IN THE CORONERS COURT OF THE NORTHERN TERRITORY

Rel No: A0047/2024

Police No: 24 94994

CORONERS FINDINGS

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

I, Elisabeth Armitage, Coroner, having investigated the death of **a 42 day old Aboriginal female infant** and without holding an inquest, find that she was born on **10 August 2024** and that her **death occurred on 22 September 2024, at Alice Springs 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.

Each of these babies passed away in an unsafe sleep environment. Some were well when they went to bed and some were sick. Red Nose reported on one study which found that babies who co-sleep are much more likely to have their airway covered by bedding for some part of the night (70%) than are babies who are sleeping alone (14%). Head covering by adult bedding makes it more likely that babies will rebreath carbon dioxide (hypercapnia) during sleep. This is an environmental stressor. While some babies may be able to cope with

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

environmental stressors like hypercapnia, a key concept in the research is that babies with underlying vulnerability have less capacity to deal with such stressors.[2]

Relying on available statistics, Red Nose reports that over 50% of all SUDI deaths involve shared surface sleeping. The risk is particularly pronounced for babies under 3 months of age. Other risks include baby sleeping between two people, tobacco exposure, soft bedding/covers/pillows, and intoxicated/fatigued care givers (adult co-sleepers). Across jurisdictions, Aboriginal and Torres Strait Islander babies remain significantly over-represented. For example, in NSW where the Aboriginal population is 6%, 24% of SUDI deaths involve Aboriginal babies.[3]

Tragically, these findings concern another SUDI death of a 42 day old Aboriginal female in Alice Springs. Mother was just 21 years old. She was known to be a good mother who was attentive to her Infants' needs. One week before Infant passed away, Mother and Infant were exited from supported housing into effective homelessness.

That Mother would be homeless was not a secret. She was well known to various agencies. However, no solution was found, and no safe sleep space for Infant was provided. And so, Mother and Infant moved into overcrowded housing. They were sleeping together on a single mattress on the loungeroom floor. It was in this unsafe sleeping environment that Infant passed away just 7 days later.

Throughout Infant's short life, she brought much happiness to her Mother and close family. Her passing is devastating for those who loved her and supported her.

Cause of death

1(a)	Disease or condition leading directly to death:	**Sudden and unexpected death in an Infant (SUDI) in an unsafe sleeping environment**

Following an autopsy on 25 September 2024, 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 fullpost-mortem examination including ancillary investigations.
- This was the sudden death of a 6-week-old Infant who reportedly went to sleep in a co-sleeping arrangement on the same mattress as the mother and was found by mother not breathing in the morning with some blood in the mouth. A maternal history of previous multiple miscarriages as a teenager and a current smoking history of smoking cannabis as recent as the night prior to the Infant passing. At birth, the Infant was hospitalised for transient tachypnea of a newborn (TTN) of an unknown aetiology. No reported chronic medical conditions or structural abnormalities.

[2] Red Nose Information Statement Sharing a Sleep Surface with a baby, Red-Nose-response-to-inquest-findings-for-publication.pdf
[3] Red Nose Information Statement Sharing a Sleep Surface with a baby, Red-Nose-response-to-inquest-findings-for-publication.pdf

- At autopsy, petechial haemorrhages of the heart, lungs and thymus were present. Structural abnormalities were not present at autopsy. Minor small healing abrasions were present on the face which were not considered significant. Post-mortem lividity was predominantly present on the right side of the thorax and the back with sparing of the left arm was present. A positive left lung swab for Pneumocystis jirovecii, DNA was present. Histology was non-specific and non-contributory to the cause of death and no respiratory tract infection was evident.
- The isolated finding of Pneumocystis jirovecii in the lung swab suggests either contamination or a subclinical colonization, rather than active infection because histopathology showed no evidence of pneumonitis or other signs of infection. While Pneumocystis jirovecii infection is rare in immunocompetent hosts, and its presence warrants consideration of potential immunodeficiency in the Infant or maternal-fetal transfer of colonisation. The finding of Pneumocystis jirovecii in the lung should be regarded as incidental as there was no further evidence of immunodeficiency or active infection.
- The triple risk model (critical period of development/1st year of life, the vulnerable Infant and exogenous stressors) proposed in 1994 by Filiano and Kinney is one of the most accepted models for sudden Infant deaths and proposes that these deaths are not due to a single common pathway but due to interrelated and overlapping factors.
- The maternal history of four previous miscarriages suggests a history of potential maternal health or environmental factors influencing pregnancy outcomes. The history of TTN may indicate underlying respiratory immaturity or susceptibility to hypoxia, though not evident in autopsy findings. The absence of cannabis in Infant toxicology does not negate the role of cannabis in this scenario, as it could have influenced maternal sleep patterns and decision-making the night prior. Substance use is associated with increased risk of unsafe sleep behaviours and may have impaired judgement or responsiveness. A co-sleeping arrangement is a well-established risk factor for Sudden Unexpected Death in Infancy (SUDI) particularly when combined with substance use.
- Petechial haemorrhage of the heart, lungs and thymus are non-specific signs but can be seen in cases of sudden Infant deaths. The "starry sky" thymus reflects increased cortical activity, often linked to acute stress or sudden death. The prone or compromised sleeping position during co- sleeping may lead to airway obstruction or impaired ventilation. Maternal cannabis use exacerbates the risk by impairing arousal and increasing the likelihood of overlay or positional asphyxia.
- **Accidental asphyxia cannot be excluded in this case where there the young Infant died in an unsafe sleeping environment (co-sleeping and maternal cannabis use).**
- Post- mortem genetic screening could be considered given the history of multiple miscarriages and no confirmation of a specific cause of death in this case.

References:

1. A.G. Howatson. The autopsy for sudden unexpected death in infancy, Current Diagnostic Pathology, Volume 12, Issue 3, 2006, Pages 173-183, ISSN 0968-6053, https:// doi.org/10.1016/j.cdip.2006.03.008.
2. Bandoli, G., Baer, R. **J.,** Owen, M., Kiernan, E., Jelliffe-Pawlowski, L., Kingsmore, S., & Chambers, C. D. (2021). Maternal, Infant, and environmental risk factors for sudden unexpected Infant deaths: results from a large, administrative cohort. The Journal of Maternal-Fetal & Neonatal Medicine,35(25),8998-9005.https://doi.org/10.1080/14767058.2021.2008899.
3. Spinelli J, Collins-Praino L, Van Den Heuvel C, Byard RW. Evolution and significance of the triple risk model in sudden Infant death syndrome. J Paediatr Child Health. 2017 Feb;53(2):112-115. doi: 10.1111/jpc.13429. Epub 2016 Dec 28. PMID: 28028890.

Relevant medical care before the pregnancy with Infant

Whilst not an exhaustive review, Mother's medical records reveal the following medical history.

Mother's available Alice Springs Hospital (**ASH**) records commence in 2015 when she attended ASH Emergency Department (**ED**) with tonsillitis. She was 12 years old. She sporadically attended ED thereafter for various childhood and general illnesses.

Between 2021 and 2023 the medical records document a history of complex trauma, suicidal ideation and some suicide attempts, and assessments by the Crisis Assessment and Treatment Team (**CATT**). There were reports of assaults by a brother and feeling unsafe at her father's house.

Antenatal/pregnancy care

On 10 January 2024 Mother attended Alukura Midwifery Group Practice (**Alukura**) and her pregnancy to her recent ex-partner was confirmed.

