IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

Rel No: D0287/2024

Police No: 24 116355

CORONERS FINDINGS

*Section 34 of the **Coroners Act 1993***

I, Elisabeth Armitage, Coroner, having investigated the death of **a 17 day old Aboriginal male infant** and without holding an inquest, find that he was born on **30 October 2024** and that his **death occurred on 17 November 2024, South Goulburn Island in the Northern Territory.**

Cause of death

1(a)	Disease or condition leading directly to death:	**Sudden unexpected death in infancy (SUDI) in the context of Rhinovirus/Enterovirus/SARS-CoV-2 (Covid-19) positivity, adrenal haemorrhage, and a history of diarrhoea, in an unsafe sleeping environment.**

Following an autopsy on 19 November 2024, Forensic Pathologist, Dr John Rutherford commented:

The decedent was a 17-day old infant found dead in bed at 0300 hours having last been known to be alive when breastfed three hours earlier. Had suffered diarrhoea the day before death. Co-sleeping with mother and two older sibs. Parents smokers. Autopsy revealed some non-specific changes (including bilateral adrenal haemorrhage) but nil to suggest trauma or a convincing specific disease process. Found to be positive for Rhinovirus/Enterovirus and SARS CoV-2 and have minor vitreous electrolyte changes **but nothing sufficiently clear to suggest a definitive cause of death.**

Whilst this case fits into the general demographic of sudden infant death syndrome (risk factors: co- sleeping and a cigarette smoking environment), there are several other factors that need to be taken into consideration. These include the history given by the mother that the infant had diarrhoea on the day before death and that virological swabs were positive for Rhinovirus/Enterovirus and Covid19. Bilateral adrenal haemorrhage was unusual also. **It is difficult to assess the relative importance of all these elements,** and the cause of death is probably best expressed broadly in terms of a sudden death in infancy in the context of rhinovirus/enterovirus/SARS-CoV-2 (Covid-19) positivity, adrenal haemorrhage, and a history of diarrhoea.

Background

The following information was obtained from the pregnancy and birth health records:

- On 1 May 2024 Mother was seen at home and reported that she had cut down on cigarettes and was only smoking one a day. She was encouraged to quit and an appointment was made for "morph booked 25/6 @RDH". This did not proceed as mother "was unable to travel".
- There was a chart review on 30 July 2024.
- There was a "clinic sit down appointment on 22 October 2024 and a caesarean section was booked for 31 October 2024.

Baby was born on 30 October 2024 at Royal Darwin Hospital by Caesarian section. At birth he weighed 327gms, 49cms in length, heal circumference 35cms and Apgar score of 1min = 4 and 5mins = 9. He had two siblings.

The birth is recorded as a "difficult caesar due to high riding bladder and dense adhesions of recuts to sheat and abterior abdominal wall, if choosing 4th caesar recommend experienced operator" and "Peads attended for resus".

Mother and baby were discharged from hospital on 4 November 2024 with baby weighing 3230g with a plan for Midwifery Group Practice (MGP) Yellow visits. Prior to discharge he received his Vitamin K and Hepatitis B vaccines.

On 12 November 2024, baby presented at the local Health Clinic for a routine checkup. He was noted to "weigh 3.57kgs, pnt fontanelle open and soft, post fontanelle closed, eyes and mouth clear, abdo soft, umbi clean & dry, wiped with alco wipe, multiple yellow stools / dry multiple wet nappies, darkened skin over lumbar spine (Mongolian spots), breast feeding well, good weight gain, mother c/s wound checked." At that checkup he presented as a "beautiful well baby", "well looked after", "chubby", "just this perfect little baby."

Circumstances of baby's passing

The following circumstances were reported by the mother to clinic staff who attended the house (first on scene), and later to attending police.

Sometime around midnight on 16 November 2024, baby was breastfed by his mother and placed to sleep on mattresses on the floor (two single mattresses pushed together). His mother and two siblings were also sleeping on the mattresses. He was dressed in a disposable nappy and was not covered. He was placed on his back next to his mother with a pillow between them, although later the mother told police and drew a diagram which indicated the pillow was between her and the older siblings. At about 3.00am his mother got up to change the nappy of one of the older siblings and went to have a smoke in the bathroom. When his mother returned to the bedroom, she noticed baby's feet were white (pale), his mouth was open, and he was cold to touch. She was unsuccessful waking him up and left the residence with him in her arms. She was screaming, which alerted the neighbours. His father had earlier left the premises to pick up some relatives.

