

IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: COR 2011 003243

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*

*Section 67 of the Coroners Act 2008*

I, ROSEMARY CARLIN, Coroner having investigated the death of JACK MICHAEL WIKAIRA without holding an inquest:

find that the identity of the deceased was JACK MICHAEL WIKAIRA

born on 30 March 2011

and the death occurred on 30 August 2011

at South Melbourne, Victoria

**from:**

1(a) UNASCERTAINED

**Pursuant to section 67(1) of the Coroners Act 2008 there is a public interest to be served in making findings with respect to the following circumstances:**

1. Jack Wikaira was born on 30 March 2011 and was 5 months old at the time of his death. Baby Jack lived with his mother in South Melbourne, Victoria. He is survived by his parents, Rebecca Wikaira and Adam Smith.
2. Victoria Police provided a brief to the Coroner which included statements and information obtained from baby Jack's mother and family, treating clinician, witnesses and investigating officers. I have drawn on all this material as to the factual matters in this finding. I have

also reviewed research and guidance provided by the Coroners Prevention Unit (CPU)<sup>1</sup> as to the safety implications of baby hammocks. I have also considered the concerns of baby Jack's family that have been communicated to the court throughout the investigation.

### BACKGROUND AND CIRCUMSTANCES

3. Baby Jack was born on 30 March 2011 and was approximately four weeks premature at the time of his birth. He remained in hospital for approximately three weeks before his mother took him home to her apartment in South Melbourne. Ms Wikaira and Mr Smith were in a relationship but lived separately, although Mr Smith spent some nights at Ms Wikaira's residence.
4. Ms Wikaira and Mr Smith had a history involving substance abuse. Specifically, Ms Wikaira had used heroin prior to finding out she was pregnant. After she discovered she was pregnant, she ceased heroin use and sought treatment for her dependency by way of prescribed methadone (160mg daily during her pregnancy and 140mg daily following baby Jack's birth). Ms Wikaira also ceased her use of serapax and valium.
5. Ms Wikaira engaged a separate clinician for her pregnancy. Prior to baby Jack's birth, Ms Wikaira and Mr Smith went to antenatal classes and counselling sessions. Ms Wikaira reported that she had received education about SIDS and safe sleeping practices. Mr Smith's mother, Fiona McDonald, who was a paediatric social worker, also provided support and advice throughout Ms Wikaira's pregnancy and after the birth of baby Jack. Ms McDonald observed the prospective parents to be diligent in their preparation for the arrival of baby Jack.
6. Following baby Jack's birth, he was observed to be healthy, well cared for and rarely ill. He received his two month and four month vaccinations. He received his 4 month vaccination approximately two weeks prior to his death. Ms Wikaira noted the only side effect was that baby Jack slept a lot. At the time of his death, baby Jack had been taking Pentavite for a Vitamin D deficiency.

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<sup>1</sup> The CPU is a specialist service that assists coroners during the course of an investigation, particularly in fulfilling their prevention role. The CPU is staffed by a range of professionals including researchers and health professionals. Further information about CPU is available on the Coroners Court Website.

7. Approximately one week prior to his death, baby Jack began having small amounts of apple juice and farax, a cereal for infants, in conjunction with his usual mixture of breast milk and S26 formula milk.
8. On 30 August 2011, baby Jack woke at approximately 6 a.m. Ms Wikaira fed him at this time, then again at approximately 9 a.m. She then placed him in a baby hammock, on his back looking upwards. The hammock was manufactured by Miyobaby International Limited ('Miyo') and was located in the lounge room. Ms Wikaira's practice was to place baby Jack in a cot to sleep and to use the hammock only for a nap or play.
9. While baby Jack was in the hammock, Ms Wikaira watched some television. At approximately 10 a.m., she had a quick shower and then checked baby Jack. He was sleeping and had rosy cheeks. Ms Wikaira walked past the hammock a few times as she got ready for a planned outing. As she walked past, she bounced the hammock.
10. Approximately 10 minutes after her shower, Ms Wikaira dried her hair and dressed. She then picked up baby Jack from the hammock and felt that he was cold. He was also not breathing and unresponsive. Ms Wikaira commenced cardio pulmonary resuscitation (CPR) on baby Jack.
11. Ms Wikaira's friend, John Hreskowsky arrived at her apartment during this time. Ms Wikaira called for help and asked Mr Hreskowsky to telephone emergency services. Her neighbour, Leigh Ferguson, heard Ms Wikaira's screams and went to her apartment. He used Mr Hreskowsky's telephone to call emergency services.
12. Paramedics arrived shortly thereafter and took over resuscitation from Ms Wikaira. Tragically, they were unable to revive baby Jack.