On 17 January 2024 Mother was assaulted by her brother and his partner (**sister in law**). She was pushed to the ground, punched in the face and her abdomen was stood on. Police attended and she was taken to ASH ED. She was very upset and scratches and bruising were documented. With the assistance of the ASH Social Worker (**HSW)** she was discharged to Woman's Safety Services of Central Australia (**WoSSCA**).

On 28 January 2024 Mother spent a couple of nights in hospital with abdominal pain.

Mother attended Alukura on 2 February 2024. Mother reported depression and smoking and issues with her family. Her father and stepmother were reported as not supportive, and her brother and his partner were "*aggressive and attack her.*" She reported being homeless and staying at a woman's shelter and she was "*too scared*" to go back home to get her Sertraline. She was given information about Alukura/My Midwives care.

WoSSCA referred her to Ampe Akweke House (**AAH**) and Mother entered the Mums and Bubs program.

By 12 February 2024 she had consented to Alukura/My Midwives care and was living at AAH.

On 15 April 2024 Mother called Midwife EM distressed about Centrelink payments. Referrals were made.

On 1 March 2024, Midwife AK visited Mother at AAH. They discussed her health and wellbeing. She was aware she could access a psychologist at Alukura.

On 6 March 2024 she reported being back on Sertraline 50mg and feeling better but her affect was noted to be flat.

On 10 March 2024 she sent a text to Midwife BM reporting back pain and was advised to attend ED (which she did) and she was informed she would be handed over to a new midwife, AK.

Midwife AK visited Mother on 17 March 2024. Her health was discussed, reminders given and Mother said she had been visiting her father's house.

On 23 March 2024 Mother re-attended ASH ED with back, hip and leg pain.

Further follow ups by Midwives from Alukura occurred at AAH: on 2 April 2024; on 9 April when Mother expressed joy that she would be having a baby girl and over her new baby sister; on 8 May when Mother reported spending a lot of time at her father's house visiting her new baby sister, when baby health was discussed and Mother reported cutting down smoking to once or twice a week and gunja a 'few times a week'. On 16 May she was picked up for a 'GTT labour birth discussion' and reported morning sickness; on 19 May she reported having had the flu but was feeling better, she was struggling with iron tablets and requested an infusion which was booked.

On 5 May 2024 Mother had an ultrasound.

On 13 May 2024 Mother called Midwife AK distressed, tired, and overwhelmed. She was supported and reported feeling better later that day.

On 19 May 2024 Mother had a short hospital visit for nausea.

On 29 May 2924, the AAH Manager sent an email to Alukura/My Midwives advising that AAH would not drop off or pick up Mother from her father's home.

On 30 May 2024 Mother received an iron infusion but appeared flat. AAH staff reported to Midwife TP that they wished to speak to Mother about being out all night, sleeping all day, not interacting, and having altercations with her father. A Family Safety Worker was also present and "*tried to chat but did not get much from Mother*."

On 15 June 2024 Mother discussed who would support her during the birth and visited the birth suite. Mother told Midwife AK that she was "*3rd in line for youth housing placement*", she did not know how long it would take and "*FPP & AAH were facilitating.*" It is noted that Mother seemed excited about having her own space. She reported trying to reduce 'smokes' and alternatives and AOD were discussed. Mother did not disclose her frequency of gunja use.

On 23 June 2024 Mother said that her smoking was down to once per week, concerns were discussed and health checks completed. Mother reported being on her "*last chance*" from AAH and an updated safety plan was noted. She attended for a maternity short stay assessment at ASH for abdominal pain.

Having experienced some 'spotting' Mother declined a cervix examination on 26 June 2024.

On 3 July 2024 there was a case meeting with Midwife AK, Mother, and AAH staff (the Manager and a Case Worker) and labour was discussed. By 31 July 2024 she met Midwife AK at Alukura and reported "*feeing over it*" and ready for the baby to come. Mother had met a psychologist at Headspace and felt comfortable with her. She reported having one chance

left at AAH after being out past curfew, not engaging with activities and not keeping her room tidy.

On 8 July 2024 she had a short hospital stay (approx. 2 hours) for body aches, sore throat, and fever.

On 9 July 2024, the AAH Case Worker phoned Midwife AK and reported that Mother had been out all night and there were concerns for her mental health. The AAH safety plan was emailed to Alukura.

On 26 July 2024 Midwife AK recorded "*last chance to meet requirements of AAH.*"

On 1 August 2024 Mother met midwife AK at Alukura having just had a Headspace appointment and was pleased to hear her baby's heart rate and to learn baby was in a good position. On 5 August 2024 records note that Mother was out overnight. On 7 August 2024 privacy, consent and care planning were discussed.

I found nothing in the Alukura records which documented any safe sleep education being given to Mother before the birth of Infant.

Birth

Mother entered hospital on 9 August 2024 under the care of Alukura midwives and gave birth by a spontaneous vaginal delivery on 10 August 2024 at 3.56am. Infant was born at 38 weeks 4 days gestation and her birth weight was 3020 grams. Midwife AK was present and assisted with the birth.

Infant experienced some respiratory distress (transient tachypnoea of newborn) and jaundice and was in the special care nursery in an incubator on "*high flow.*" Infant improved and was considered "*well from day 3*" and was in an "*open cot.*" Infant was breastfeeding on demand.

A midwife completed the ASH Vaginal Birth Clinical Pathway record and initialized a tick-a-box section on parent education which included the topic SIDs prevention strategies and safe sleeping. Initials were also placed next to the topic 'Education about safe sleeping' on 10 and 11 August 2024.

These tick-a-box initials are the best, and only, documented evidence of safe sleep education being provided to Mother.

Postnatal care

On 14 August 2024, during her discharge process from ASH, Mother told a hospital social worker (**HSW**) she did not need further help from them and would follow up with Alukura. Infant and Mother returned to AAH House.

Midwife ES notes that Alukura had not received discharge information from ASH. An SMS was sent to Mother who replied by text and a visit was arranged for the following day.

Mother and baby were visited by Midwives on 16, 19, 20, 22 and 28 August. Infant was well and nil concerns were noted with baby. Mother's pain care and breastfeeding were discussed.

On 30 August 2024, the AAH Manager phoned Midwife AK to report that "*Mother has breached program rules - curfew, unsafe restraint of child in car, visiting unsafe places. Has been given 2 weeks to find alternative accommodation.*"

On 4 September 2024 Midwife ES recorded that "*Mother butting heads with Manager at supported accommodation. Mother aware she has no other option for accommodation and therefore needs to make this work by working with the staff."* On 5 September 2024 Midwife ES recorded, "*States trying to get babe used to the bottle so she can have a girl's night out. Discussed alcohol and cannabis in breastmilk. Given written info sheets."*

On 15 September 2024 Midwife AK recorded:

> *"Met out the front of AAH by support worker. Informed of incident just prior where Mother became upset and escalated to verbal aggression. Likely linked to lacking adequate sleep overnight and stress of upcoming exit from AAH tomorrow as planned 2-3wks prior.*
> *Mother met in her room with baby Infant. Engaged in discussion around concerns while looking at phone, no eye contact, engaging with Infant well. Discussed plans and options, becoming tearful, anger towards AAH management. Offered MSW attend AAH for external support during ?meeting/discussion tomorrow around exit and options with an aim to encourage Mother to engage in calm conversation and negotiate. Mother consented to this - email sent to MSW TL, AMGP Mgr, copied in ANFFP nurse home visitor and social worker well known to Mother."*

I found nothing in the post-natal care records to indicate that safe sleep education had been provided to Mother by Alukura.