A neighbour contacted the clinic nurse who arrived shortly after in an ambulance. The records indicate that baby was "unresponsive, mottled face and legs, centrally cyanosed, cool peripheries" and "stiff limbs".

Mother and baby were driven to the local Health Clinic in the ambulance. He was noted to be not breathing with very cold feet and hands. He was very pale, his lips were blue and he was

a little mottled on his upper chest. At the clinic CPR commenced and the clinic manager was contacted.

Baby could not be revived, and he was declared deceased at 3.40am.

Additional Information

In June 2024 the Department of Children and Families (**DCF**) received a notification in which concerns were raised about a lack of antenatal care for the mother. The mother was not permitted to attend the clinic unless in the company of the father. The mother was supposed to fly to Darwin for a pregnancy scan but was prevented from flying by the father. The father yelled at clinic staff and said they should bring the machine from Darwin to the community. There was an investigation which resulted in no further action and family arrangements were put in place to support the father to care for the older children when the mother attended Darwin for appointments.

There was no evidence in the hospital or clinic records that safe sleeping and safer co-sleeping education was provided to the parents or family. Although there was a Yellow Book located at the home, this does not equate with safe sleeping education for a remote Aboriginal mother. In the *Inquest into the deaths of baby K, Baby B and Baby S* [2026] NTCC 06 at paragraphs [132] – [133] I heard that "there was nothing in the Yellow Book to connect it with a young Aboriginal mother and there was little or no authentic consultation in the development of the Yellow Book. Applying a cultural lens, it was described as 'awful', and only relevant for a 'certain demographic of mothers'."

There was no evidence as to how baby and mother were sleeping at RDH. I have learned that co-sleeping in hospital is a common practice and in my view, NT Health should ensure that baby's hospital sleeping arrangements are clearly documented.

Midwife BR from the local Health Clinic provided the following information:

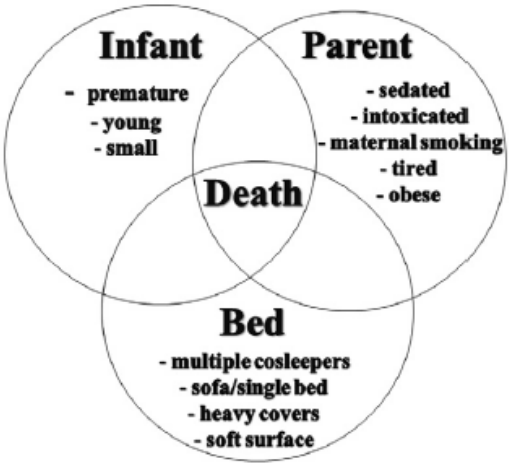
> *In my capacity as a midwife, I attended scheduled antenatal checks for [Mother] at 30, 32, 34, and 36 weeks' gestation. Upon review of her clinical notes, safe sleeping practices and SIDS prevention were not documented as having been discussed during these visits.*
>
> *I am aware that other Red Lily Health Board midwives conducted antenatal checks at the initial visit and at 14, 20, 28, and 38 weeks' gestation. A review of the PCIS notes indicates that safe sleeping practices and SIDS prevention were also not documented as discussed at those appointments.*
>
> *SIDS prevention is included in the standard antenatal checklists, which are applied uniformly across antenatal visits. However, discussion of SIDS prevention is not typically prioritised during earlier visits, where emphasis is generally placed on addressing modifiable risk factors such as smoking, substance use, diet, and exercise.*
>
> *The list of topics that can be discussed comprises 22 items and discussion regarding safe sleeping practices and SIDS prevention is generally considered more relevant in the later stages of pregnancy or in the very early postnatal period.*
>
> *I am not aware of any educational materials on SIDS prevention currently available in Maung, Kunwinjku, Warray (Walang), Gupapuyngu (Galpu), or Iwaidja languages.*

Unsafe sleep environment

Sudden unexpected death in infancy (SUDI) is a broad term used to describe the sudden and unexpected death of an infant for which the cause is not obvious. An autopsy will be conducted in an attempt to find the cause of death or to exclude possible causes. Where no sufficient cause (illness, trauma or defect) is found, a forensic pathologist will consider the environment in which the death occurred. Following these investigations, where no sufficient other cause of death is identified, some deaths may be explained by risk factors identified in the child's sleeping arrangements. When all other causes of death have been excluded, sufficient risk may be identified in the sleeping arrangements to conclude accidental suffocation/asphyxiation as the likely cause of death.

