

IN THE CORONERS COURT OF THE NORTHERN TERRITORY

Rel No: D0193/2025

Police No: 25 82637

CORONERS FINDINGS

Section 34 of the Coroners Act 1993

I, Elisabeth Armitage, Coroner, having investigated the death of a **3 day old Aboriginal female** and without holding an inquest, find that the deceased was born on **13 August 2025** and that her **death occurred on 16 August 2025, at Royal Darwin Hospital in the Northern Territory.**

Introduction

On 30 April 2026 inquest findings into the deaths of Baby K, Baby B and Baby S were published.¹ Each of these babies died from Sudden Unexpected Death of an Infant (SUDI) in an unsafe sleeping environment. These Aboriginal babies were from Alice Springs and Tennant Creek. These inquests considered educational failings, particularly the lack of educational materials for Aboriginal families and communities in the Northern Territory. The inquests also considered how co-sleeping, family sleeping or bedsharing could be made safer with a safe sleep device for babies, such as a Pēpi-Pod® or Coolamon.

Following those inquests, chamber's findings concerning further SUDI deaths have been published.

- SUDI Death of a 5 week old Aboriginal female from Charles Creek Camp published on 13 May 2026.
- SUDI Death of a 45 day old Caucasian female from Darwin published on 23 June 2026.
- SUDI death of a 33 day old Caucasian female from Darwin published on 23 June 2026.
- SUDI Death of a 17 day old Aboriginal male from Goulburn Island published on 9 July 2026.
- SUDI death of a 42 day old Aboriginal female infant from Alice Springs published on 31 August 2026.

Each of these babies passed away in an unsafe sleep environment.

Tragically, these findings concern another SUDI death of a 3 day old Aboriginal female who passed away in Royal Darwin Hospital. Baby was small and very young. Her 20 year old Mother was exhausted following an emergency C-section and a demanding 3 hourly (with expressed top-ups) breastfeeding regime. Mother was breastfeeding in the early hours

¹ *Inquest into the deaths of Baby K, Baby B and Baby S* [2026] NTCC 06

of the morning when she accidentally fell asleep and Baby accidentally asphyxiated in the unsafe co-sleeping environment (the RDH single hospital bed).

The risk of mothers accidentally falling asleep while breastfeeding are well known. However, NT Health policy and guidelines failed to explicitly identify this risk and they did not provide any strategies for addressing or mitigating this risk.

Similarly to the other SUDI deaths, there was no contemporaneously documented evidence of any safe sleeping education being provided to this Mother.

Cause of death

1(a)	Disease or condition leading directly to death:	Sudden unexpected death of a small for gestational age infant (SUDI), accidental mechanical asphyxia in an unsafe sleeping environment
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Following an autopsy on 18 August 2025, Forensic Pathologist, Dr Salona Roopan commented:

- The opinion as to the cause of death is based on the available police and medical information, and a full post-mortem examination including ancillary investigations.
- A postmortem CT scan did not show any trauma. At autopsy, the infant showed no congenital abnormalities, no evidence of infection and no significant natural disease process. The lividity was prominent over the front/anterior surfaces of the body with pallor (absence of lividity) of the forehead, nose, chin and knees and patterned pressure pallor (similar to the embroidery of the mother's clothing) of the chest. Internal organs were congested but otherwise unremarkable and appropriate for gestational age. There was no obvious evidence of neglect or trauma. The only abnormality identified was a small focal subgaleal haemorrhage of the occiput, with no skull fractures which was histologically confirmed. Histology showed no evidence of infection, inflammation or natural disease, and microbiological and serological investigations did not identify any infectious pathogens. There were features suggestive of hypoxic-ischaemic injury to the brain. Toxicological analysis did not detect alcohol or other drugs in the tissues analysed including opioids within the laboratory's testing scope apart from ondansetron (an anti-emetic).
- The anterior distribution of lividity prominent anteriorly with pallor over the nose, chin and forehead indicates that the infant was either lying prone at the time of death or had the face against another surface (such as the mother's body). In the absence of natural disease or toxicological cause and given the circumstances of bed-sharing with a sedated adult, this raises the concern of accidental asphyxia or overlaying.
- At birth, the infant had good Apgar scores but was also noted to have low blood