Ampe Akweke House (AAH)

Ampe Akweke means small babies in the Arrernte Language of Central Australia. AAH is a five bedroom house which provides a transitional accommodation service for young women (14-21yrs) who are pregnant or with their first baby and have nowhere safe or appropriate to stay. AAH House provides a support program for young mums and mums to be that assists new mothers to develop independent living skills. The program and house are run by Alice Springs Youth Accommodation and Support Services (**ASYASS**).

Upon entry into the program in February 2024 Mother signed a document agreeing to the conditions of stay for the program. ASYASS records show that Mother was taking prescribed medication being Sertraline 50mg for Anxiety/Depression/PTSD, when she entered the program.

Staff held concerns for Mother due to her lack of engagement with the AAH program both before and after the birth of Infant. Due to her lack of engagement and concerns about domestic violence related incidents with her father throughout her time in the program, safety plans were put in place for Mother. As it was identified that her father's residence was not a safe place for her to visit, the safety plans specified that staff were not to drop off or collect Mother from her father's address. The safety plans also specified curfew conditions to address Mother staying off site, missing medication, not engaging with the program, lying and 'escalating.' These safety plans were shared with Alukura.

Throughout Mother's pregnancy there were multiple occasions when she did not follow the house rules, curfews and safety plans and she was "*given another chance"* to stay in the program. She received warnings about not following the rules on 3 June 2024, and on 9 and 10 July 2024.

On 22 July 2024 Mother was at AAH and reported that she needed to go to the hospital because her brother had stabbed himself in the neck. She said that he was 'sectioned' and her stepmother came and collected her to ostensibly take her to ED where family had gathered.

However, on 23 July 2024 Mother denied that her brother had been in hospital and said he was out bush. Because her story changed, and after some collateral checks were made, staff at AAH thought Mother was lying to them about this event.

After Infant was born safety concerns were documented in the AAH records.

On several occasions staff observed Infant being transported in family cars in the arms of family and not in a capsule. These are recorded on:

- 14 August 2024 - when Mother and Infant were discharged from hospital, they were driven back to AAH by her brother in a car without a capsule. AAH staff saw Infant in Mother's arms in the car.
- 20 August 2024 - Infant returned to AAH in the arms of her grandmother in the front seat of a car.
- 21 August 2024 – Infant was observed in the arms of her grandmother in the front seat of car when it arrived at AAH.
- 25 August 2024 - Infant was in Mother's arms in the front seat of a car when the car pulled up and in the same position shortly after when the car left AAH. When the car returned later, Infant was again in Mother's arms. When asked why Infant was not in a capsule, Mother said that it was hard to get a capsule, but she also said that she did not need help.
- 26 August 2024 – there were two observations of car travel by Infant not in a capsule.
- 28 August 2024 - Mother and Infant were collected by the Mother's father and they drove off with Mother holding Infant in her arms and later returned to collect food in the same manner.

Concerns were documented about Mother using a stroller for Infant without a harness on 21 August 2024.

Mother engaged with Headspace for support prior to Infant's birth, however, AAH staff were concerned that she cancelled appointments after the birth.

Of relevance to these findings, the AAH records also document:

- that Mother smoked regularly after Infant was born; and
- instances of apparent co-sleeping on -

  16 August 2024 – Mother is recorded as sleeping with her back towards Infant,
  25 August 2024 – Mother was sleeping in bed with Infant,
  26 August 2024 – Mother was sleeping in bed with Infant.

There was nothing in the AAH records to indicate that any safe sleeping education had been provided to Mother.

Mother and Infant are required to leave AAH

Mother's continued breaches of AAH rules resulted in her being exited from AAH with two weeks' notice being given on 30 August 2024.

This was communicated to Alukura/My Midwives and the Department of Children and Families (**the Department**) orally and a comprehensive summation of the reasons for

Mother's exit decision was sent by the Senior Program Manager ASYASS/AAH to Alukura/My Midwives and the Department on 11 September 2024.

By email of 10 September 2024, the Congress Family Partnership Program indicated it would endeavour to support Mother to find secure and safe accommodation.

Also on 10 September 2024, a Departmental Care and Protection Practitioner (**CPP**), circulated an email that Mother wanted to live with her father who was due to move into a new three bedroom unit on 16 September and, "*TFHC will follow up and safety plan with [Mother's Father] and Mother to ensure there is a plan for this arrangement*."

On 15 September Mother was upset and had a long talk with an ASYASS worker. She said she had nowhere to go and was scared Infant would be "*taken off her.*" She said there was no room for her to live with family, and she did not believe her father would get his own place.

On 16 September 2024, Mother was assisted by her midwife and a Congress Social Worker to vacate the premises and take her belongings.

Unit, a property of Alice Springs Youth Accommodation Support Services (**ASYASS**).

This Unit is managed by ASYASS.

This Unit was allocated to Mother's **sister in law** (an ex AAH client) and her **partner**, Mother's **brother**, in about December of 2023. It was this couple that Mother had reported were "*aggressive and attack her*" on 2 February 2024, causing her to seek refuge at WoSSCA and then to reside at AAH.

In February of 2024 ASYASS were notified that this couple (sister in law and brother) had separated and brother's rent payments were cancelled. Sister in law remained at the address and was receiving support from the Youth Housing Program (**YHP**).

On 1 July 2024 ASYASS workers saw a broken window at the property and sister in law claimed that she had leaned against it and it broke. Inconsistently with that explanation, sister in law also said, "*the cops were called to board it up*." Later, on 4 July 2024, a different explanation was provided. Sister in law said that brother had come home intoxicated and smashed the window.

On 8 July 2024, a Central Intake Team (**CIT**) report was made to the Department about the couple due to *"high concerns of children and their safety"* and a police welfare check was requested.

On 1 August 2024 ASYSS records indicate that brother had been arrested for Domestic and Family Violence (**DFV**).

On 4 September 2024 concerns about overcrowding at Unit were documented.

On 6 September 2024, brother struck his partner, sister in law, with a toy guitar and threatened her with a 30cm kitchen knife.

On 8 September 2024 brother and sister in law argued about a Facebook post and he threatened her with a 7 kg dumbbell and scissors, punched her several times, choked her, and threatened the children. Sister in law received bruising and a 2 cm laceration on her thigh and smaller lacerations on her hand and lip.

Brother was arrested at 3.47pm on 8 September 2024 (for both the 6 and 8 September incidents). On 10 June 2025 he was sentenced to 10 months imprisonment, backdated and suspended on the same day under the supervision of Probation and Parole.

Mother's father was seen at the Unit on 8 and 9 September 2024 and a dog was also identified at the Unit. It was suspected that Mother's father and other family were staying at the Unit.

A home visit was conducted on 11 September 2024 by a Youth Housing Officer (**YHO**) and ASYASS Program Manager. They spoke to sister in law. Overcrowding, and that there was a puppy at the Unit, were discussed. Mother's father and his partner and their two children were noted to be residing there. Sister in law said Mother's father and his family were waiting for a house. The ASYASS staff concluded that there were 4 adults and 4 children at the Unit and sister in law was 'breached' for overcrowding. These concerns about overcrowding at Unit were reported to the Department on the same day.