#### POST MORTEM EXAMINATION

13. On 1 September 2011, an autopsy of baby Jack's body was undertaken by Dr Heinrich Bouwer, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM). He noted that the fact baby Jack's sleeping arrangements were not in accordance with Sudden Infant Death Syndrome (SIDS) guidelines meant that he could not completely exclude

mechanical asphyxia as having occurred, although there were no signs of it. No significant neuropathological abnormality was identified. Despite extensive investigations, Dr Bouwer was unable to determine a precise mechanism of death and recorded baby Jack's cause of death as 1(a) Unascertained<sup>2</sup>.

14. On 14 August 2013, Dr Yeliena Baber, Forensic Pathologist at VIFM provided a supplementary report to the Coroner in relation to the possibility the hammock contributed to baby Jack's death. She considered previous medical reports, correspondence from baby Jack's family, a report prepared by the CPU and the known circumstances of the death. Research indicated that known cases of baby deaths or injuries involving hammocks were babies in a prone position or who had fallen, unlike baby Jack. Dr Baber concluded that there was no evidence at the scene or at autopsy to suggest that baby Jack's death occurred as a result of him being placed to sleep in a hammock.

#### BABY HAMMOCKS

15. In 2010, following a review into the safety of baby hammocks, the New South Wales (NSW) Products Safety Committee published a report for the NSW Minister for Fair Trading. A media release dated 11 August 2010 by NSW Fair Trading indicated that the report recommended that the use of baby hammocks as an alternative sleeping device be discouraged and that the Minister called for the development of appropriate Australian Standards. Further, as recommended by the report NSW Fair trading proposed a public education campaign with key messages including that baby hammocks do not comply with established SIDS guidelines and are not recommended unless for therapeutic reasons.
16. Ms McDonald (Jack's paternal grandmother) commissioned a report from Professor Jeanine Young, Chair of SIDS and Kids National Scientific Advisory Group in relation to the safety of the Miyo baby hammock. The report dated 11 October 2014 was provided to the Coroner. Professor Young considered that baby Jack 'had infant, parent [and] socioeconomic factors which contributed to his vulnerability and external stressors in his sleeping environment which increased the risk of a sudden unexpected death'. Although noting that there was no definite evidence to show that baby Jack's cause of death was

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<sup>2</sup> Dr Bouwer also noted that due to an error viral studies were not performed.

directly related the hammock, she concluded that 'it was a likely contributing factor in his death'. She believed the Miyo baby hammock was an unsafe sleep environment not suitable for unsupervised use as it increased the risk of suffocation in two ways. First by allowing curvature of the infant's spine with consequent compromise of the airway (even face up) and secondly by allowing the baby to roll with consequent occlusion of the nose and mouth.

17. The CPU analysed the literature together with Ms McDonald's concerns. It found that although the baby hammock used by baby Jack did not meet the accepted safe sleeping criteria, the factual circumstances of his death indicated that the hammock did not contribute to his death.
18. On 2 January 2015, Dr Baber produced a final report in light of Professor Young's report. She noted that the rapidity of baby Jack's death (based on Ms Wikaira's account) made a terminal cardiac event a more plausible a cause of death than slow suffocation.
19. Dr Baber agreed that hammocks were not a safe sleeping environment for anything other than a supervised short sleep, particularly for an infant with known risk factors of SIDS.<sup>3</sup> However, there was no circumstantial or direct evidence at autopsy of asphyxia and therefore the question of the potential contribution of the Miyo baby hammock to the death of baby Jack was hypothetical.
20. I acknowledge the assistance I have received from the CPU and by way of source material from NSW Fair Trading, Consumer Affairs Victoria, the Australian Competition and Consumer Commission and Dr Christine McIntosh<sup>4</sup>.