glucose which was corrected. The infant was otherwise stable during the hospital stay. The infant's background of intrauterine growth restriction and perinatal stress (fetal decelerations) implies a degree of hypoxic vulnerability which may have reduced the ability to tolerate hypoxic events. Neonates with prior hypoxia or growth restriction have diminished physiological reserve and may be less capable of mounting an effective compensatory response to airway obstruction or rebreathing in a prone position.

- The mothers use of oxycodone, an opioid with sedating and respiratory depressant effects would have been expected to cause sedation and reduced arousability increasing the risk of accidental overlaying or failure to respond to the infant during sleep.
- There is an increased risk of sudden death infants who share a sleeping surface with another. A triple risk model has been described to demonstrate the risk factors for infant death in a shared sleeping position. In this particular case, notable risk factors included:
 - Infant factors: premature birth (37 weeks) and intrauterine growth restriction.
 - Parental factors-sedation
 - Environmental factors: single bed, soft surface
- The subgaleal haemorrhage likely reflects minor birth-or handling-related trauma with no intracranial haemorrhage and was not contributory to death.
- The postmortem diagnosis of asphyxia can be difficult and there is usually a paucity of features present at autopsy. Taking into account the available history, maternal factors such as sedation and the unsafe environment likely contributed to the death of the infant with accidental mechanical asphyxia by means of overlaying and/or obstruction of the external airways due to a prone position the most likely explanation.

Background

Mother was born in Darwin to parents of mixed but non-Aboriginal heritage. She graduated Year 12 in 2023 and is continuing her study through TAFE. She started dating Father, who is Aboriginal, in 2023.

Pregnancy care

In around November or December 2024 Mother fell pregnant. She saw her GP on 06, 15 and 18 January 2025 and was referred to the Family Planning Clinic.

Mother attended the Family Planning Clinic on 23 January 2025.

Mother saw GPs on 25 February 2025 and 13, 15 (telephone consult) and 19 March 2025.

Mother had an ultrasound on 18 March 2025 which confirmed an intrauterine uncomplicated pregnancy of 16 weeks fetal age. On 21 March 2025 her GP made a Royal Darwin Hospital (RDH) New Antenatal Referral.

On 14 April 2025 Mother had her first appointment with the RDH core midwives. She reported being a non-smoker and drinker and she had a supportive partner and family. The records document further visits with the midwives on 30 April 2025 for an ultrasound, and on 12 and 26 May, 02 and 30 June, and 15 July 2025 for regular pregnancy follow ups and advice. During the course of her care Mother was referred to a dietician for low BMI.

Mother participated in 'Birth Suite Telephone Screens' on 18 April 2025, and on 11, 12 and 25 July 2025.

On 28 July (34 weeks gestation) it was noted that Mother was likely developing pre-eclampsia. A plan was put in place for weekly Dappers (non-invasive medical devices that use high-frequency sound waves to measure blood flow, velocity, and pressure in blood vessels), Amniotic Fluid Index (AFI) scans and cardiotocography monitoring. The plan included an induction at 38 weeks or prior if required.

Pregnancy appointments continued on 06 and 08 August 2025. On 11 August 2025 it was decided to admit Mother as there was "significant facial and pedal oedema today/IUGR (Intrauterine Growth Restriction) baby."

There was no contemporaneously *documented* evidence of safe sleeping education being provided to Mother in any of her pregnancy appointments.