Reports to the Department of Children and Families (then Territory Families) (the Department)

Mother was known to the Department of Children and Families (**the Department**). She had been brought into the care of the CEO for short periods of time on four occasions: twice in 2004, and once each in 2008 and 2011.

Between January 2024 and September 2024, the Department received six notifications about Infant. Two were recommended for Further Inquiry (**FI**) and one progressed to a Child Protection Investigation (**CPI**).

On 18 January 2024, the Department received a notification that Mother was experiencing domestic and family violence (**DFV**). The Department was advised that WoSSCA had previously assisted Mother to move to Queensland following DFV perpetrated by her father. Mother was now 9 weeks pregnant and had been assaulted by her brother and his partner (sister in law). Police were involved and Mother was hospitalised. A bed was available for her at WoSSCA after hospital. In response, the Central Intake Team (**CIT**) made an unborn baby alert to NT Health requesting NT Health to notify the Department when Mother's baby was born, so it could assess whether any Departmental intervention was required.

On 22-23 July 2024, the Department was notified that Mother was 36 weeks pregnant and was staying out past curfew at AAH, in the company of an unsafe person (Mother's father) and was using gunja daily. It was reported that Mother's father supplied her with cannabis and that a brother had attempted suicide. It was reported that Mother was sleeping all day and was out all night. The Department opened an FI to establish if there were risks to the unborn baby.

On 4 August 2024, the Senior Program Manager ASYASS/AAH made a report of concern for the unborn baby to the Department.

On 10 August 2024, the Department was notified of the birth of Infant. It was reported that Mother's father perpetrated violence, the father of the baby had returned overseas, and Mother and Infant had accommodation at AAH. Follow up was to be conducted in the FI case.

On 13 August 2024, an Aboriginal Community Worker (**ACW**) saw Mother and Infant in hospital. Mother said that now she had the baby she would stop using marijuana and would stop visiting her father. She said she was supported by her cousin-sister and a friend. She was said to be engaged with Headspace and the Australian Nurse Family Partnership Program (**ANFPP**) delivered by Congress. Mother was noted to be attentive to Infant.

On 14 August 2024, the Department was notified of Mother and Infant's discharge from hospital. It was reported that she had left in a car driven by her brother without a proper baby restraint and there were worries that Mother's gunja use was "*reducing her capacity as a mother."* These concerns were to be addressed in the open FI.

On 21 August 2024, the Department was notified about further instances of Infant travelling in cars without a baby restraint, being pushed unrestrained in a stroller and Mother taking Infant to Mother's father's place which was deemed an unsafe place. This report was progressed to a CPI with a 3 day response timeframe.

On 5 September 2024, a Departmental Care and Protection Practitioner (**CPP**) and the ACW met Mother and Infant at AAH. The CPP provided advice on appropriate car restraints and Mother said she would buy one. It was noted that Mother had an age appropriate pram for Infant. Mother "*appeared high during the conversation (red eyes, droopy eyelids)"* but signed a safety plan.

On 9 September 2024, the ANFPP social worker contacted the CPP to advise that Mother had been given two weeks' notice to leave AAH for breaches of conditions, and no other accommodation had been identified. Apparently, Mother wanted to live with her father who was said to be receiving larger accommodation, but this was not considered appropriate given he was the perpetrator of DFV and because his accommodation was already full (with 2 adults and 4 children already on the tenancy).

On 10 September 2024, the AAH Program Manager confirmed Mother's breaches and made it clear to the CPP that Mother and Infant could no longer stay in the service. She reported "*as of 16 September 2024 [Mother] will be exited from the program due to repeated non-compliance with the conditions of stay and failure to adhere to safety plans, escalating risk-taking behaviours that have posed a consistent risk to herself, her baby and the ASYASS staff."* The unacceptable behaviours included returning after curfew or staying out overnight, lying, and not engaging with staff and programs which was not fair on the other mums who were following the rules. It was also noted that Mother was attentive to Infant who was gaining weight.

On 12 September 2024, the FI was closed because the CPI was open. A CAAC Family Partnership Home Visitor, sent an email to the CPP requesting an urgent meeting over concerns that Mother and Infant were visiting/staying with Mother's father who was a DFV perpetrator and in an "*overcrowded environment."* It is reported that *"moving into the new unit with her father and his family is only being considered as a very temporary option due to her having absolutely no other choice except homelessness"* and Mother is concerned that *"her newborn will be witness to the same trauma and violence that Mother has experienced with her volatile family"* and *"I am looking forward to working with you to find a safer solution."* In a follow up phone call the ANFPP social worker reported that Mother was significantly depressed, Mother's father was "*a dangerous person and not a suitable care giver*."

On 13 September 2024, the CPP and ACW visited Mother's father outside his house. He confirmed that Mother and Infant could stay with him and told the CPP that there was no fighting. Having reviewed a draft of these findings, The Department concedes that "it was not good enough to accept the claim from Infant's maternal grandfather that there was 'no fighting.' Strengthening of safety planning with known perpetrators would have been helpful at this stage."

On 13 September 2024, the CPP and ACW also visited Mother and Infant at AAH. It was noted that Mother appeared sober and was attentive to Infant's needs. Mother said:

a) her relationship with her father had improved, he was medicated for schizophrenia and now rarely drank;

b) she was on a wait list for housing, she did not want to live in supported accommodation, and she could not live with her cousin sister T because her partner was in goal and he was not a safe person;

c) her brother was in goal and her relationship with sister in law had improved;

d) she wanted a medical appointment;

e) she wanted to move to formula so she could leave Infant with her stepmother when she wanted to go out partying and the CPP "*acknowledged that this is a really good plan for when [Mother] wants to drink or party, just to always ensure [Infant] is with a safe and sober adult."*

On 16 September 2024, the day Mother and Infant left AAH, the CPP knew that the father's larger house had not yet been allocated and in any event would be overcrowded. The CPP made calls attempting to find accommodation for Mother and Infant. She tried: Stuart Lodge, NT Shelter, WoSSCA, Topsy Smith Hostel, Akangkenty Hostel, Apmere Mwerre Visitor Park, and Ayiparinya Hostel; all without success.

The matter was escalated to the Department's Director Urban who in turn escalated it to the Director Urban Housing. Ultimately, the CPP said that as the Department was not taking Infant into care, there was no funding for accommodation in the circumstances.

The Departmental records do not document where Mother and Infant stayed after this call.

Mother and Infant stay at Unit

After leaving AAH Mother and Infant did stay at the ASYASS Unit, a two bedroom dwelling.

According to Mother, the following persons were residing at the property: Bedroom 1 – sister in law and her two children aged 9 months and 3 years; Bedroom 2 – Mother's father and his partner and their baby aged 5 months; Living room lounge – Mother's 7 year brother; Living room floor - Mother and Infant on a single mattress next to the front door. With 9 residents the unit was very overcrowded.

(There is also some evidence that another person was also staying. She is seen on the body worn video of a Police Officer and her name is recorded in his notebook. If she was there, that makes 10 residents.)

Infant passes away

During the afternoon of 21 September 2024 Mother smoked some cannabis.

Mother said that Infant was well when she was put to bed that evening on a single mattress on the floor of the loungeroom.

On 22 September 2024, around 3am, Mother breastfed Infant for about half an hour before they both went back to sleep on the single mattress. Infant was dressed in a jumpsuit, wrapped in a blanket, and placed on her back, closest to the wall.

