances of death and the clinical history" (Krous et al., (2004) p235)*

That the death must occur '*apparently during sleep*' in part recognises the heightened risk associated with infant co-sleeping practices within households.[2] As there are many different forms of co-sleeping mentioned in the literature including "room-sharing[3]", this report has adopted the definition provided by Bugeja et al., (2016) in their analysis of Victorian Infant deaths:

> *"…the term bed-sharing is adopted to describe circumstances where an infant and caregiver share the same sleep surface, whether sleeping with the infant on the shared surface was intended or not" [p1033]*

Using the definitions above, this report provides data on sleep-related deaths of infants aged less than 1 year in Tasmania between 2000 and 2021. To facilitate the ongoing monitoring of sleep-related infant deaths a Tasmanian Sudden Infant Death Register (TSIDR) located in the coronial division was created. A brief overview of the TSIDR is given below.

[1] This 2015 paper by Fleming et al., reviewed Sudden Unexplained Death in Infancy in the United Kingdom (primarily) and provided general updated information on the aetiology, pathophysiology, epidemiology and prevention.

[2] More accurately it only recognises the potential risk elevation associated with sleep

[3] Room-sharing refers to situations where both infant and care givers sleep in the same room but on physically distinct surfaces.

THE TASMANIAN SUDDEN INFANT DEATH REGISTER (TSIDR)

The Tasmanian Sudden Infant Death Register (TSIDR) is a password-protected Microsoft Access database that stores data on sleep-related infant deaths in Tasmania (2000-2021).[4] The register contains both general socio-demographic, and a comprehensive set of rationally derived risk-factors including (but not limited to):

(1) infant-related (low-birthweight, prematurity)
(2) care-giver related (young maternal age, maternal parity)
(3) sleeping environment (sleeping surface, co-sleeping exposure), and
(4) miscellaneous risk factors (toxicology, reduced arousal).

Accompanying the TSIDR is a data dictionary containing the full list of risk-factors and coding rules. This dictionary should be used when coding deaths into the TSIDR. A stable database version and all accompanying documents including the data dictionary are currently located on a Department of Justice server (N:\Tasmanian sleep-related infant death (TSIDR)), which will allow for future database coding and analyses.

SOURCE MATERIAL | LIMITATIONS

The TSIDR relies on the record of investigation that accompanies each coronial finding. These investigations typically include Coroners' findings, police reports, medical records/ reports (such as autopsy/ toxicology), affidavits from family and first-responders, and other accompanying documents. The inclusion of a risk factor in any particular death contained in the database is therefore dependent on information being present in the coronial record.

Although analysed as a population, the use of an observational case-study design precludes the TSIDR's ability to assign causal relationships between any set of risk-factors and the death. Simply put, outside of coronial findings (and post-mortem reports) we are *not permitted* to further state that any risk factor "caused the death" of any infant.

COMMENT ON REPORT

This report is correct as of 12 October 2022.

In some of the data tables below, percentages may not add up to 100% as rounding errors may be present, especially when dealing with low case numbers.

[4] Dates are current as of October 2022.

OVERVIEW OF ALL SLEEP-RELATED DEATHS

Between 1 January 2000 and 31 December 2021 Tasmania recorded:

80 sleep-related[5] deaths involving infants aged between 0 and 12 months.
46 (58%) of deaths involved male infants
5 (6%) deaths were of Aboriginal and/or Torres Strait Islander infants
79% of co-sleeping deaths involved infants aged ≤ 4 months

Table 1: General socio-demographics for all infant sleep-related deaths, Tasmania (2000-2021)

	Female N (%)	Male N (%)	Total N (%)
Sex	34 (42%)	46 (58%)	**80 (100%)**
Aboriginal / Torres Strait Islander	2 (6%)	3 (7%)	5 (6%)
age (months)			
0	6 (18%)	2 (4%)	8 (10%)
1	8 (24%)	11 (24%)	19 (24%)
2	3 (9%)	9 (20%)	12 (15%)
3	5 (15%)	11 (24%)	16 (20%)
4	2 (6%)	3 (7%)	5 (6%)
5	3 (9%)	3 (7%)	6 (8%)
6	2 (6%)	0 (0%)	2 (3%)
7	2 (6%)	2 (4%)	4 (5%)
8	0 (0%)	1 (2%)	1 (1%)
9	1 (3%)	1 (2%)	2 (3%)
10	0 (0%)	0 (0%)	0 (0%)
11	2 (6%)	2 (4%)	4 (5%)
12	0 (0%)	1 (2%)	1 (1%)
Total	**34 (42%)**	**46 (58%)**	**80 (100%)**

