CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Baby J**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
DATE:	13/05/2021
FILE NO(s):	2015/264
FINDINGS OF:	Jane Bentley, Deputy State Coroner
CATCHWORDS:	Coroners; co-sleeping; risk factors; Department of Communities, Child Safety and Disability Services; child tracking register.

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Background

1. Baby J was twenty-three weeks old at the time of his death. He was born in 2014. He was a healthy baby. He lived with his parents and siblings in a cabin at a holiday park.

2. In early 2015 Baby J was admitted to the Gold Coast University Hospital with respiratory distress and was diagnosed with bronchiolitis. He was immunized during his admission and was discharged a few days later.

3. Eleven days later Baby J was well and happy. He had his last bottle of formula at about 9pm. The family were sleeping in the lounge room as it was air conditioned. Baby J was put to sleep with a sibling on a makeshift bed of two sofa lounges pushed together. He went to sleep in the hollow where the two seat cushions met with his head on two large pillows arranged in a v-shape.

4. At about 11.30pm his father awoke and prepared a bottle. He gave Baby J his bottle and they played for about twenty minutes then went back to sleep. The father went to sleep with his back against the joins of the sofa arm chairs and his face and chest facing Baby J.

5. At about 8.10am the next day the mother awoke and found Baby J lying chest to chest with the father. He was unresponsive.

6. The father attended the reception area at the park and called 000.

7. Queensland Ambulance Service paramedics attended and attempted CPR but it was unsuccessful and Baby J was pronounced deceased at 8.27am.

Autopsy

8. An autopsy was performed, and it was determined that Baby J died from Category II Sudden Infant Death Syndrome (co-sleeping).

9. Sudden Infant Death Syndrome (SIDS) is a term used to describe the sudden unexpected death during sleep of an infant aged under 12 months that is not explained by circumstances surrounding death, death scene examination and a thorough post-mortem examination. The cause of SIDS is not known, but is likely multi-factorial, involving both environmental, developmental, and hereditary or genetic aspects.

10. SIDS Category II is defined as the sudden and unexplained death of an infant under one year of age, and apparently occurring during sleep, and 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 but where age range outside of greater than 21 days but less than 9 months, where there is a history of deaths in siblings or other infants, under the same caregiver, where mechanical asphyxia considered but not determined with certainty and/or where abnormal growth, or more marked pathological abnormalities are identified at autopsy.

11. Taking into account Baby J's sub-optimal sleeping conditions it is most likely that he asphyxiated in his sleep.

Police Investigation

12. The father told police officers that he recalled removing a pillow from Baby J's face when he was awoken by the mother.

13. Police officers found drugs and drug paraphernalia in the house including ice pipes.

14. Investigating police identified the following factors which were present in Baby J's case and which have been shown to increase the risk of death by SIDS:

- Bed sharing with a parent and a sibling;
- Sleeping on two couches pushed together;
- Sleeping between two large soft pillows;
- Sleeping on a surface with loose bedding;
- Face covered with bedding;
- Living in a confined dwelling where both parents smoke cigarettes;
- Sleeping beside a smoking and drug using parent;
- Father used dangerous drugs including ice and cannabis;
- Baby J had suffered bronchiolitis one week prior to his death;
- Baby J had not been breastfed since birth;
- Domestic and family violence (DFV) perpetrated on mother by father;
- Mental health issues of mother;
- Unemployment;
- Extensive family history with Department of Child Safety.

Systems and Practice Review

15. The Department of Communities, Child Safety and Disability Services (the department) conducted an internal review of the department's involvement with Baby J's family.

16. The father was known to the department since his first child was born in 2001. It was reported over the years that he was violent to his partner. He had been imprisoned for domestic and family violence (DFV). There were also concerns noted in relation to substance abuse and transience. His daughter was removed from his and her mother's care and placed with her grandmother under a long-term guardianship order.

17. The mother was known to the department in relation to her previous children and allegations of DFV by her then partner.

18. In July 2013 Baby J's sister was born and a few weeks later the department received information that the father had been violent to the mother.

19. In November 2013 the department was advised by a professional notifier that the family was about to be evicted, the mother's mental health had deteriorated noticeably, that the mother and father had paranoid beliefs about a new world order, that they did not believe in immunisations and Baby J's sister had not been immunised.

20. An Investigation and Assessment (I&A) was commenced. Child safety officers (CSOs) visited the Gold Coast residence in mid-January 2014 but by that time the family had left that address.

21. On 17 January 2014 a CSO contacted police to obtain an address for the family and was told they appeared to be in a town in north Queensland.