Around 7:20am, Mother woke and noticed that Infant was limp, cold to touch and had some blood coming from her mouth. Mother called out to other family members for help including her father, his partner, and sister in law.

Sister in law contacted 000 at 7.22am on Sunday 22 September 2024 requesting urgent help. The phone was then handed to Mother, and instructions were given by the call taker on how to check Infant's airways and commence CPR.

Police arrived at approximately 7:30am, and St John Ambulance (**SJA**) arrived soon after. Infant was in Mother's arms and CPR was not in progress at the time of their arrival. Paramedics immediately commenced medical treatment on the floor of the unit, while Police dealt with the distraught family members.

Medical treatment continued as Infant was transported by SJA with Mother to ASH. ASH were advised of their approach and prepared for their arrival.

They arrived at ASH around 7:58am with CPR still in progress. ASH Doctors noted that Infant's pupils were fixed and dilated bilaterally, Infant was grey in colour, and a rhythm check demonstrated no cardiac activity. Medical intervention continued. However, following a collaborative medical team decision, Infant was declared deceased at 8:11am.

Support provided to Mother after Infant's passing

On 22 September 2024 ASYASS staff learned that Infant had passed away.

On 23 September 2024, the Department received reports that Infant had passed away and learned that Mother and Infant had been staying at Unit on a mattress in the lounge room.

On 22 September 2024 Mother phoned Midwife AK. Mother was crying and quiet as she spoke of Infant's passing. Mother said that she was staying with her sister in law and accepted the offer of a visit the next day.

Midwife AK visited Mother on 23 September 2024 at the Unit. Mother accepted hugs and words of support. Practical advice was given.

On 24 September 2024 Mother attended Alukura and saw Midwife AK. Grief, lactation suppression, mastitis, and contraception were discussed. Headspace information was provided. A GP appointment and medical check were offered but declined. A viewing of baby at the morgue was explained, including that Mother would not be able to touch Infant until after the forensic examination was completed.

Midwife AK visited Mother again on 25 September, and on 26 September assisted her with a viewing at the morgue. A second viewing was requested which was denied. The Mortuary Technician said only one viewing was permitted.

Midwife AK visited Mother at a new address on 6 October 2024 and provided ongoing medical care and support.

The coronial investigation

Police were at Unit when Infant and Mother left in the ambulance. Although they remained at the Unit, the scene was not formally secured until Infant was declared deceased. At that time, a crime scene was declared and was processed by the Southern Crime Scene Examination

Unit and Detectives from Serious Crime, in consultation with Forensic Pathologist Dr Salona Roopan.

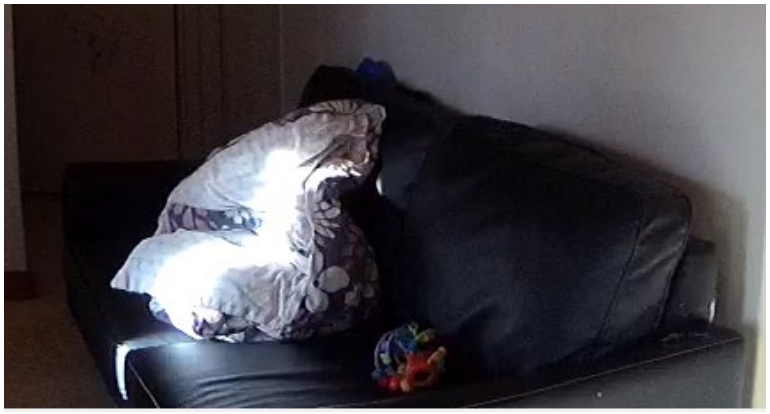
The NT Police Sudden Child or Infant Death Checklist was completed and recorded that the Infant was sleeping on single mattress in the front loungeroom with the mother. No other bedding materials were documented. This was partly inaccurate.

When police first attended the scene, there was a floral doona (or similar) on the single mattress which was subsequently moved by one of the household occupants. This is recorded on attending police officers' body worn video (**BWV**).

Stills from the BWVs are extracted below.

A soft floral doona type cover can be seen on the single mattress (behind the legs of another attending police officer).

That bedding is then removed from the mattress and placed on the lounge.



The single mattress was in the lounge room next to the front door and Mother said Infant slept closest to the wall.

During the scene examination a bong was found in the loungeroom consistent with Mother's admission of consuming gunja.

Multiple attempts were made to obtain a statement from sister in law, without success.

Autopsy

Following an autopsy, the Forensic Pathologist found no illness, trauma, or defect as a cause of death. However, she did find that there was an unsafe sleeping environment (co-sleeping and maternal cannabis use) and was of the opinion that given that sleeping environment accidental mechanical asphyxia/fatal sleep accident could not be excluded. I note that the Forensic Pathologist did not seem to be aware of the doona on the single mattress or the history of maternal cigarette smoking.

SUDI, SIDS, co-sleeping and the research of RW Byard and the "Triple Risk Model"

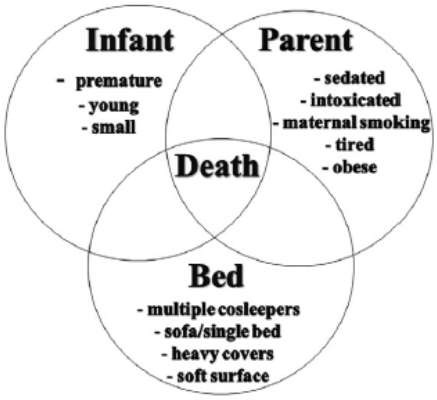
Sudden unexpected death in infancy (SUDI) is a broad term used to describe the sudden and unexpected death of an Infant for which the cause is not obvious. An autopsy will be conducted in an attempt to find the cause of death or to exclude possible causes. Where no sufficient cause (illness, trauma or defect) is found, a forensic pathologist will consider the environment in which the death occurred. Following these investigations, where no other sufficient cause of death is identified, some deaths may be explained by risk factors identified in the child's sleeping arrangements. When all other sufficient causes of death have been excluded, enough risk may be identified in the sleeping arrangements to conclude accidental suffocation/asphyxiation as the likely cause of death.[4]

A subset of SUDI is Sudden Infant Death Syndrome (SIDS). This is the sudden unexpected death of an Infant (<1year 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.

Co-sleeping is common. According to the Australian Breastfeeding Association, 75% of all babies spend at least some time sharing the parent's bed in the first three months of life,

4 Byard RW, Is co-sleeping in infancy a desirable or dangerous practice?, J. Paediatr.Child Health 1994; 30

including unplanned sharing (for example, when the carer unintentionally falls asleep with baby).[5] However, the Australian Breastfeeding Association makes it clear in its advice that shared sleep environments "increase the risk of SUDI for a baby" and that "adult beds were not designed with Infant sleep safety in mind and may contain hazards for babies." [6]
In the *Inquests into the Deaths of Baby K, Baby B, and Baby S* [2026] NTCC 06 the risks of unsafe and co-sleeping were considered in detail. I heard evidence from Professor Roger Byard who has been researching and publishing on the risks of co-sleeping since 1994.[7] 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.[8] 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:[9]



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 also increase the risk. Features of parents which increase the risk include obesity, sedation, fatigue, intoxication, maternal smoking, and multiple co-sharers.

