QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of B, an eleven week old infant.**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
DATE:	17/02/2021
FILE NO(s):	2016/1339
FINDINGS OF:	Jane Bentley, Deputy State Coroner
CATCHWORDS:	CORONERS: sudden infant death syndrome; SIDS; co-sleeping; overlay; risk factors; parental drug use; child protection

Contents

At the time of her death B was eleven weeks old. She was born on 19 January 2016 by caesarian section at 38 weeks gestation. B lived with her mother, her maternal aunt, her aunt's partner and her two siblings (aged four and two years at the time). The mother and her three children all slept in a queen size bed in one of the bedrooms. B's father was in custody at the time of her death.

The family went to bed on the evening of 1 April 2016. At about 10pm the mother fed B a bottle. She appeared well and happy. B went to sleep in bed on her mother's chest. The mother got out of bed and left B in bed. She smoked some cannabis mixed with tobacco. She gave B another bottle at 2am and then fell asleep with B lying on her chest. The other two children were sleeping to one side of her.

The aunt awoke at about 3.30am and looked into the bedroom and saw that the mother was sleeping on top of B. She woke her up and the mother rolled over and went back to sleep. The aunt presumed that B was asleep at that time.

At about 6.30am on 2 April 2016 the mother awoke to find B head down with her legs in the air beside the bed. She picked her up and called the aunt who called 000.

Queensland Ambulance Service paramedics attended and pronounced B deceased at the scene.

Autopsy

An autopsy was conducted but the cause of B's death could not be conclusively determined.

She had skull fractures but there was no evidence of injury to her brain so they could not be said to contribute to her death. There were two lineal fractures on the right side of her skull which showed evidence of healing which was consistent with the fractures occurring when she was five weeks of age. (B was taken to hospital at that time after her sister dropped her on her head).

The Forensic Pathologist concluded that there were two potential mechanisms to account for B's death:

(a) Her death occurred in bed and she fell to the floor following death – cause of death would be sudden infant death syndrome or asphyxiation due to co-sleeping or overlaying;
(b) She fell from the bed and died in a head down position which caused positional asphyxia.

The Forensic Pathologist concluded that the first potential cause was the most likely.

Child Protection History

During the two years prior to B's death, the family had been the subject of five Child Concern Reports (CCR), one Intake Event and one Notification and consequent Investigation and Assessment (I&A) by the Department of Communities, Child Safety and Disability Services (the Department).

Most of the notifications concerned parental drug use, parental mental health issues (the mother suffered from borderline personality disorder, anxiety, hyperactivity, panic attacks and agoraphobia, and the father had been diagnosed with an adjustment disorder), homelessness, financial issues and domestic and family violence perpetrated by the father on the mother. Both parents had a history of suicidality. There was a history of domestic violence protection orders with the mother as the aggrieved and the father as the respondent.

B returned a positive drug screen at birth for amphetamines, benzodiazepine and cannabis but did not suffer symptoms of withdrawal.

A Support Service case was current at the time of B's death and her siblings were subject to an Intervention with Parental Agreement. However, the support worker had ceased attending the residence on 8 February 2016 due to continued drug use and threats by the father towards her and the mother. Regardless, the Child Safety Officer allocated to the family continued to visit regularly and was proactive in attempting to assist the family deal with the child protection issues. The mother, with the support of her sisters, was making real attempts to address the child protection concerns. She had obtained stable accommodation and was doing her best to care for her children.

Reviews of the child protection history (by the Department and the Queensland Child Death Case Review Panel) concerning the family identified that although there was a safety plan in place for the family it was not sufficient to fully mitigate the risk for B. The family had numerous issues and understanding and addressing the totality of the issues was a complex matter. It was noted that the issues of co-sleeping and the impact of substance abuse by the parents were not adequately addressed and considered.

A further issue identified was the lack of collaborative case planning and collaborative practice between the Department and Qld Health. Medical staff notified the Department of concerns on numerous occasions but this information was not given the significant weight it deserved. Although the matter was referred to SCAN (Suspected Child Abuse and Neglect multidisciplinary team comprising officers of the Department, Qld Health, the Department of Education and Qld Police Service) the Department treated the process as an information gathering exercise rather than instigating a team approach to the family and the case was closed to SCAN at the first meeting.

I note that changes have been made to the SCAN procedures since B's death.

Conclusion

B's cause of death could not be conclusively determined at autopsy, however, taking into account all of the circumstances, I find that she died from sudden infant death syndrome or asphyxiation due to co-sleeping or overlaying.

B's death occurred in the context of numerous risk factors for SIDS including co-sleeping and parental drug use.

I publish these findings to highlight the risk factors for SIDS and the dangers of co-sleeping and parental drug use.

Findings required by s.45

Identity of the deceased – B, an eleven week old infant.

How she died – B died from an undetermined cause whilst sleeping in the same bed as her mother and siblings**.** It is probable that she was accidentally asphyxiated.

Place of death – Logan Central

Date of death– 02/04/2016

Cause of death – The medical cause of B's death is unable to be conclusively determined but it is probable that she died from SIDS in the context of co-sleeping resulting in accidental asphyxiation.

I close the investigation.

Jane Bentley
Deputy State Coroner
CORONERS COURT OF QUEENSLAND - SOUTHERN REGION