Birth

Mother was 20 years old when she was admitted into RDH on 11 August 2025. Baby was at 37+1 weeks gestation. Labour was induced at 37+2 on 12 August 2025. Following an abnormal CTG, the birth proceeded via emergency Caesarian section. Baby was born at 7.05am on 13 August 2025 with Apgar scores of 9 and 9 and a birthweight of 2240g. Following her birth, Baby experienced hypoglycaemia, hypothermia and jitteriness and these were all managed and resolved.

For pain management Mother received diclofenac, paracetamol and Oxycodone. Oxycodone is a short term opioid analgesic routinely used in combination with paracetamol and anti-inflammatory for post operative / caesarean pain and it may cause drowsiness. On 15 August 2025 Mother received 5mg Oxycodone at 8.12am.

The 'Caesarean Birth Pathway' provides tick-boxes for education to be covered with Mother in the first 24 hours. Numerous tick-boxes addressing feeding were initialed as having been discussed with Mother. However, the tick-box for safe sleeping was not initialed and there was no parent signature next to the statement, 'My midwife has explained to me how my baby can sleep safely and provided me with the safe sleeping brochure from SIDS and Kids.'

As Baby was < 2300gms she was started on a 'Borderline Low Birthweight Baby' Pathway (**Pathway**). According to this Pathway, Baby was not to be admitted to the maternity ward, a midwife was to review positioning and attachment at every feed, there was to be daily review by a lactation consultant or experienced midwife, and Baby was under 4 hourly observations. This Pathway document was initialed on 13 August 2025 at AM, PM and ND; on 14 August at AM and PM; and on 15 August at ND.

Baby was seen by the NICU Registrar on 13 August at 7.15am and 10.45am, on 14 August at 2.54 and 5.20pm, and on 15 August at 1.45pm. The lactation consultant saw Mother and

Baby on 14 August at 9.30am and on 15 August at 3.45pm. As Baby's weight was down by 6.4% and as Baby was small, the lactation consultant explained a 3 hourly breastfeeding and top-up regime to Mother.

The New Born Chart records that all breast feeds were witnessed by a midwife on 13 August. On 14 August there are 15 recorded feeds and 6 of those were unwitnessed. On 15 August there were 4 recorded feeds and two were unwitnessed. On 16 August there was one recorded feed at 2 am which was witnessed.

Hospital care

Although on its face the Pathway indicated Baby should be in NICU, there was input from the Paediatric team and Baby was allowed to stay in ward 6A with Mother.² They were in a typical hospital room for two patients. Mother's bed was hospital issue and single size and Baby had a hospital issued crib. Mother and Baby shared the room with another mother and her newborn for part of their stay but were alone in the room on 15 August 2025.

Mother said she lacked confidence and thought she was annoying the nurses when she pressed the buzzer for assistance. She thought Baby was choking and found it hard to sleep and she also recalled being told her efforts at breast feeding were not "good enough as I was not able to get my baby to latch on."³ However, by 15 August 2025 at 4.30pm and at 7.30pm Mother was breastfeeding Baby in the absence of a midwife, and the records note that "Mother is independent with baby cares."

By 15 August 2025 Mother was considered safe for discharge, but Baby still needed to gain some weight. The plan was for Mother and Baby to be discharged on 16 August 2025, if Baby's weight was sufficient.

The Visitor Guideline⁴ sets the maternity ward visiting hours of 8am-8pm (for partners) and the circumstances when a relative might be approved to stay overnight. Overnight stays must be approved by the Team Leader or CMM and in determining whether to approve an overnight stay they are advised to consider whether:

- There is a single room available.
- The mother has a significant social/emotional or physical risk factor, for example, non-English speaking, traumatic birth, mental health issue, is <18 years old, has had a pregnancy loss, or has an extremely unwell baby in the Special Care Nursery.