Cause of death

5 Australian Breastfeeding Association, Bed-sharing and your baby: the facts; see also Common Brief 1.5 SUDI and the practice of co-sleeping/bed sharing in the NT

6 Australian Breast Feeding Association – Bed-sharing your baby: the facts, June 2021, aba.asn.au/bed-sharing

7 Byard RW, Is co-sleeping in infancy a desirable or dangerous practice?, J. Paediatr. Child Health 1994; 30

8 Inquest into the deaths of Baby K, Baby B and Baby S [2026] NTCC 06 - evidence of Professor Byard on 17 July 2025 at 278

9 Byard RW, The Triple Risk Model for Shared Sleeping, J. Paediatr. Child Health 48 [2012] p947-948; although not considered in these inquests it is also known that bottle fed babies are at greater risk when co-sleeping because mothers who bottle feed do not demonstrate the same responsiveness at night as breastfeeding mothers - see Inquest into the deaths of *Baby K, Baby B and Baby S* [2026] NTCC 06 Common brief 1.5 SAF,T, SUDI and the practice of Co-Sleeping/Bed Sharing in the NT which references the research of Professor James J. McKenna

In the absence of any identified illness, trauma or defect sufficient to explain the death of Infant, and consistent with the approach taken by the Forensic Pathologist, it is appropriate to consider the sleeping environment as potentially contributing to the death.

Applying the triple risk model the following risks can be identified in Infant's sleeping environment:

- Infant – young (42 days old)
- Parental – maternal cigarette and cannabis smoking
- Bed – co-sleeping, single size mattress, soft mattress, large doona

Noting all the evidence, I am satisfied this was a SUDI death in an unsafe sleeping environment.

I also note that the single mattress was against the wall and Infant was placed to sleep on the side closest to the wall. The gap between the mattress and the wall was an additional risk. Babies can roll into that kind of gap and suffocate. There is no evidence that this occurred in this case, but it was a further unsafe factor in the sleeping arrangements.

Safer co-sleeping

These sleeping risks are discussed not to blame anyone, but rather to educate, and to acknowledge that it can be difficult to create safe sleeping environments, particularly when confronted with insecure and overcrowded housing.

However, in all situations it is recommended that babies, particularly small babies, sleep on their back 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. The first image depicts a firm mattress to the side of the parent's mattress. The second depicts a Pēpi-Pod® which can be placed next to or on the parent's mattress. The third depicts a coolamon which can be placed next to or on the parent's mattress.

In the *Inquests into the deaths of Baby K, Baby B and Baby S [2026] NTCC06* I discussed the Pēpi-Pod® program (including by referencing a recent Flinders University evaluation[10]) and the partnership between Miwatj Health Aboriginal Corporation and the Coolamon Community Inc.[11] In those inquests I made a recommendation that relevant agencies initiate

10 https://sites.flinders.edu.au/ssabsa/
11 A First-Nations led registered charity, Coolamon community.org.au

pathways to promote the availability of safe sleeping devices such as Pēpi-Pods® and coolamons. I will make a similar recommendation in these findings.

Information provided by ASYASS/AAH to the investigation

Noting that there were instances of co-sleeping between Mother and Infant at AAH, the CEO provided further information about sleeping arrangements and sleep education. The CEO advised that cot beds are provided (and a cot was in Mother and Infant's bedroom) but mothers may make their own choices about sleeping and could choose to co-sleep in the double bed provided. The evidence satisfies me that Mother and Infant co-slept at least on some occasions, and possibly always, while residing at AAH.

The CEO explained that a midwife employed in the program provided parenting advice including on safe sleeping, and that evidence of any education provided would be in Mother's records. I note that no specific record of sleep education was identified by the CEO, and I did not find any evidence of such education in my review of the records. From the lack of documentation, combined with the evidence of Mother's reluctance to engage in the program, ***I was satisfied that there was no evidence that Mother received education on safe sleeping or the risks of co-sleeping at AAH.***

Pēpi-Pods® and coolamons are not part of the AAH program and a safe sleeping device was not provided to Mother when she exited the program.

Given that Mother co-slept at AAH (which was permitted), that there is no evidence as to education about safe sleeping being provided to her, and no portable safe co-sleeping device was provided for use at AAH or on her exit with a 6 week old baby, I consider it likely that Mother did not fully appreciate the risks of co-sleeping or an unsafe sleeping environment.

An undated and unsigned documented titled *"ASYASS Summary of findings re: CCK(Mother)"* is in the AAH records. It contains recommendations in response to Infant's passing which are extracted below at a) – g). The CEO was asked about the implementation of these recommendations and, in an undated response received by the Coroner's Office in July 2026, the CEO provided information on progress (which is summarised below after each of the recommendations).

a) Looking at just Mother: that her first potential exit from the program (when she was pregnant) may have given more opportunity to explore accommodation options upon leaving AAH – *The CEO advised that ASYASS operates the Youth Housing Program, a 12 month transitional accommodation program for young people in Alice Springs. Demand for the program is high, there are waiting lists, and no places were available when Mother was exited from AAH.*

b) AAH to write an Exit policy that includes the exploration of secure accommodation for exiting clients, and how to proceed in incidents, such as this, where engagement is minimal and non-compliant – *Although not developed, the importance of such a policy was acknowledged and the CEO said that 'development of this policy will be prioritised.'*

c) Incoming ASYASS clients to sign agreement that, upon exit, they are prepared to voluntarily engage with the process of securing housing – *The CEO said that this will be incorporated into the Conditions of Stay agreement.*

d) Wraparound support services to work more cohesively in securing appropriate and safe accommodation beyond AAH – *The CEO said that ASYASS provides wrap around support through individualised case planning and will work collaboratively to explore accommodation and support options, noting that many young mothers choose*

to return to family. However, Mother had nowhere to go and in those circumstances was effectively left to choose between homelessness and an overcrowded ASYASS unit occupied by her sister-in-law and extended family.

e) Exiting ASYASS clients be prioritised with safe and secure housing by Territory Housing – *While ASYASS can advocate, ultimately the Housing Department determines allocation and priority.*

f) Wraparound support services to work more cohesively in supporting complex clients who have minimal engagement, who have tendency to not abide by expectations of programs such as AAH and who are at risk of homelessness – *The CEO said that ASYASS recognises the need to focus on sustained engagement and coordinated responses across services rather than relying on strict compliance requirements.*

g) Shared comprehensive safety planning across all wraparound services to ensure best possible outcomes for clients upon exit of ASYASS programs – *The CEO said that the acute shortage of housing in Alice Springs creates significant barriers to securing safe and appropriate accommodation for young people in Alice Springs but ASYASS works with the Housing Reference Group in an effort to deliver a coordinated response to reduce homelessness.*

All in all, while intentions are good, it appears that there has been little done by ASYASS/AAH to progress their own recommendations.

