



ATTORNEY-GENERAL

Parliament House
State Square
Darwin NT 0800

GPO Box 3146
Darwin NT 0801

REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to section 46B of the *Coroners Act 1993*

In the matter of the Coroner's Findings and Recommendation regarding the death of



Under section 46B of the *Coroners Act 1993* (the Act), I provide this Report on the findings and recommendation of Local Court Judge Elisabeth Armitage, Territory Coroner, dated 9 June 2026, regarding the death of [REDACTED] (the Deceased) (Attachment A refers).

This Report includes the response to the recommendation of the Territory Coroner, by Ms Susan Bowden, Acting Chief Executive Officer (CEO), Department of Health (DoH).

The Deceased was a six week old female infant who passed away on 1 August 2025 in Moulden, Palmerston, while co-sleeping with her mother and two-year-old brother. The cause of death was identified as sudden unexpected death of an infant in an unsafe sleeping environment. The main contributing factors of risk in the context of co-sleeping were identified as the young and small infant placed in between multiple co-sleepers, one of which was her mother who had consumed alcohol that night and was of a larger build.

Under section 16(1) of the Act, the Coroner decided to not hold an inquest because the investigations into the death disclosed the time, place and cause of death, and the relevant circumstances concerning the death.

Recommendation of the Territory Coroner

The Territory Coroner made one recommendation regarding the death of the Deceased:

1. I recommend to **NT Health** that it take all necessary steps, including by amending policy, practice, procedure, guidelines and training, to ensure that baby safe sleep education is provided to pregnant and new mothers at regular intervals during pregnancy and after the birth. The mother's/baby's medical records should document when the education is given and include some detail as to the content and nature of the education. A single 'tick a box' next to SIDS is insufficient to capture what must be recorded.'

Response to Territory Coroner's Recommendation

A copy of the Coronial Findings was provided to Ms Bowden, on 24 June 2026, in accordance with section 46A(1) of the Act.

A written response was received from Ms Bowden on 8 September 2026, as required by section 46B(1) of the Act. The response includes the following:

'On behalf of NT Health, I acknowledge the Coronial Findings and extend sincere condolences to the family of [REDACTED] for their loss. Northern Territory (NT) Health acknowledges the Coroner's recommendations relating to infant safe sleeping and co-sleeping and is committed to working collaboratively across government, Aboriginal Community Controlled Health Organisations, researchers and community stakeholders to strengthen systems, services and supports for families.

NT Health context

NT Health acknowledges the profound impact of this death on the family and community affected. The recommendation arising from the death of [REDACTED] is being considered alongside recommendations from other recent coronial findings and recommendations relating to co-sleeping and sudden unexpected death in infancy (SUDI). NT Health is taking a coordinated, Territory-wide approach to implementing sustainable improvements that strengthen culturally safe care, support First Nations parents and babies, improve safe sleeping education and resources, and enhance collaboration across services and sectors.

...

NT Health response

NT Health supports this recommendation and recognises the importance of providing consistent, documented safe sleeping education to parents throughout pregnancy and the postnatal period. The office the Chief Nurse and Midwife will lead progression of this recommendation through existing NT-Wide maternity and midwifery governance arrangements. As part of this work, NT Health will review relevant policies, guidelines and supporting documentation to strengthen expectations regarding the delivery, recording and monitoring of safe sleep education. Consideration will also be given to documentation requirements to ensure medical records appropriately capture when education has been provided and the nature of information discussed.'

I am satisfied that the Acting CEO of DoH has considered the recommendation of the Territory Coroner and has responded to the recommendation.

DATE: - 9 OCT 2026



MARIE-CLARE BOOTHBY

Attachment A - refer to
findings