On 15 August 2025 at 8pm, Father was asleep in a chair next to Mother's bed. Mother wanted him to stay to support her overnight, but he was directed to leave by Midwife LM as per the Visitor Guideline. According to Midwife LM, when he was told to leave Father was very upset and said, "she can't be left alone with this baby." When Midwife LM asked why he said, "I need to be here for them both." He then reluctantly left.⁵ Mother was upset as she had observed other mother's being permitted to have a family member stay overnight. Mother wanted additional support and she asked whether a *female* family member might be permitted to stay with her, but this was also refused.⁶ There are no contemporaneous records of this request and decision, and the Visitor Guideline contains no requirement for these types of

² Witness Statement RN JP dated 2 May 2026

³ Witness Statement Mother dated 1 May 2026

⁴ Security and Visitor Access to Maternity Units and Suitable Non-Maternity Patient Admissions TEHS Guideline Version 16 (Visitor Guideline)

⁵ Witness Statement Midwife LM dated 22 April 2026

⁶ Witness Statement Mother dated 1 May 2026

requests to be documented. As Mother and Baby were the only occupants of this room, there does not appear to be any compelling reason why Father (or a female family member) could not have been approved to stay.

That evening expressed breastmilk was provided to Baby at 8pm and 11pm. Registered Nurse (RN) and Midwife trainee, JP, recalled sitting with Mother and giving Baby a bottle. As RN JP's shift started at 9pm it is likely she did that at around 11pm. She recalled putting Baby back in the cot.⁷

Registered Midwife KH said that she saw Mother feeding Baby sometime after 10pm. Mother told Midwife KH that she was feeling exhausted and complained of C-section tenderness. Mother debriefed about the birth and "how tough the last couple of days had been." Midwife KH reassured Mother that she was "doing great" and offered breastfeeding support with positioning and technique. Midwife KH also offered Panadol and Diclofenac which were accepted. Midwife KH conducted a set of documented observations on Baby and Mother and said she would be back at 2am for the next set of observations. Midwife KH recalled that Mother buzzed once more during the night for breast feeding support. At around 2:00am on 16 August 2025, Midwife KM documented the next set of observations on Baby who was in the cot next to Mother's bed.⁸

Mother commenced breastfeeding Baby shortly after these observations were completed.⁹

Team Leader SD recalled Mother coming out to the nurses' station at one point with baby.¹⁰

Midwife LM said that Mother was mother-crafting well, though "was very overwhelmed." *Importantly*, she recalled that on one occasion during the early hours of the morning, "I did go into her bay and wake her up because she had [fallen] asleep with baby in her arms. This is a normal occurrence with new mums and not out of the norm. I reminded mum this wasn't safe. She agreed and apologised. I changed baby's nappy and put her back in the cot where she was safe, reducing the risks of SIDS. I can't recall exactly what time I changed her nappy. I'm guessing around 3 or 4 am."¹¹ There is no contemporaneous medical record of this interaction.

Circumstances of Baby passing away

Sometime before 4:30am, and probably during the 2.00am breastfeed, Mother took a SnapChat phone video of herself breastfeeding baby. Baby was lying on the bed between Mother's torso and right arm, and was breast feeding from the right breast.¹²

During this or a later feed Mother believes that she must have nodded off, she thought for only a very short time. When she woke Baby was to Mother's left side and not breathing. She picked Baby up and yelled for help. RN JP entered the room and Mother handed baby to her.

RN JP yelled out "I need help." Baby was very mottled, cold, unconscious and did not have a heartbeat. RN JP immediately commenced CPR.¹³ Another nurse entered and pressed the

⁷ Witness Statement RN JP dated 2 May 2026

⁸ Witness Statement Midwife KH dated 22 April 2026

⁹ ED AGM Case Summary

¹⁰ Witness Statement RN and Team Leader SD dated 14 June 2026

¹¹ Witness Statement Midwife LM dated 22 April 2026

¹² Witness Statement Mother dated 1 May 2026

¹³ Witness Statement RN JP dated 2 May 2026

emergency buzzer and the Code Blue response commenced at 4.39am. A doctor arrived and Baby was taken to the treatment room.