Response of the Department to the passing

The Care and Protection Investigation which commenced on 4 September 2024 was completed on 11 October 2024 and found as follows:

> *CPP spoke with Mother regarding these new concerns of leaving ASYASS and living with her father. Mother stated she does not want to live in Ampe Akweke house as she is sick of sharing with other people she does not know, so she will go and live with her father, but ultimately, she would like her own place. CPP asked Mother about her relationship with her father, brother and his partner[sister in law], who have previously been reported to have perpetrated violence on Mother resulting in her entering ASYASS. Mother advised that her relationship with her family is better now since Infant has been born. Mother stated she doesn't have any worries living with her father and that she is looking forward to having support from him and his partner to care for Infant. The plan was for Mother to move in with her father at his new 3-bedroom house. Her father had abandoned his previous flat due to unconfirmed reasons and was currently living with other family members. It was initially informed by housing that her father would move into his new place on the same day Mother would leave ASYASS, hence, it was planned Mother would stay there. On the day of move in, CPP was informed that this date was not accurate and that there was no date set for her father to move in. CPP was then advised to contact ASYASS and see if Mother could stay until the new house was ready. ASYASS advised that Mother had escalated and was abusing staff for kicking her out and getting welfare involved, so they were not willing to have her stay any longer. Mother could not identify any family within Australia that she could live with. CPP called all hostels in town, but there were no availabilities. CPP was advised to leave it with congress to support Mother for accommodation, as there is currently no Child Protection concerns and Infant does not need to come into care then DCF does not need to be involved.*

According to Section 20 of the Care and Protection of Children Act 2007, Infant is not in need of departmental care and protection as the mother [h]as a good attachment with baby and is caring well for Infant's needs. According to Section 129 of the Act, a protection order is no[t] in the best interest of Infant. The least intrusive means to safeguard Infant is for her to remain in the care of Mother.

Following the death, The Department conducted a Practice Review and concluded:

[Mother] exited the ASYASS program on 16 September 2024, and Infant was found deceased six (6) days later, on 22 September 2024. [Mother] was a highly vulnerable young mother, with an extensive trauma history as reflected in the Department's records. Infant was extremely vulnerable at six-weeks of age. It is evident that [Mother] and Infant exited the ASYASS program into homelessness. The only housing options available to [Mother] were with family, and yet these households were known to be overcrowded, and occupied by people who had perpetrated extensive violence towards her.

The records confirm the CPP advocated for [Mother] and Infant to extend their stay at AAH on at least three (3) separate occasions, with the ASYASS Senior Program Manager, in recognition of their significant vulnerabilities. The Department recognised however that [Mother's] circumstances were highly complex, and she often chose to stay with family despite the services and support available for her to utilise. [Mother] had also told the CPP that she did not want to remain in supported accommodation, as she wanted her own space, and not share with people unfamiliar to her.

The review finds that the Department appropriately assessed there were no child protection concerns for Infant, as [Mother] had demonstrated she was meeting the care and protection needs of her daughter. In 2024[Mother] was referred by different agencies into numerous services, including ASYASS, AFNPP, WoSSCA, Alukura Women's Health Service, and Headspace to help address some of the complicating factors such as DFV, homelessness, mental health, and caring for a child as a young mother. The review finds that [Mother] may have benefitted from clarification as to which service was taking the lead role in providing a holistic service response. If none of the services were suited to lead the coordination, then the Department should have referred [Mother] into Family Support Services (FSS) to provide a more integrated approach.

The records confirm that on one occasion, on 5 September 2024, Departmental workers checked on the sleeping environment for [Mother's] Infant child, and case-noted what they observed. This presented as a missed opportunity to engage [Mother] in a conversation about safe sleeping practices. There is no documented evidence that the Department held a conversation with [Mother] on Infant safe sleeping.

This review highlighted the gap in policy, procedures, guidance and resources, as well as the provision of mentoring and training to operational staff which the Department has taken steps to address.

I could find no evidence that Departmental workers case noted the sleeping environment on 5 September 2024, nor was there any evidence of either safe sleeping education or a safe sleeping device being provided to Mother. Following a review of a draft of these

findings, the Department conceded that there was no evidence that Departmental workers had checked on, or case noted, Infant's sleep environment.

Despite documented reports of Mother regularly using cannabis, that it was affecting her capacity to parent, and a CPP directly observing that Mother appeared to be "*high"* on 5 September 2024, there was no evidence that the Department took any steps to engage Mother in a suitable drug and alcohol program. Following its review of the draft findings, the Department noted verbal safety planning on 13 September 2024 but accepted that a referral for AOD services may have supported longer term changes for Infant's mother and there was nothing in the records to confirm these steps were taken.

The Department knew or should have known that it was probable that after being exited from AAH and with no other housing options, Mother and Infant would reside at Unit. The Department knew that Unit was: already overcrowded; occupied by family members who had perpetrated DFV against Mother, including her father; her father was said to be supplying cannabis to Mother; and her family were transporting Infant in cars without a capsule. The Department must have known that, although Mother was an attentive mother and was tending to Infant's needs, her ability to keep Infant safe was at risk if she did not have somewhere safe to stay.

In those circumstances, the comment that *"the review finds Mother may have benefitted from clarification as to which service was taking the lead role in providing a holistic service response"* entirely misses the mark. Of the services the Department claimed were engaging with Mother:

- ASYASS was evicting Mother from the AHH program and was not providing any further accommodation;
- Mother had not engaged with Headspace since the birth of Infant (and previously only minimally);
- WoSSCA had no role to play except if Mother was exposed to further acts of DFV;
- Alukura midwives' involvement necessarily ceased when Infant was 8 weeks old; and
- there was very little evidence, if any, that Mother had any direct contact with AFNPP.

In circumstances where the Department knew that Mother was highly vulnerable with a complex trauma history and that she was being exited from a supportive environment into homelessness with a 42 day old baby; to support the safety of Infant, it was incumbent upon the Department to continue to deliver services and/or to ensure appropriate services were actually actively engaging with Mother and Infant to safeguard Infant. The Department should not have turned a blind eye to Mother's predicament and the sleeping risks this created for Infant.

To be clear, child removal is not an answer to homelessness. This 21 year old single Mother was attentive, caring and protective of her Infant. Addressing their joint homelessness and the risks that created for Infant was the necessary and called for response.

ASYSS and AAH were given an opportunity to consider and respond to a draft of these findings

Having considered the draft findings ASYASS responded as follows:

In line with the recommendations, ASYASS will undertake the following actions:

- Procure Pepi-Pods®, coolamons (or similar safe sleeping devices) for mothers and babies identified as being at risk of unsafe sleeping environments.
- Implement and deliver culturally sensitive and appropriate education on safe/safer Infant sleeping practices to AAH clients through the midwifery program.
- Develop an Exit Policy that includes clear processes for exploring and securing safe accommodation options for clients exiting the program, including those with complex or low engagement.
- Update the Conditions of Stay agreement to include a client commitment to actively engage in securing appropriate housing upon exit.

We will also continue to work collaboratively with the Housing Reference Group (HRG) and relevant stakeholders to support clients in accessing safe and secure accommodation.

ASYASS takes these findings and recommendations seriously and is committed to prioritising the implementation of the above actions.

Central Australian Aboriginal Congress / Alukura was given an opportunity to consider and respond to a draft of these findings

The interim CEO responded as follows:

Thank you for providing your findings and recommendations into the tragic death of Infant.

Congress acknowledges receipt of your draft report and confirm that we accept the findings and recommendations outlined in the report.

Congress appreciates the thoroughness of your investigation and the time taken to consider the circumstances and identify opportunities for improvement.

Congress is fully committed to implementing the recommendation and continues to take meaningful action to strengthen systems, processes and practices that support improved outcomes for Aboriginal mothers, babies and families.

