QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

Non-inquest findings of the investigation into the death of a four month old baby

CITATION:	**Investigation into the death of a four month old baby**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Southport
FINDINGS OF:	Mr James McDougall, Southeastern Coroner
CATCHWORDS:	CORONERS: Death of a baby, sudden infant death syndrome , Department of Communities, Child Safety and Disability Services

These are findings into the death of a four month old boy, born on the 23 March 2012 in Logan. He resided in a caravan at Loganholme, with his mother. Also residing in the caravan was the deceased child's stepfather. The house property at Loganholme was owned and occupied by the paternal grandmother.

The deceased child was born at Logan Hospital by spontaneous vaginal delivery and had a birth weight of 3510 grams. He was within the median percentile. His gestational age at birth was 39 weeks plus five days. At birth a urinary drug screen was conducted, which revealed that he was positive for amphetamines and codeine. He underwent withdrawal treatment, staying in a special care nursery before being discharged into foster care as a consequence of a Temporary Assessment Order and then a Court Assessment Order obtained by officers of the Department of Communities, Child Safety and Disability Services under the *Child Protection Act 1999*.

The mother was known to be an intravenous drug user. She was gravida 4 and para 3 during pregnancy. All antenatal tests were uneventful, including negative hepatitis B and C and HIV screen. An ultrasound at 30 weeks gestation was within normal limits.

The deceased child presented to hospital three weeks after birth with bilious vomiting. He was diagnosed with pyloric stenosis whilst under foster care. He underwent uneventful surgery (laparoscopic pylorotomy) at the Mater Hospital (admission from 17/4 to 21/4/12). He showed no further problems relating to pyloric stenosis.

The deceased child was returned to his mother at the end of April at the expiry of the Court Assessment Order. The decision to return him to the care of his mother has been the subject of a review conducted by the Department of Communities, Child Safety and Disability Services. I will refer in more detail to the review later in these findings.

As mentioned above, the deceased child had a half sister born in 2004, who resided with her father (her mother's ex partner) in New South Wales, and a sister and brother who were in foster care in New South Wales. There was an extensive child protection history in relation to those siblings.

The department had an extensive involvement with the deceased child's siblings, with 11 notifications and three Child Concern Reports recorded from 2004 to 2011. In 2010 a Child Protection case was opened in relation to his half sister as she had been abused by her father. The deceased child's brother and sister were in care following action taken by Child Protection in New South Wales.

The department's involvement with the deceased child commenced with the recording on an unborn child notification in February 2012. Additional notified concerns were recorded on the 20 February 2012 which incorporated information from Child Safety in New South Wales about concerns raised in relation to the siblings in the previous 12 months. Concern was held for him, given the substantial history for the family and his mother's recent drug use, prostitution, transience and neglect of her two older children. The department

made a decision not to commence the investigation and assessment, due to the mother being assessed as a flight risk.

Following the deceased child's birth on the 23 March 2012, a Temporary Assessment Order was sought and an investigation and assessment was commenced. A Court Assessment Order was obtained and he was placed in the care of foster parents.

On the 18 April 2012, the deceased child's case was reviewed by the SCAN Team and it was noted that the assessment of the risk was underway and the matter was set for review on the 9 May 2012. Queensland Police confirmed that there had been no incident of domestic violence reported since the parents resumed their relationship in January 2012.

On the 24 April 2012, departmental officers conferred and it was decided that the deceased child should have an unsupervised weekend contact visit at home with his mother and stepfather and that would occur from 27 to 29 April 2012. It was decided that, should all go well, he would be returned to the care of his parents from 30 April 2012.

The investigation was finalised on the 30 April 2012 and a safety assessment on that day recorded that the deceased child was safe. It was decided that there were no immediate risk factors present for him and he was returned to his mother and stepfather. This was in spite of the Family Risk Evaluation outcome indicating that he was at very high risk. A number of risk factors were listed in the text of the assessment and outcome, including: the vulnerability of the infant, the parents minimising the concerns and denying substance misuse, history of long term chronic drug use by the parents, sibling subject to statutory intervention and child protection history.

On the day before the deceased child's death, the family was at home at Loganholme. The deceased child's stepfather was in the garden and the mother was feeling ill. She was in the caravan with the deceased child. During the afternoon the deceased child went into the main house to spend some time with his grandmother. This was about an hour and a half before returning to the caravan between 5pm and 6pm.

During this timeframe the deceased child's mother and stepfather shared a quantity of methamphetamine by injection at about 4pm. Following this, the deceased child's stepfather proceeded to build and light a fire to burn rubbish behind the caravan, which caused a substantial amount of smoke to engulf the property and the surrounding street. That night the temperature dropped to about 5-6 degrees Celsius. There was a heater located within the caravan, but according to the mother, she did not like it being used at night when they were in the caravan. The deceased child was provided with a wash and bottle of formula and was put to bed at about 7:30pm. His mother recalls falling asleep at about 10pm, but waking up again, as he wanted another bottle. The deceased child went back to sleep and woke again at about 2:30am.