Mother was brought to the treatment room and was asked to call Father.

During the resuscitation attempts 100% oxygen was applied. At 4:40am, anaesthetics attended and a neonatologist was requested. The Paediatric Consultant on call that night arrived 9 minutes later. At 4:47am, Baby was intubated and 3 doses of adrenalin were administered via an endotracheal tube (ETT, which is a flexible, PVC plastic tube inserted through the mouth or nose into the trachea to maintain an open airway). Life-saving efforts were unsuccessful and Baby was declared deceased at 5:03am on 16 August 2025.

Father, his mother, and Mother's sister arrived at RDH and staff told them that Baby had passed away. The family were moved to the Bougainvillea room for privacy. Mother discharged herself from the hospital at 7.30am and went home with her family.

Mother's discharge summary documented that she had received a memory box, the necessary follow up medical supports, and that there was a need for bereavement support. The Discharge Care plan noted a "social work referral for bereavement support." Mother's MFU discharge summary indicated that Mother would be notified for a "debrief appointment" with "the obstetric team at the gynecology clinic."

Domiciliary midwives conducted a thorough clinical visit at Mother's home the next day. They ceased the visit when Mother became distressed and asked them to leave.

The Domiciliary team attempted to contact the Mother on 18, 19 and 20 August 2025. The calls were not answered and Mother did not respond to text messages.

The RDH Social Work team attended on Mother on 21, 22 and 25 August 2025 and provided assistance with bereavement care, funeral arrangements, and appropriate information for the Births, Deaths and Marriages Registry. A referral to Amber NT was offered but declined.

Mother was offered a clinical review and debrief appointment on 13 October 2025 which was rescheduled to 20 October 2025, but Mother did not attend. A further appointment was booked for 30 October 2025, but again Mother did not attend.

It is accepted that Mother was free to choose whether she attended any appointments.

There was no contemporaneously *documented* evidence of safe sleeping education being provided to Mother in any of her hospital records.

Cause of death

The autopsy did not identify any illness, trauma or defect sufficient to explain Baby's death. Where no other sufficient cause of death is identified, consideration is given to the risk factors identified in the child's sleeping arrangements. Enough risk may be identified to conclude that accidental suffocation/ asphyxiation is the likely cause of death.

In this case Baby had lividity over the nose, chin and forehead indicating she was lying prone or had her face against another surface (such as her Mother's body). As she was very young, only 3 days old, and small for gestational age, she was at greater vulnerability of hypoxic events. Based on all the evidence I was satisfied that she passed away from accidental mechanical asphyxia in an unsafe sleeping environment.

Coroner's Constable Investigation

There was a question as to where the cot was the night Baby passed away.

According to Red Nose, positioning at the bottom of the bed (near feet) would be considered poor practice for an immobile patient because the mother cannot reach the infant safely and a foot-of-the-bed position encourages unsafe stretching and twisting. Red Nose suggests that the challenge of reaching a baby at the foot-of-the-bed may result in baby being brought into bed, which becomes a co-sleeping risk. While there is no single national 'one-line rule' about where a bassinet/cot must be positioned for every hospital, there are consistent clinical standards and expectations used across Australian maternity wards as follows:

- Baby must be within immediate reach of a mother who is post-caesarean or immobile or medicated.
- The cot/bassinet should be parallel to the side of the bed and level with the mother's upper body (torso/arms) so the mother can safely lift and settle baby.
- The cot/bassinette should NOT be at the foot of the bed.

Initially Mother thought that the cot *was* at the foot of her bed, but all the midwives said it was on the left side of her bed. Mother now accepts that she was mistaken.

Mother's phone showed that her last phone call on 15 August was to Father at 9:15pm. The next phone call was at 4:37am on 16 August 2025, to her Mother-in-Law. The time that the breastfeeding SnapChat video was taken could not be determined.

On 17 August 2025, Mother assisted police to complete the SUDI Checklist.