To get a historical overview of infant deaths, annual frequencies were calculated for male and females separately (Figure 1).

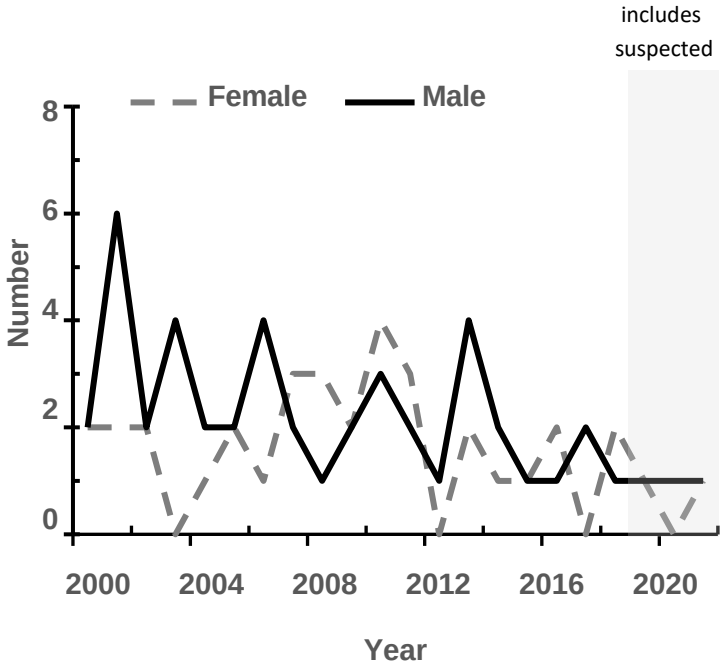

Figure 1: Annual frequency of sleep-related infant deaths by sex in Tasmania (20002-2021). Male and female deaths are presented separately with data from 2019 to 2021 containing both confirmed cases (closed cases) and open deaths (suspected).

To help identify longer-term trends in annual frequencies, data were also expressed as a 3 year moving average (Figure 2).[6] Although moving averages help identify longer-term data trends, their use removes the ability to calculate absolute differences.

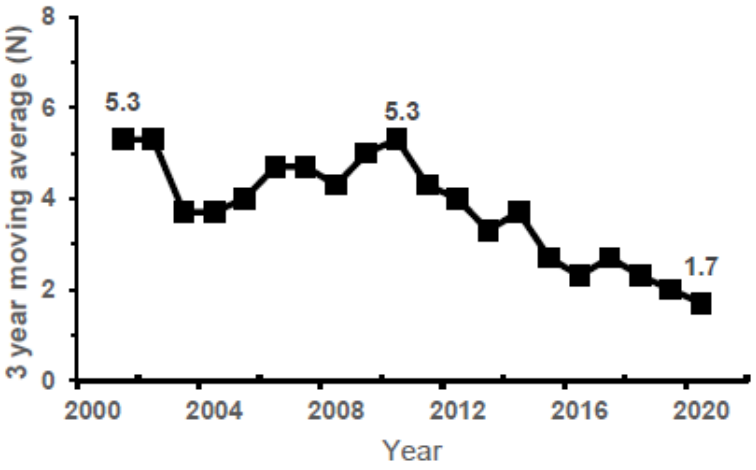

Figure 2: Analyses of deaths over a moving 3-year period reveal relatively high average death counts (5.3) between 2000-2004 and again for 2009-2011. Average 3-year death counts have substantially declined since 2009-2011 to a minimum of 1.7 per year over the 2019-2021 period.