22. On 21 January 2014 a professional notifier advised the department of allegations of DFV by the father and suspected drug dealing from the residence.

23. On 29 January 2014 the investigation was transferred to a departmental service centre in the town.

24. On 13 May 2014 (five months after being advised of the family's whereabouts and six months after the concerns were received), CSOs visited the family and found that they were in the process of moving. The CSOs spoke to the mother and three children were sighted. The father was not interviewed as he was not home.

25. A Safety Assessment was completed that day and it was determined that the children were safe.

26. On 14 May 2014 staff from the children's school told the department they were always well presented with clean uniforms. On 15 and 16 May 2014 the CSO tried unsuccessfully to contact the parents to advise that they had been referred to Act for Kids and Rent Connect.

27. On 19 May 2014 the department was advised of the mother's whereabouts and further child protection concerns including the mother's drug use and psychiatric issues. A CSO spoke to hospital staff and ascertained that the mother denied drug use but refused a drug test, that she'd had no antenatal care and that she had argued with the father at the hospital. The family left the hospital later that day (against medical advice) to return to the Gold Coast. The hospital advised the department that staff were very concerned about the safety of the unborn child and the sibling.

28. A CSO visited the residence and tried to phone the family but could not locate them. The CSO contacted the Department of Education who advised that Baby J's siblings had not been enrolled in any schools on the Gold Coast.

29. On 3 June 2014 the father advised the department that they were living in a motel but would not disclose where. An appointment was made for the family to attend the department's office on 5 June 2014. They did not attend. Between then and 19 June 2014 the department tried to contact the parents by phone, but they did not respond.

30. On 25 June 2014 a decision was made to finalise the I&A "given the lack of engagement by the parents".

31. On 30 June 2014 a state-wide Unborn Child High Risk Alert (HRA) and a Family Risk Evaluation were completed. The final risk was assessed as "moderate." The I&A in relation to Baby J and his sister was "No Outcome."

32. The Child Safety Practice Manual (CSPM) required the I&A for an unborn child to be kept open until the child was born and the I&A completed or two months have elapsed since the estimated date of delivery and the child has not been located. Other actions include consideration of a SCAN team referral and recording a "member of a mobile family" alert.

33. The review team considered that the matter should have been referred to SCAN and the decision to record the matter as "no outcome" was incorrect.

34. The HRA was sent to Qld Health and the department was alerted when Baby J was born.

35. I find that the I&A was not conducted in accordance with the CSPM and was finalised without an appropriate investigation when the department was unable to locate the family. The I&A was not conducted in accordance with departmental policy and the closure led to significant risks being overlooked.

CS

36. Subsequent to Baby J's birth the department received further information on three occasions – 7 August 2014, 2 September 2014 and 4 January 2015. That information was recorded as Child Concern Reports which had the result that no action was taken in relation to that information.

37. On 7 August 2014 the department was advised by medical staff of Baby J's birth. The staff had no concerns about the family at that time. It was noted that a midwife would visit the mother on 9 and 11 August 2014 and then make a referral to child health. It was concluded that the children were not at risk of harm and the family would be referred to Act for Kids. This referral was made on 30 September 2014.

38. The review team found that although this decision was appropriate there was insufficient consideration given to the family's history with the department.

39. On 2 September 2014 the department received two notifications in relation to concerns that the father was using drugs, screaming at the children, assaulted the mother, assaulted the grandmother, the children were scared of him and wandered around on their own a lot. The information was assessed, and it was decided that there was no information to suggest that the children were at an unacceptable risk of harm.

40. The review team found that this decision was not appropriate, and the matter warranted an I&A. The family history supported the concerns and it was known that the family was transient and avoidant of child services. The information indicated probable risk of neglect and physical and emotional harm of children.

41. On 4 January 2015 a mandatory notifier advised the department that Baby J and his sister had been taken to the emergency department by their mother suffering with respiratory illnesses. She was told by a GP to take them to hospital the day before but delayed for a day. The departmental officer who took the call did not look at the child protection history recorded on the department's database and noted, "Nil child protection history could be located for the family" and concluded that the children were not at risk of harm. The review team considered that the fact that child protection history was missed in its entirety was of concern given "its significance and length."

42. The review team concluded:

Overall, review of this case identified a number of key points in the Department's involvement with the family which became missed opportunities for attempts to provide more meaningful intervention to the family. Initially, the I&A was finalised with unassessed concerns for the unborn Subject Child. An HRA was appropriately recorded following the completion of the I&A. When

information was next received at the birth of the Subject Child on 07/08/2014, the significance of the HRA and the unassessed concerns from the previous I&A were overlooked and a CCR was recorded. The CCR recorded that Child Health would have ongoing involvement with the family which was incorrect. This information then appeared to form the basis for recording another CCR when concerns were received about the family one month later 02/09/2014. This case highlights the importance of checking new information against the family's child protection history and clearly and accurately recording risks and unassessed concerns.