A subset of SUDI is sudden infant death syndrome (SIDS). This is the sudden unexpected death of an infant (<1 year of age) during sleep which remains unexplained even after autopsy and in circumstances where the sleeping environment did not present a risk (or a sufficient risk to be considered a likely cause of death).

Professor Roger Byard has been researching and publishing on the risks of co-sleeping since 1994.[1] To assist in identifying SUDI in an unsafe sleeping environment, Professor Byard developed the "triple risk" model; the greater the number of risk factors in a sleeping situation, the greater the risk of an infant death.[2] The model demonstrates the interrelationship of risk factors and provides a conceptual framework for understanding accidental suffocation/smothering and unexpected infant death in a shared sleeping situation:[3]



Professor Byard said that the model demonstrates the potential interaction between three components in a shared sleeping situation: the infant, the bed and the parents (or other co-sleepers). Infants who are most at risk are young, small for gestational age and premature. Bed/sleep environments that increase the risk of suffocation/smothering include beds with soft surfaces such as compressible mattresses, bean bags, waterbeds, sofas and pillows. Heavy covers sharers also increase the risk. Features of parents which increase the risk include obesity, sedation, fatigue, intoxication, maternal smoking and multiple co-sharers. He

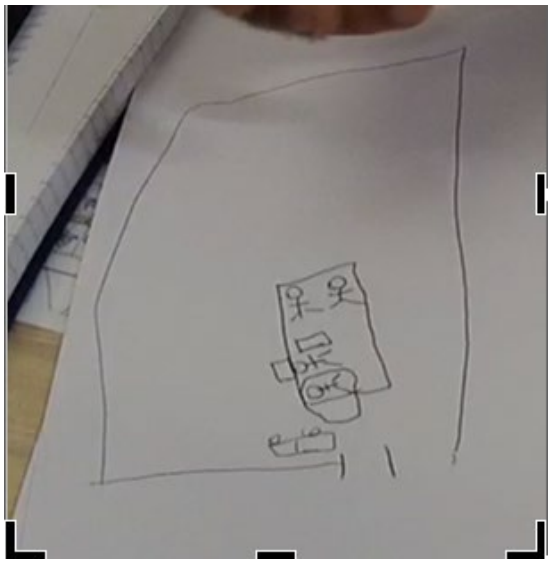
[1] Byard RW ,Is co-sleeping in infancy a desirable or dangerous practice?, J. Paediatr. Child Health 1994; 30
[2] Inquest evidence of Professor Byard on 17 July 2025 at 278
[3] Byard RW, The Triple Risk Model for Shared Sleeping, J. Paediatr. Child Health 48 [2012] p947-948

said that, while it must be recognized that many situations do not result in a lethal outcome, in certain infants the compounding effect of these risk factors may result in death.[4]

Baby's death occurred in an unsafe sleep environment which presented risk.

The sleeping arrangements consisted of:

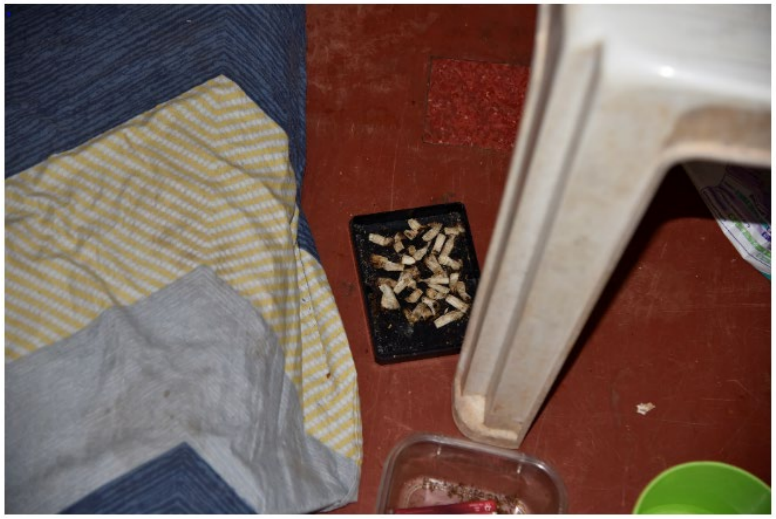
- Two mattresses pushed together and covered by a sheet. The gap between the mattresses is a suffocation risk, but the evidence indicates that baby was not placed next to this gap.
- The mattresses appeared to be very soft foam which is a suffocation risk, a firm mattress is recommended for safe sleeping.
- There were two children and the mother sharing the mattresses with baby. Multiple people co-sleeping increases the risk.
- Pillows were present on the bed which create suffocation risks, but the pillows do not appear to have been directly adjacent to baby.
- There was only one blanket nearby which creates a suffocation risk, but it seems that it was not near baby's face/head.
- Both parent's smoked and, although there is no evidence of smoking in the bedroom on the night that baby passed away, there was evidence of smoking taking place in the bedroom at some earlier time. Smoking increases the risk to babies when co-sleeping with the person who smokes.



Still taken from interview with mother, depicting her drawing of the sleeping arrangements. The two stick figures with heads towards the top of the image represent the two older children, the stick figure in the middle of the bed represents the mother with a pillow at her head and between herself and the older children. The stick figure at the bottom represents the position of Baby with a blanket around him "half off, half on."

[4] Byard RW, The Triple Risk Model for Shared Sleeping, J. Paediatr. Child Health 48 [2012] p947-948

The two soft mattresses side by side on the floor. Two pillows are present and a full ashtray is located bottom right indicating cigarette smoking in that room.

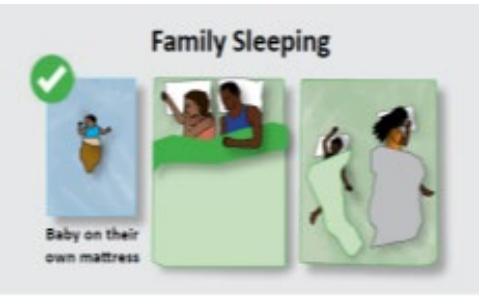


Closer image of the ashtray.

These sleeping risks are discussed not to blame to anyone, but rather to educate, and to acknowledge just how difficult it can be to create a safe co-sleeping environment. Given these difficulties, it is recommended that babies, particularly small babies, sleep on their own, separate, clear, firm, sleep surface.

The images below are three ways a baby can be given their own safe, firm, sleep space when co-sleeping with parents and/or siblings. The first image[5] depicts a firm mattress to the side of the parent's mattress. The second depicts a Pēpi-Pod®[6] which can be placed next to or on the parent's mattress. The third depicts a coolamon[7] which can be placed next to or on the parent's mattress.

[5] Image from a Ketherine West information brochure on Safe Sleeping for Baby
[6] Image from the now defunct Bubba Basket program that operated between 2021-2023 in Tennant Creek
[7] Image from the Coolamon Community Inc. website https://www.coolamoncommunity.org.au/




Conclusion:

The Forensic pathologist found that it was difficult to assess the relative importance to this death of the unsafe sleep environment, infant diarrhoea on the day before death, and virological swabs which were positive for Rhinovirus/Enterovirus and Covid19.

I cannot exclude any of these as contributors to the death and so am satisfied that the cause of death is sudden death in infancy (SUDI) in the context of rhinovirus/enterovirus/SARS-CoV-2 (Covid-19) positivity, adrenal haemorrhage, and a history of diarrhoea, in an unsafe sleeping environment.

On all the evidence provided, which includes a review of all pre-birth records, the records of the birth and period of hospitalisation and the records from after her birth, there was **no evidence at all** that safe sleeping education was provided to this mother. There was also no evidence that any safe co-sleeping device was discussed or offered to the mother.