[5] Note there are 2 open cases, and 1 closed sleep-related infant death that have been excluded from analyses.

[6] A 3 point moving average calculates the average number of deaths over a 3 year period centred over a single year. For example, to calculate the 3-year average for year 2008, the numbers of deaths occurring in 2007, 2008 and 2009 are added together and the total divided by 3. This technique is used to identify underlying trends in highly variable, or 'noisy' data.

To investigate age-related patterns in sleep-related deaths, male and female deaths were combined and analysed according to age (in whole months). Tragically, over 75% of all sleep-related deaths occurred in infants aged <= 4 months (Figure 3a), with relatively few deaths occurring in infants aged 10 months or older (6.4%). Analysing sleep-related deaths according to co-sleeping and no co-sleeping (see section below on coronial classification) shows that over 75% of co-sleeping deaths (79%) involved infants aged ≤ 4 months compared to 70% of no co-sleeping deaths (Figure 3b). This finding suggests that younger infants may be more susceptible to sleep-related risks such as exposure to unsafe sleeping environments or sleeping practices (e.g. co-sleeping with parents) (Colvin et al., 2014; Harrington et al., 2022; Thompson et al., 2016).

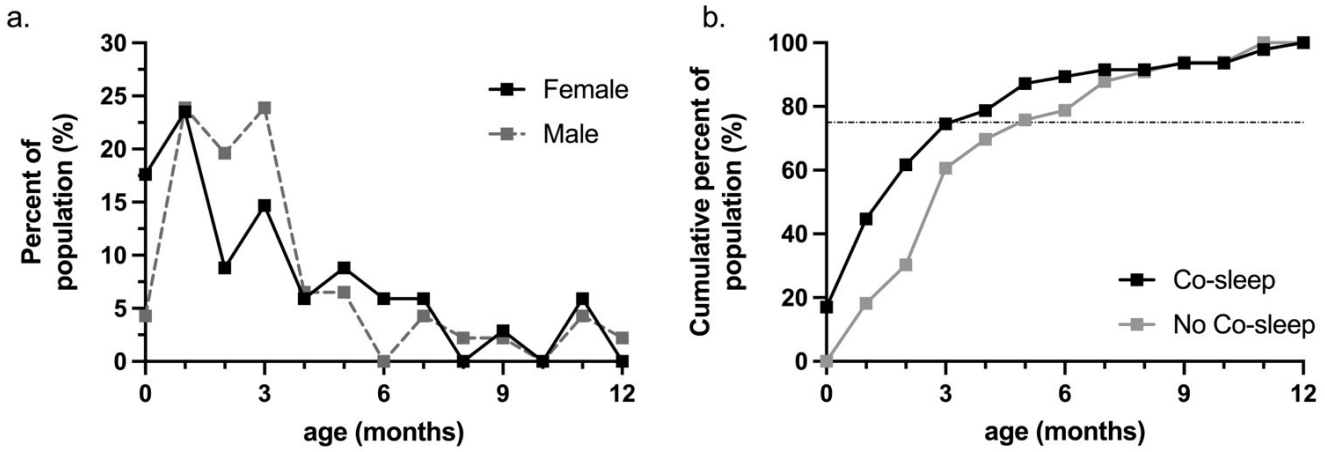

Figure 3: Overview of sleep-related infant deaths in Tasmania (2000 – 2021) (a) age breakdown (months) of deaths grouped by sex. (b) Younger infants (aged ≤ 4 months at time of death) comprised over 75% (horizontal) of co-sleeping deaths, as compared to 69% of deaths occurring in the absence of co-sleeping

CORONIAL CLASSIFICATION OF CAUSE OF DEATH

After identifying all sleep-related infant deaths, coronial findings (where present) were further analysed and assigned to one of 5 separate classifications. If the circumstance of death was ambiguous, additional analyses of post-mortem reports were completed to assist in classification.

The following categories were used to group individual deaths.