Mother had several conversations with the Coroner's Constable and on 1 May 2026 provided a statement. In her statement and conversations Mother reported some of her concerns and distress.

- The first days after the birth she said she had no sleep and was given medication. She thought Baby should have been in NICU Ward until she (Mother) had healed enough.
- She thought Father or her Mother-in-Law should have been permitted to stay with her to provide support.
- She was uncomfortable with the nurse who sent Father away. That nurse was rude to her and seemed frustrated with her. She said Father and his mother (Mother-in-Law) witnessed some of the inappropriate interactions of this nurse. However, Mother did not wish to make a formal complaint as she was too stressed and could not cope. (Another Midwife told the Coroner's Constable that Midwife LM had received similar complaints from other patients.)
- The couple have since separated and Mother said she was being supported by Catholic Care. She said she would like to see a counsellor as she is mentally and physically broken.

When the autopsy report was completed, it was sent to Mother's GP so that it could be explained to her. On 3 March 2026 her GP explained the post-mortem findings to Mother and her accompanying family members.

Father and Mother-in-Law declined the opportunity to provide statements to the Coroner's Constable.

NT Health Policy and Guidelines

Before birth

The NT Health Midwives Antenatal Clinics ASH guideline Version 12 notes, inter alia, that one topic for education during antenatal visits is ‘Sudden Infant Death Syndrome (SIDS) and safe sleeping practices.’ It is not clear whether this Guideline applies at RDH (or whether there is a similar guideline). Assuming this Guideline (or equivalent) applied, the Guideline indicates that this topic should be discussed at the 36-38 week visit. Mother had concerning health issues developing at this stage that no doubt took precedence over other issues. I consider that leaving the discussion of this topic to this late stage of the pregnancy was too little and too late. In this case there was no *documented* evidence that safe sleeping education was provided to Mother during any of her antenatal visits.

After birth

The ‘NT Health Bed-sharing for Parent/Carer and Baby Guideline’ (the **Bed-sharing Guideline**) and the ‘NT Health Safe Sleeping for Infants Guideline’¹⁴ instruct that it is “imperative that staff promote recommended safe sleeping practices, educate parents on risk factors and any risk mitigation strategies.” However, there was no hospital documentation of any such education being given to Mother, even though Baby should have been recognised as at elevated risk of a sleep accident, due to her low for gestational age birthweight.

The co-sleeping on this tragic occasion was not an on-going or deliberate choice by Mother. Instead, it appears that Mother nodded off while breastfeeding. This is a known breastfeeding risk.

The Australian Breastfeeding Association recognises that night feeds can be long “and it’s very common to fall asleep while breast feeding.”¹⁵

Similarly, in 2018 Red Nose conducted a survey of Victorian mothers. Of those in the study, half said they had bed-shared with their baby. Of those who had bed-shared, 77% said that the bed sharing was not planned, instead they had unintentionally fallen asleep with baby.¹⁶

In addition, the Australian Breastfeeding Association¹⁷ recognises that co-sleeping is never safe for babies born early or with a low birth weight.

Similarly, Red Nose makes it clear that sharing a sleep surface is particularly high risk for babies less than 3 months of age, or who are pre-term, or who are born small for gestational age. Red Nose reported on studies that have found that the risk of SUDI is 8-10 times higher for babies under 12 weeks of age when compared to older babies.¹⁸

NT Health has an extensive ‘Breastfeeding Policy’.¹⁹ However, this Policy makes no reference to the risk of a mother falling asleep while breastfeeding or what steps should be taken to mitigate the risk. Further, there is no mention of the higher risk this might create for pre-term and small for gestational age babies.