At about this time he was provided with another bottle and was back in bed and asleep by about 3am. Between 7:30am and 8:00am the mother and stepfather woke up and the stepfather went over to the house to get some

breakfast. He did not check on deceased child when he did this. On his return to the caravan the mother asked the stepfather if he had checked on the deceased child and the stepfather went to do so. The deceased child was located in a makeshift cot/bed, which had been fashioned out of a sofa bed with added bumper and substantial bedding and sheeting. This bed was contained by a railing which prevented the deceased child from rolling out. When the stepfather went to check on the child he found him to be deceased.

The Queensland Ambulance Service was called and a neighbour, who is a paramedic, came to the assistance of the parents. Once the Queensland Ambulance Service arrived they pronounced the child deceased at the scene.

The mother told police that when the deceased child woke at 2:30am she got up and heated a bottle and propped the bottle in the same way, but he was wide awake and wanted to play. She lay next to him in bed whilst he had his bottle. He eventually went back to sleep after about 20 minutes. He had drunk only about 100mls of the formula.

The stepfather gave a statement to police, which basically confirmed the version given by the mother leading up to about 7:55am when he left the caravan to walk to the main house. The stepfather said that when he returned he checked on the deceased and found him to be lying on his left side facing away from him. He scooped him up and saw that he had lost all colour in his face and his skin was cold to the touch. He called on the child's mother to help. The child's mother took the infant and ran outside and began to scream for help. He saw her put him on the ground on a mat and commence CPR. The stepfather said he ran across the road to a neighbour, who he knew was a paramedic. The Queensland Ambulance Service was summoned and attended.

The neighbour told police that she was summoned by a knock on her door at about 9am from the grandmother. She said: 'The baby's dead. Quick, quick. The baby's dead.'

The neighbour told police that she went up to the baby and saw he was dressed in a blue jumpsuit and it was totally done up. He was not wrapped in anything. He was very still, lips purple, and she felt his chest with her hands to feel his sternum and felt it was sopping wet. The suit was spongy and wet and she knew that this was odd. Her immediate reaction was to smell the wet substance, thinking it may be urine or vomit, but it had no smell at all. She said she could not smell a thing and was wondering why his front was so wet.

The neighbour had her son with her and he called the Queensland Ambulance Service. She took the baby inside the caravan and put him on a sofa and looked for signs of life. She gave a commentary of what she was doing to the Communications Officer at the Queensland Ambulance Service. The neighbour said she did not know why the baby had died, but recalled it being very cold that night. She could smell smoke in the caravan.

The neighbour's son also spoke to police confirming his mother's version. Police from the Child Protection Unit conducted an investigation, but could find no suspicious circumstances.

An autopsy was conducted on the 31 July 2012. The pathologist made the following comments: 'The post mortem findings noted an infant within normal vital parameters. The deceased appeared to be well nourished with food present in the stomach and intestines. There was a scar on the abdomen in keeping with known previous surgery. No findings of significance that could account for death were noted in the post mortem examination, despite a thorough examination. Internal examination was essentially unremarkable. Further investigations were performed. The microbiology tests were essentially unremarkable. Organisms were detected in the brain and liver, but could be attributed to post mortem contamination. The vitreous humour biochemistry was unremarkable after considering post mortem change. The metabolic tests were within normal limits. Fibroblast and blood have been stored for further tests if required. Imaging procedures performed were non-contributory. The toxicology analysis did not detect any drugs.'

The post mortem failed to identify a cause of death. No injuries were noted. The pathologist commented: 'A possible cause of death where there is a negative autopsy is sudden infant death syndrome (SIDS). SIDS is defined as death in a child less than one year of age during sleep with no cause of death elicited after a thorough review of the scene, clinical history and post mortem findings.

It was described the environmental temperature was low and the caravan where the child was staying had no heating. Therefore, there was a possibility the child might be hypothermic. Hypothermia is a potentially fatal condition and results in minimal pathological changes, i.e. negative autopsy similar to what was found here. As a result, death due to hypothermia in this instance cannot be confirmed pathologically.

As the description of the scene suggested there was a possibility that the child might succumb to hypothermia (could not be confirmed), the cause of death is further subcategorised under SIDS to Unclassified sudden infant death (USID) where an equivocal cause of death cannot be ruled out."

The cause of death was found to be sudden infant death syndrome (unclassified sudden infant death subclassification).

Having considered all of the facts in this matter and the comprehensive police investigation report, and the review of the procedures of the Department of Child Safety and Disability Services, I have formed the opinion the public interest would not be served by proceeding to inquest. I am satisfied that the Department of Communities, Child Safety and Disability Services has taken measures to review their procedures in the light of the death.

Cause of death:

1a) Sudden infant death syndrome (unclassified sudden infant death subclassification)

James McDougall
Southeastern Coroner
7 August 2014