## FINDING

21. I am satisfied that no further investigation is required. I am satisfied that there were no suspicious circumstances.

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<sup>3</sup> Dr Baber based this conclusion on the risk of an infant turning onto their front and suffocating, becoming entangled or falling out of the hammock, but not from chin to chest airway compromise as postulated by Professor Young.

<sup>4</sup> Dr McIntosh co authored a study on baby hammocks.

22. I am satisfied that baby Jack was well cared for by his parents and in particular his mother Rebecca.

23. I am not satisfied there is enough evidence to conclude that the Miyo Baby Hammock caused or contributed to the death of baby Jack. The evidence is that Jack was placed on his back face up and he remained in that position until he was found unconscious. Further, there were no features observed at autopsy to indicate asphyxiation, such as a foam plume or petechial haemorrhages. The absence of these features does not rule out asphyxiation, but the fact remains there is no circumstantial or clinical evidence of suffocation. A cardiac event or other unexplained mechanism of death is equally, if not more, possible

24. I find that baby Jack Wikaira died on 30 August 2011 and that the cause of his death was unascertained.

## COMMENTS

**Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comment(s) connected with the death:**

1. Public health messages, including those regarding hammock safety, must be consistent across the health sector. These messages should be informed by conservative risk management practices based on existing evidence.
2. I am not satisfied there is enough evidence to support a recommendation that baby hammocks be banned altogether. Nevertheless, baby hammocks do not meet the accepted safe sleeping guidelines for infants and the evidence supports the following:
  - a. Baby hammocks may be unsafe because of the risk of falls or suffocation;
  - b. Baby hammocks may pose a particular risk to infants once they are old enough to turn or roll over;
  - c. Since it is not possible to predict when infants will first attempt to turn or roll over, infants should not be left unsupervised in a hammock;
3. Maternal and Child Health Services current literature contains a specific warning that 'hammocks can be dangerous and are not considered a safe sleeping environment for

infants'. The hospital circular, *Victorian Infant Safe Sleeping Policy for Health Services* does not specifically refer to baby hammocks, however the Department of Health is currently engaging with other organisations to review infant safe sleeping literature with a view to develop infant safe sleeping guidelines with other key stakeholders in this area. Following publication of these guidelines, the Department of Health will review relevant policies including the hospital circular.

4. To date no Australian Standards have been developed to promote the safe use of baby hammocks. The existence of relevant Australian Standards would serve as useful safety guidelines for manufacturers and suppliers of these products. As the Standards could cover such things as appropriate product labelling they could also serve to educate the public as to the safe use of baby hammocks, namely with the baby in the supine (face up) position for short supervised periods only.

## **RECOMMENDATIONS**

**Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:**

1. That Standards Australia develop an appropriate standard for baby hammocks, particularly in relation to design features affecting breathability, capacity to fall and safety labelling.
2. That the Australian Competition and Consumer Commission (ACCC) support the development of appropriate Australian Standards.
3. That the ACCC update its 'Keeping baby safe' booklet on its website with material similar to that on the Queensland Government website that alerts consumers to the potential risks of baby hammocks and instructs them on their safe use, that being with the baby in the supine position and for short supervised periods only.

I direct this finding be published on the internet.

I direct that a copy of this finding be provided to the following:

The family of baby Jack Michael Wikaira;

Office of the Child Safety Commissioner;

Secretary, Department of Health;

Secretary, Department of Education and Early Childhood Development;

New South Wales Fair Trading;

Consumer Affairs Victoria;

Australian Competition and Consumer Commission;

SIDS and Kids Victoria;

Interested parties; and

Investigating Member, Victoria Police.

Signature:



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ROSEMARY CARLIN

CORONER

DATE: 15 May 2015