COSLEEP *Death has occurred in the context of co-sleeping with either a care-giver and / or sibling but no evidence of mechanical overlay or suffocation was identified.*

SIDS *Sleep-related death has occurred in the absence of co-sleeping*

OVERLAY *Death has occurred in the context of co-sleeping and evidence of mechanical overlay has been identified whether by affidavit, and/or post-mortem findings*

OTHER *Death has occurred in a sleeping environment that does not satisfy co-sleeping or overlay. Examples include positional asphyxia (sleeping in pram), or suffocation in bedding*

SUDI[7] *Death has occurred in a sleeping environment that does not satisfy co-sleeping or overlay. This classification dependent on language used in coronial findings and may or may not involve an unsafe sleeping environment. For example: "I find that the deceased died as a result of Sudden Unexpected Death in Infancy" [Findings]*

Table 2: Coronial classification of sleep-related infant deaths in Tasmania (2000-2021)

	Female (N %)	Male (N %)	Total (N %)
COSLEEP	16 (47%)	21 (46%)	37 (46%)
SIDS	11 (32%)	18 (39%)	29 (36%)
OVERLAY	5 (15%)	4 (9%)	9 (11%)
OTHER	1 (3%)	2 (4%)	3 (4%)
SUDI	1 (3%)	1 (2%)	2 (3%)
TOTAL	**34 (42%)**	**46 (58%)**	**80 (100%)**

To simplify subsequent analyses, each death underwent a final classification according to evidence of bed-sharing or co-sleeping at time of death (Bugeja et al., 2016). More specifically, deaths occurring in the context of co-sleeping and overlay were grouped as 'co-sleeping', whereas deaths determined to be SIDS or SUDI were grouped as 'no co-sleeping'.[8] In three deaths initially classified as 'other', one was found to have occurred in a co-sleeping context and two were classified as not co-sleeping. The process of classification of all deaths including those excluded in the following analyses is presented in Figure 4 below.

[7] L0019/2009, H0084/2013

[8] In contrast to the Bugeja et al. analysis of Victorian infant deaths, this report will use the terms co-sleeping or no co-sleeping when referring to bed-sharing.