Similarly, the NT Health Bed-Sharing Guideline provides guidance for when a mother *chooses* to co-sleep. In those circumstances there is an escalation policy (resulting in additional observations and education on safe sleeping and risks). But it provides no guidance

¹⁴ Version 5

¹⁵ Breast Feeding and Co-sleeping, [Breastfeeding and co-sleeping | Australian Breastfeeding Association](#)

¹⁶ Information Statement Sharing a Sleep Surface with Baby p 2 [Red-Nose-response-to-inquest-findings-for-publication.pdf](#)

¹⁷ Breast Feeding and Co-sleeping, [Breastfeeding and co-sleeping | Australian Breastfeeding Association](#)

¹⁸ Information Statement Sharing a Sleep Surface with Baby p 4 [Red-Nose-response-to-inquest-findings-for-publication.pdf](#)

¹⁹ Version 2

which alerts staff to the risks of accidental or unintended co-sleeping or how to mitigate that risk.

RDH conducts an In Depth Case Review (IDCR)

By memorandum dated 25 May 2026, NT Health noted that this incident was given the highest severity rating (ISR 1) and an IDCR was completed to determine systems issues.

The IDCR identified an infrastructure issue at RDH. The maternity ward and NICU are at opposite sides of the building. In NICU there is no space for mothers to room in with baby so when babies are in NICU this increases mother and baby separation. The IDCR reported, “A formal infrastructure gap analysis...identified infrastructure and service delivery gaps within RDH maternity, newborn and NICU services and demonstrated non-compliance with Australian Health Facility Guidelines.” I assume the desirability of keeping Mother and Baby together, which has a better outcome for successful initiation and duration of breastfeeding,²⁰ contributed to the decision to have Mother and Baby in ward 6 instead of having Baby in NICU.

The IDCR concluded that Baby’s death “was associated with a sleeping environment that did not align with safe sleeping.”

The main factors contributing to the death were identified as:

- Baby had an increased vulnerability for SUDI due to multiple recognised factors including young maternal age, small for gestational age, First Nations background, low birth weight, hypothermia, hypoglycaemia, co-sleeping and suspected polycythaemia.
- Baby’s death was associated with a sleeping environment that did not align with safe sleeping principles. System gaps in assessment processes, documentation frameworks, and monitoring mechanisms reduced the capacity for timely identification and management of sleep related risks.

Recommendations included:

- The need to improve clinical documentation during neonatal resuscitation.
- Safety concerns identified in maternity, newborn, and NICU services are to be escalated to and managed by NT Health.

Further recommendations are discussed in the Comments section below.

Comments

As Baby was small, Mother was strongly encouraged to breastfeed on demand, and at least every three hours, and to express for top-ups. This is a grueling, relentless, and exhausting regime for any mother.

Instinctively, Mother and Father knew that she was struggling. They asked Midwife LM whether a family member could stay to provide support overnight and this was refused. Her exhaustion was again raised with Midwife KH, who offered verbal encouragement. Seemingly, neither midwife identified her exhaustion as a *red flag* for accidental co-sleeping

²⁰ NT Health Bed-Sharing for Parent/Carer and Baby Guideline Version 2 p2

and nor did they consider the risks to Baby of an unsafe sleep environment if this were to occur.

Alarmingly, according to Midwife LM, shortly before baby passed away, she found Mother accidentally co-sleeping with Baby when Mother had unintentionally fallen asleep while breastfeeding. Midwife LM addressed the immediate risk by placing Baby back in the cot. However, despite telling Mother about the risk (which may have felt like rousing, given Mother apologised) she took no further steps to ensure any future risk was effectively mitigated. Albeit with the full benefit of hindsight, I consider that Baby should have been removed from Mother's room, to allow Mother to get the sleep she desperately needed.

I am not surprised the midwives did not fully appreciate the risks a mother's exhaustion might pose while breastfeeding. NT Health's Breast Feeding Policy does not expressly address the *known* risk of unintended co-sleeping while breastfeeding and nor does it offer any guidance on how that should be mitigated. Furthermore, while NT Health has policies and guidelines on safe sleeping, the SUDI deaths I have considered demonstrate that compliance, or otherwise, with these policies and procedures is not well documented.