I agree with those conclusions.

Child Death Case Review

43. A Queensland Child Death Case Review was undertaken into the circumstances surrounding Baby J's death. The panel noted that there was no state-wide system to provide the ability to track children between state and independent schools or ascertain if a child has not been enrolled at school.

44. The panel noted that this was of particular concern given a previous Cairns case that was the subject of a coronial inquiry where a child was removed from school for one year before her death to hide her abuse and prevent her half siblings coming to the attention of child safety services (findings published as "Faith, an 8 year old child" on 27 June 2014). The inquest resulted in a Coronial Recommendation made in June 2014 about the urgent need for the development of information sharing systems with partnering departments including the Department of Education, Qld Police Service, Qld Health, and representatives from the non-state school sector.

45. The panel was concerned that a compulsory register for school enrolments still does not exist despite that recommendation. The panel noted that such a register could be similar to the electoral roll or systems used for tracking immunisations. Currently it is up to individual schools to track when children leave a school and re-enrol or not re-enrol in another school.

46. The panel noted that there had been preliminary discussions in relation to a national system to include all children however, this would not be implemented for a significant period. The panel found the system should be expedited and a state-wide system implemented for recording all school aged children to track their movements between state and independent schools.

47. The panel found that the department should not have finalized the I&A without

finding the family and assessing the safety of the children.

48. The panel found that information received on 7 August and 2 September 2014 about the family should have been investigated rather than being recorded as a child concern report as it revealed risk to the family as a result of violence by the father and drug use.

49. The panel concluded that the case demonstrated the multiple high-risk factors of domestic violence, drug use and high mobility of families and the increased risk to infants.

50. The panel found that the family should have been referred to SCAN (Suspected Child Abuse and Neglect) team to be further assessed and monitored.

Department of Education

51. In response to the panel's concerns about the lack of a compulsory register for school enrolments, in April 2021 the Department of Education (DoE) provided the following information:

    - DoE continues to engage and participate on cross-agency data sharing working groups;

    - DoE remains interested in considering expanded information sharing arrangements with relevant Commonwealth Australian Government agencies in cases where known children are not re-enrolled or enrolled in school and continues to monitor such trials in other jurisdictions;

    - DoE is participating at a national level in projects to improve data sharing across levels of government including the development of a national system of identifying and potentially tracking the enrolment of school students;

    - Under the National School Reform Agreement the states and territories are working with the Australian Government to develop a national unique student identifier (USI) for students across all schooling sectors with full possible full implementation by mid 2023;

    - All states and territories are now working together to establish a more contemporary approach to support student information exchange between states and sectors with will enable education systems to securely search, retrieve and exchange records for students leaving one school system and

enrolling in another in a more timely and cost effective manner;

- DoE is currently investigating the potential for a new Multi-Agency Data Integration Project (managed by the Department of Statistics), combining linked information of health, education, government payments, income, taxation and employment to determine characteristics and early indicators of children who are at risk of not attending school.

Conclusion

52. I find that Baby J died from Category II Sudden Infant Death Syndrome in the context of the risk of co-sleeping. Numerous other SIDS risk factors were present in his home.

53. Although Baby J and his family were known to the department the investigation commenced shortly before his birth was not conducted in accordance with departmental policies and procedures and no action was taken to assess the risk to Baby J and his siblings. Further information was provided to the department on three occasions in the months following Baby J's birth, but the department recorded this information without investigating it appropriately.

54. Whilst the department's failures did not directly contribute to Baby J's death it cannot be ascertained whether the involvement of the department with Baby J's family may have resulted in a different outcome for Baby J. As the SPR review team noted there were, "missed opportunities to intervene with the family which may have created increased safety for [Baby J]."

55. It is of significant concern that there continues to be no system in Queensland or nationally for tracking children from birth to school and through school. This omission leaves vulnerable babies and children at risk of undetected abuse, neglect and homicide.

Findings required by s.45

Identity of the deceased –	Baby “J”
How he died –	It is most probable that Baby J asphyxiated when he was co-sleeping with his father.
Place of death –	Queensland, Australia
Date of death–	January 2015
Cause of death –	1(a) Category II sudden infant death syndrome (co-sleeping)

I close the investigation.

Jane Bentley
Deputy State Coroner

13 May 2021