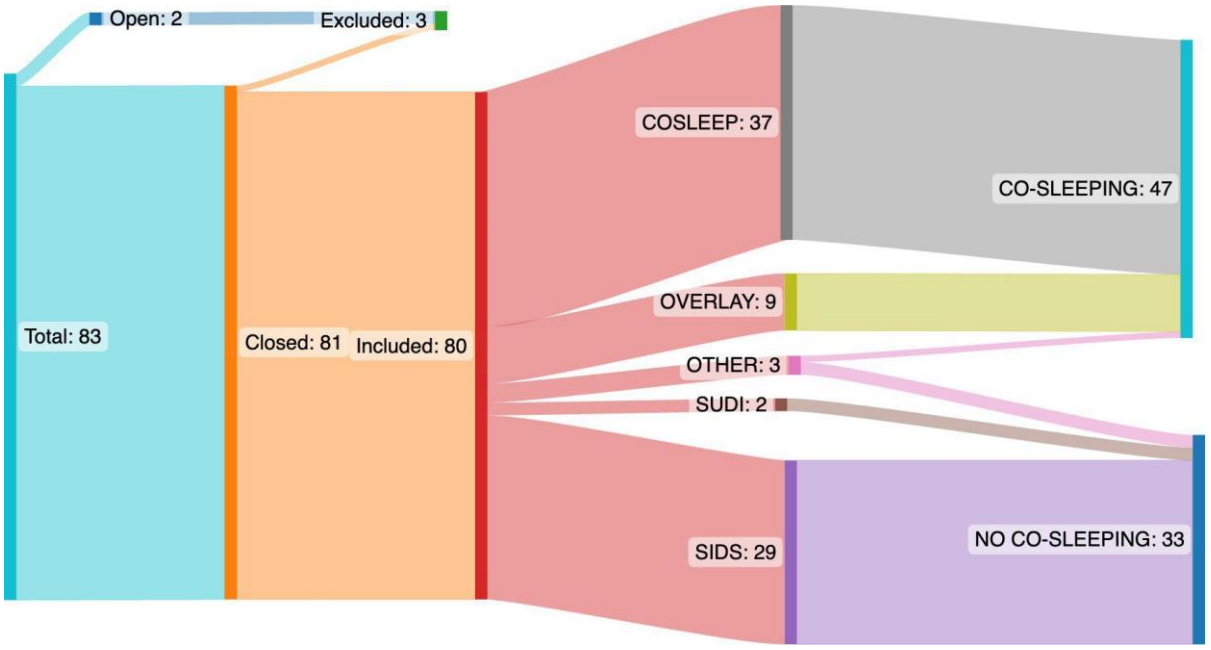

Figure 4: Overview of sleep-related infant death classification. Of a total of 83 infant deaths, 3 were excluded from analyses due to their open status (2 cases), or undetermined cause of death (1 closed case). The remaining 80 included deaths were classified into 5 categories (COSLEEP, OVERLAY, SIDS, OTHER, SUDI) according to coronial findings and/ or post mortem reports. To assist in statistical analyses, deaths were further dichotomised into 'co-sleeping' or 'no co-sleeping' depending on reported sleeping circumstances at time of death. **Note**: one death classified as OTHER involved the death of an infant in the context of bed-sharing, but may not have occurred in the context of sleeping, as the parents were likely engaged in non-sleep activities at the time of death.

General comment on Risk Factors in sleep-related infant deaths

The remainder of this report outlines the presence and/or absence of previously identified risk factors associated with sleep-related infant deaths (Bugeja et al., 2016). Although deaths have been classified according to sleeping environment, it should be noted that some risk factors act to increase the risk of death (low infant birthweight, Table 3) whereas other factors such as breast feeding are more complicated. Breast-feeding may exert a protective benefit in the context of SIDS deaths, or may be potentially harmful when analysed in the context of co-sleeping practices (Hauck et al., 2011; Thompson et al., 2017). Care must therefore be taken to analyse the wider context surrounding each death when determining the likely impact of individual risk factors.

The data tables below present frequencies and percentages of deaths according to co-sleeping status. Each table comprises data specifically relating to: infant-related risk factors (Table 3), caregiver-related risk factors (Table 4), environment-related risk factors (Table 5), and miscellaneous risk factors (Table 6).

INFANT RELATED RISK-FACTORS

Table 3: Frequency and percentage of infant-related risk factors in sleep-related infant deaths according to co-sleeping status, Tasmania (2000-2021)

	Evidence of co-sleeping 80) (n=47)		No evidence of co-sleeping (n=33)		Total (n =	
	n	%	n	%	n	%
Birthweight						
≥ 2500 g	31	66.0	30	90.9	61	76.3
< 2500 g	13	27.7	2	6.1	15	18.8
Unknown	3	6.4	1	3.0	4	5.0
Gestational Age						
≥ 37 weeks	34	72.3	28	84.8	62	77.5
< 37 weeks	9	19.1	2	6.1	11	13.8
Unknown	4	8.5	3	9.1	7	8.8
Male Sex						
No	22	46.8	12	36.4	34	42.5
Yes	25	53.2	21	63.6	46	57.5
Multiple births						
No	45	95.7	33	100.0	78	97.5
Yes	2	4.3	0	0	2	2.5
First Born*						
No	33	70.2	27	81.8	60	75.0
Yes	12	25.5	5	15.2	17	21.3
Unknown	2	4.3	1	3.0	3	3.8
Any breastfeeding (at time of death)						
No	25	53.2	21	63.6	46	57.5
Yes	22	46.8	12	36.4	34	42.5
Neonatal hospital admission^						
No	23	48.9	27	81.8	50	62.5
Yes	15	31.9	2	6.1	17	21.3
Unknown	9	19.1	4	12.1	13	16.3
Physical ill health (2 weeks prior)^						
No	21	44.7	16	48.5	37	46.3
Yes	17	36.2	13	39.4	30	37.5
Unknown	9	19.1	4	12.1	13	16.3
Aboriginal or Torres Strait Islander						
No	44	93.6	31	93.9	75	93.8
Yes	3	6.4	2	6.1	5	6.3
Immunised^						
No	6	12.8	3	9.1	9	11.3
Yes	32	68.1	26	78.8	58	72.5
Unknown	9	19.1	4	12.1	13	16.3

^ 13 deaths did not contain sufficient medical records or reports to include neonatal, physical ill health or immunisation status.