It is time for this to change.

In response to this death the ICDU further recommended that:

- Clinical acuity and care allocation processes be developed to support timely identification, monitoring, escalation and allocation of care for infants meeting or nearing NICU admission criteria to optimise monitoring compliance and maintain neonatal safety outcomes.
- NT Health develop and implement a standardised safe sleep and infant safety risk assessment tool to identify infants at increased sleep-related or safety risk. This is to be completed by nursing and midwifery staff and include escalation requirements for infants identified at higher risk. Higher risk infants should be clearly flagged and included in enhanced care strategies including regular documented rounding and targeted monitoring.

I will make both of these recommendations.

The ICDU also recommended that NT Health develop accurate, relevant and culturally sensitive and appropriate educational materials about infant safe sleeping and safer co-sleeping to be delivered antenatally, intrapartum and in post-natal care. In my view this recommendation could be strengthened by adding a requirement that the provision of education be contemporaneously documented.

I will also recommend that the Breastfeeding Policy (and any related guidelines or training) be reviewed and amended to explicitly address the risk of and mitigation strategies for unintentional / accidental co-sleeping during breastfeeding.

In light of the circumstances of this death, I will also recommend that the Visitor's Policy be reviewed to determine whether there is any room for greater flexibility for overnight family support for mothers who are expressing exhaustion or who are identified as being exhausted, overwhelmed or who are otherwise struggling with the demands of a newborn.

NT Health respond to a draft of these findings

NT Health was provided with a draft of these findings and given an opportunity to offer further information or submissions.

NT Health acknowledged that safe sleeping practices for Baby were not followed and extended its deepest sympathies to Baby's family for this tragic death.

NT Health identified policies and procedures which support the provision of safe sleeping education to mothers. NT Health explained that, through their various engagements with mothers, midwives provide opportunistic education and it is not expected that this will always be documented.

NT Health relies on Red Nose material as the primary written source of SUDI/SIDS, co-sleeping and safe sleeping educational materials and a Red Nose pamphlet is given to all mothers with the birth registration documents. There is also information about safe sleeping in the Yellow Book which is also given to all mothers.

NT Health reminded me of the dedicated and often thankless work undertaken by its midwives and social workers. I acknowledge the critically important public service that they provide.

NT Health indicated that it agreed in principle with the following recommendations.

Recommendations

Recommendation No. 1

I recommend to **NT Health** that it develop and implement clinical acuity and care allocation processes to support the timely identification, monitoring, escalation and allocation of care for infants meeting or nearing NICU admission criteria to optimise monitoring compliance and maintain neonatal safety outcomes.

Recommendation No. 2

I recommend to **NT Health** that it develop and implement a standardised safe sleep and infant safety risk assessment tool to identify infants at increased sleep-related or safety risk. This is to be completed by nursing and midwifery staff and include escalation requirements for infants identified at higher risk. Higher risk infants should be clearly flagged and included in enhanced care strategies including regular documented rounding and targeted monitoring.

Recommendation No. 3

I recommend to **NT Health** that it develop accurate, relevant and culturally sensitive and appropriate educational materials about infant safe sleeping and safer co-sleeping to be delivered antenatally, intrapartum and in post-natal care. The provision of education is to be contemporaneously documented.

Recommendation No. 4

I recommend to **NT Health** that it review and amend the Breastfeeding Policy (and any related guidelines or training) to ensure that it explicitly addresses the risk of and mitigation strategies for unintentional / accidental co-sleeping during breastfeeding.

Recommendation No. 5

I recommend to **NT Health** that it review, and if identified as feasible, amend, the Visitor's Policy to allow for greater flexibility for overnight family support for mothers who are expressing exhaustion or who are identified as being exhausted, overwhelmed or who are otherwise struggling with the demands of a newborn.

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;
- 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; and
- 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.