NT Health is aware of concerns held by the Territory Coroner about a) the quality and frequency of safe sleeping education being provided to mothers and families, and b) the scarcity of provision of safe sleeping devices to mothers and babies at risk of unsafe co-sleeping.

The Wurruwi Community Health Centre is an Aboriginal Community Controlled Health Service (ACCHS) run by the Red Lily Health Board (which also operates health clinics in Minjilang on Croker Island, Jabiru and Gunbalanya). I note that the Red Lily Health Board promotes itself as a Child Safe Organisation and is committed to child safety and wellbeing.[8] Similarly to other communities that I have heard about, there does not seem to be locally developed educational material on safe sleeping and safer co-sleeping in Wurruwi and nor is there any program for providing safe sleeping devices (and education) to mothers and babies at risk of un-safe sleeping.

A copy of draft findings was provided to the Red Lily Health Board and the Wurruwi Health Clinic on 2 June 2026. Each organisation was invited to respond to the suggested recommendations or to provide further evidence or make submissions. Neither organisation replied to that invitation.

In light of the sensitive nature of these findings the Coroner's Grief Counsellor will explain these findings to Baby's parents before they are anonymised and published.

[8] Redliliy.org.au, 'Red Lily Health Board Statement of Commitment to Child Safety', accessed 2 June 2026.

I make the following recommendations:

Recommendation 1

That the **Red Lily Health Board,** in consultation with **NT Health** or other Aboriginal or health organisations, develop or adopt accurate, relevant and culturally sensitive and appropriate educational materials about infant safe sleeping and safer co-sleeping, which meets the needs of parents with low literacy and/or of linguistically diverse backgrounds (especially Aboriginal language speakers). This should be done through authentic co-design with Aboriginal stakeholders and Aboriginal controlled service providers from inception through to implementation. Consideration should be given to developing:

a) educational material with realistic representations of the known risks of co-sleeping (and other unsafe sleep risks);

b) complementary educational tools such as videos in language, story based resources, visual or practical aids; and

c) an educational awareness campaign directed at relevant groups such as Aboriginal community groups, early childhood services and Grandmothers, in recognition of their vital roles in engaging with and educating mothers.

Recommendation 2

That the **Red Lily Health Board** ensure that each of its clinics have clear, up to date and comprehensive policies and guidelines addressing all aspects of infant safe sleeping and safer co-sleeping practices, with access to culturally relevant and appropriate educational materials (such as any materials created in accordance with recommendation (1)). The policies and guidelines should ensure that staff engaging with expectant mothers, care givers, and infants:

a) provide culturally sensitive and appropriate ongoing education on safe/safer infant sleeping to parents, extended family or care givers;

b) take reasonable steps to identify whether an infant is exposed to an unsafe sleeping environment; and

c) provide clear guidance as to the proactive actions to be taken by staff to mitigate an unsafe sleep environment. By way of example only, by ensuring staff: (i) provide education on safer sleeping; (ii) make appropriate referrals (such as for priority housing or alcohol/drug/smoking education or rehabilitation) and ensure the referrals are actioned as expected; and (iii) provide practical assistance (for items such as a firm mattress, light weight baby blanket, Pēpi-Pod® or Coolamon etc).

Recommendation 3

That the **Red Lily Health Board** take all necessary steps to make available Pēpi-Pods®, coolamons (or similar) to mothers and babies (identified by its clinic staff as being at risk of unsafe sleeping) in each community in which it operates health clinics. By way of example only, the Red Lily Health Board could consider and progress a partnership with the Coolamon Community Inc. similarly to Miwatj Health Aboriginal Corporation. When a program of delivery is established, Red Lily Health Board should have in place a process that evaluates the efficacy of safe sleeping devices, the program of delivery and education materials.

Decision not to hold an inquest:

Under section 16(1) of the *Coroners Act 1993* I decided not to hold an inquest because the investigations into the death disclosed the time, place and cause of death and the relevant circumstances concerning the death. I do not consider that the holding of an inquest would elicit any information additional to that disclosed in the investigation to date. The circumstances do not require a mandatory inquest because:

- The deceased was not, immediately before death, a person held in care or custody; and
- The death was not caused or contributed to by injuries sustained while the deceased was held in custody; and
- The identity of the deceased is known.