* 3 deaths did not have sufficient information on maternal parity to confirm first-born status.

CARE-GIVER RELATED RISK FACTORS

Table 4: Frequency and percentage of care-giver risk factors in sleep-related infant deaths, Tasmania (2000-2021)

	Evidence co-sleeping		No evidence of co-		Total (n=80)	
	n	%	n	%	n	%
Maternal Age						
≥ 20 years	37	78.7	29	87.9	66	82.5
< 20 years	7	14.9	2	6.1	9	11.3
Unknown	3	6.4	2	6.1	5	6.3
Maternal Relationship Status						
In a relationship	36	76.6	28	84.8	64	80.0
Not in a relationship	10	21.3	2	6.1	12	15.0
Unknown	1	2.1	3	9.1	4	5.0
Mother short inter-pregnancy interval						
≥ 6 months	18	38.3	20	60.6	38	47.5
< 6 months	8	17.0	4	12.1	12	15
Not applicable*	12	25.5	5	15.2	17	21.3
Unknown^	9	19.1	4	12.1	13	16.3
Maternal smoking during pregnancy						
No	10	21.3	19	57.6	29	36.3
Yes	37	78.7	14	42.4	51	63.8
Maternal drug/ alcohol use (including during pregnancy)						
No	29	61.7	26	78.8	55	68.8
Yes	18	38.3	7	21.2	25	31.3
Infant exposure to smoking party in period proximate to death						
No	18	38.3	22	66.7	40	50.0

* Not applicable numbers refer to nulliparous mothers

^ 13 records did not contain sufficient information from medical records to indicate maternal parity and therefore are classed as unknown.

ENVIRONMENT RELATED RISK FACTORS

Table 5: Frequency and percentage of environmental risk-factors in sleep-related infant deaths, Tasmania (2000-2021)

	Evidence of co-sleeping (n=47)		No evidence of co-sleeping (n=33)		Total (n=80)	
	n	%	n	%	n	%
Sleep surface						
Adult bed	36	76.6	3	9.1	39	48.8
Bassinet	0	0.0	6	18.2	6	7.5
Car seat	0	0.0	1	3.0	1	1.3
Cot	0	0.0	15	45.5	15	18.8
Couch	5	10.6	3	9.1	8	10.0
Mattress on floor	4	8.5	1	3.0	5	6.3
Other (blankets only on floor)	0	0.0	1	3.0	1	1.3
Pram	0	0.0	2	6.1	2	2.5
Sofa-bed	2	4.3	0	0.0	2	2.5
Unknown	0	0.0	1	3.0	1	1.3
Infant sleep position (when put to bed)						
Back	25	53.2	17	51.5	42	52.5
Front	3	6.4	4	12.1	7	8.8
Side	17	36.2	11	33.3	28	35.0
Unknown	2	4.3	1	3.0	3	3.8
Infant sleep position (when found)						
Back	26	55.3	7	21.2	33	41.3
Front	7	14.9	18	54.5	25	31.3
Side	11	23.4	5	15.2	16	20.0
Unknown	3	6.4	3	9.1	6	7.5
Improper bedding in sleep environment						
No	12	25.5	19	57.6	31	38.8
Yes	35	74.5	14	42.4	49	61.3
Pillow present in sleeping environment						
No	26	55.3	17	51.	43	53.8

				5		
Yes	21	44.7	16	48.5	37	46.3
Evidence of low-socioeconomic status#						
No	31	66.0	28	84.8	59	73.8
Yes	16	34.0	5	15.2	21	26.3

	Evidence of co-sleeping (n=47)		No evidence of co-sleeping (n=33)		Total (n=80)	
	n	%	n	%	n	%
Bed partners						
Mother	20	42.6	-	-	20	25.0
Father	2	4.3	-	-	2	2.5
Both parents	14	29.8	-	-	14	17.5
Parents and sibling(s)	11	23.4	-	-	11	13.8

includes caregivers living in temporary accommodation (including tents), Housing Department supported residence, fixed-income only families (Centrelink support payments are sole source of income).

MISCELLANEOUS RISK FACTORS

Table 6: Frequency and percentage of miscellaneous risk factors in sleep-related infant deaths, Tasmania (2000-2021)

	Evidence of co-sleeping (n=80) (n=47)		No evidence of co-sleeping (n=33)		Total	
	n	%	n	%	n	%
Evidence of safe sleeping message						
No	30	63.8	20	60.6	50	62.5
Yes	17	36.2	13	39.4	30	37.5
Feeding episode prior to sleep (including breast-feeding)						
No	17	36.2	32	97.0	49	61.3
Yes	30	63.8	1*	3.0	31	38.8
Toxicology findings (in infant)						
No	34	72.3	26	78.8	60	75.0
Yes	13#	27.7	7#	21.2	20	25.0
Evidence of reduced arousal (parent or infant)						
No	27	57.4	29	87.9	56	70.0
Yes	20	42.6	4^	12.1	24	30.0
Known to child services						
No	29	61.7	31	93.9	60	75.0
Yes	18	38.3	2	6.1	20	25.0
Evidence of domestic violence (including historical)						
No	39	83.0	28	84.8	67	83.8
Yes	8	17.0	5	15.2	13	16.3

Notes: * infant fell asleep (bottle fed) during feeding and was immediately placed onto couch. No evidence of bed-sharing (SIDS death), # in one death, positive toxicology finding may reflect medical intervention prior to blood sampling.

^ refer to table below.

LCN	Comment on coding
L0127/2015	Mother consumed alcohol the night of death “more than she wanted to consume” [Maternal Affidavit]
H0030/2007	Caregiver prescribed SERTRALINE, also consumed 3 glasses of wine during the evening
H0084/2013	Father inserted ear plugs prior to sleep (this appeared to be normal sleeping behaviour)
L0017/2013	Mother consumed 5 vodka squashes, father consumed half a carton of Carlton Draught beer prior to sleep.

APPENDIX A

Table A1: Tasmanian infant sleep-related deaths (TSIDR) by case status (17 March 2022)

Status	N	%
Closed	81^	98
Open	2	2
Total	**83**	**100**

Open Cases as of 12/10/2022

LCN	Date	Year	Age	Surname	Sex	Comment
H0101/2019	06/04/2019	2019	3	Infant W	F	Open
H0188/2019	15/06/2019	2019	1	Infant P	M	Open

Note: Age is in full months. Sex: F – female, M –male.

^ Closed case undetermined death (not included in preliminary analysis)

LCN	Date	Year	Age (m)	Surname	Sex	Comment
L0214/2012	28/11/2012	2012	2	Infant B	F	" The cause of [infant's] death cannot be determined" [Findings] "I accept the view of Dr Ritchey and Dr Lawrence {Forensic Pathology}. I cannot determine whether [infant] died as a result of Sudden Infant Death Syndrome, sudden infant death while bed sharing or accidental suffocation within her parents' bed" [Findings]

APPENDIX B - INCLUSION/ EXCLUSION CRITERIA

Inclusion Criteria

Ages: 0-12 months (inclusive)

Sex: Male, Female

State of death: Tasmania

Year of death: 2000-2021

Exclusion criteria:

Death with clear evidence of natural aetiology
Death that is not sleep-related

Death arising from assault
Death of a neonate (<7 days)

APPENDIX C: REFERENCES

1. Bugeja L., et al., (2016) Sleep-Related Infant Deaths in Victoria: A Retrospective Case Series Study, *Maternal and Child Health Journal*, 20(5): 1032-1040

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8. Thompson et al., (2017) Duration of Breastfeeding and Risk of SIDS: An Individual Participant Data Meta-analysis, *Pediatrics*, 140(5):e20171324
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VERSION CONTROL

Date	Version	Author	Comment
21/03/22	1.0	Garrett, A	Preliminary report (N=78) generated.
17/05/22	1.1	Garrett, A	data figures updated (N=79), Harrington et al., 2022 reference included
12/10/2022	Final	Garrett, A	final coding and report preparation.