Following the findings and recommendations arising from the inquests into the tragic deaths of Baby K, Baby Band Baby S, Congress has commenced a comprehensive program of quality improvement focused on strengthening Infant safe sleeping practices, enhancing clinical governance, and ensuring families receive culturally safe, evidence-based information and support throughout pregnancy and beyond.

This work includes:

- Implementing a Safe Sleeping and Safer Co-Sleeping Clinical Procedure to ensure all expectant mothers receiving antenatal care at Congress are provided with ongoing, culturally safe and evidence-based information about Infant safe sleeping and safer co-sleeping practices. The procedure supports informed decision-making, promotes safer sleeping environments, and aims to reduce the risk of Sudden Unexpected Death in Infancy (SUDI) during pregnancy and throughout the

postnatal period. Where possible, clinicians will also assess the home sleeping environment to better understand and support each family's circumstances.

- Building workforce capability by ensuring all staff providing antenatal care complete Red Nose Safe Sleep training, strengthening staff knowledge, confidence and consistency in delivering safe sleep conversations with families.
- Increasing access to safer sleeping options through the purchase of 300 Pepi Pods for distribution to eligible Congress clients. Distribution of Pepi Pods is supported by clear guidelines requiring safe sleep discussions, assessment of suitability, and ongoing education to ensure they are used as part of a broader safer sleeping approach.
- Advocating for sustainable funding to enable Congress to continue purchasing Pepi Pods and other culturally appropriate, approved safer co-sleeping devices, including options such as Coolamons, to support families to create safer sleeping environments.
- Partnering with the Congress Women's Committee and Alukura Grandmothers to co-design culturally relevant resources that reflect community knowledge, experiences and ways of sharing information. This includes the development of safe sleep resources in Central Australian languages, available in both written and video formats, to improve accessibility and strengthen community understanding.

Through this work, Congress is committed to embedding continuous quality improvement, cultural safety and community-led approaches to ensure Aboriginal families are supported with the knowledge, resources and care required to keep mothers and babies safe.

The recommendations will assist Congress in strengthening our processes and supporting improved outcomes in the future.

Thank you again for your work and for providing guidance aimed at preventing similar circumstances from occurring.

The Department was given an opportunity to consider and respond to a draft of these findings

Concerning Mother and Infant's exit from AAH into effective homelessness, the Department said:

> DCF appropriately assessed there were no child protection concerns while Infant's mother was in supported accommodation. Based on what was known, however, once exited from ASYASS, Infant's mother's housing circumstances placed Infant at risk, and ongoing CP involvement was warranted, until she secured safe accommodation. DCF agrees that clarification around the service lead would not have been meaningful to CCK's mother in the circumstances.
>
> …
>
> …there was discretion for the DCF to fund interim accommodation for Infant's mother and Infant until a more suitable arrangement could be made.

> There are preventative supports available to assist families where there are concerns that without intervention a child may be at increased risk of harm or entry into care. The purpose of these supports is to reduce risk factors and strengthen a family's capacity to safely care for their children. DCF's Financial Support for Children and Families Policy (Attachment B [*Policy: Financial Support for Children and Families*] refers) provides that preventative family care payments can be made. Consideration of financial support for Infant and her mother should have been made.

The *Policy: Financial Support for Children and Families* makes provision for Preventative Family care payments (**PFC**) as follows:

> The aim of Preventive Family Care (PFC) payments is to reduce the risk of harm to a child and the subsequent likelihood of a child coming into the care of the Chief Executive Officer.
>
> This may be through the provision of financial payments to parents or other adults caring for the child or, on rare occasions, directly to a young person who is living independently. In all cases, PFC payments may only be made after the development of an approved care plan which clearly identifies the purpose, duration and expected outcomes of the proposed payment/s. Payments may be made on a one-off basis, or as a continuing but time-limited payment, defined by the care plan. A PFC payment can only be made for a child who has an open Child Protection, Family Support or Protective Assessment case.
>
> PFC is a casework tool. It is not a form of income support or emergency financial assistance. The use of PFC generally requires a relationship of some duration between the client and Territory Families.
>
> The onus lies with the Manager to ensure that any recommendation for the use of PFC payments complies with the spirit of the policy and procedures.

Accepting that insecure housing was a significant issue for Mother and Infant the Department advised:

> Since 1 July 2025, investment in homelessness services has increased through the National Agreement on Social Housing and Homelessness and a stronger accommodation continuum is now available for young people, young parents and families. This includes the continuation of all three Alice Springs Youth Accommodation and Support Services (ASYASS) accommodation programs - the Youth Crisis Refuge, the Youth Housing Program and Ampe Akweke Place for young mothers and babies. Funding for both the Youth Crisis Refuge and Ampe Akweke Place has increased, strengthening specialist accommodation options for vulnerable young people and young parents.
>
> The service system has also been enhanced through the introduction of the Central Intake Service, which provides a coordinated entry point into homelessness services. The Central Intake Service supports improved visibility of vacancies across multiple services, streamlines referrals, and assists in prioritising accommodation and support for people with the highest levels of vulnerability and need.
>
> More broadly, the NT Homelessness Strategy 2025-2030 recognises the need for stronger accommodation responses for young people and families in Central Australia and has established a framework for ongoing service improvement, regional planning and better coordination between homelessness, housing and community support services.

While accommodation pressures remain, Central Australia now has a more coordinated, better funded and more accessible homelessness service system than existed in 2024.

NT Health was given an opportunity to consider and respond to a draft of these findings

NT Health extended its deepest sympathies to Mother and acknowledged the critical importance of safe sleep education while noting that it is not an authoritative source for educational materials and relies primarily on Red Nose. NT Health also noted its limited role in the care for Mother given the lead role was undertaken by Alukura for antenatal, birthing and post-natal care.

NT Health pointed to its ASH Vaginal Birth Clinical Pathway which contains topics for safe sleeping education. These topics were initialed on three occasions while Mother was at ASH which indicates that safe sleep education was provided to her during her hospitalisation. NT Health also advised that on discharge a Red Nose pamphlet is given to all mothers.

NT Health agreed in principle with Recommendations 1 and 2 below.

NT Health reminded me that its staff undertake a critically important public service and the dedicated and often thankless work of Midwives should not be overlooked.

The NT Police Force was given an opportunity to consider and respond to a draft of these findings

The NTPF provided a detailed and considered response which included the following (summarised) information:

> The NTPF current General Order guidance establishes a clear command, notification and oversight framework for infant and child death investigations. Upon notification of a Sudden Unexpected Death of an Infant (SUDI), Sudden Unexpected Death of a Child (SUDC), or the death of a young person, divisional command is required to ensure that Crime Division is notified as soon as practicable. Crime Command retains oversight of reportable infant and child death investigations, irrespective of whether the death occurs in an urban, regional or remote setting.
>
> The NTPF accepts that sudden infant death investigations require careful management of concurrent obligations, including the preservation of life, protection of potential evidence and appropriate engagement with acutely distressed family members. The Coroner's observations regarding scene preservation are acknowledged and will be considered together with existing operational guidance, training arrangements and procedural requirements applying to sudden infant and child death investigations. With an emphasis on the interviewing training to ensure conversations are carefully considered in instances such as Sudden Child or Infant Death.
>
> The SUDI/SUDC Checklist (updated December 2025) is identified in the General Order as an essential investigative instrument. The General Order provides clear directions for police to access the document under the standard documents / coroners. It is to be commenced at the scene and completed as soon as practicable thereafter. The checklist requires information to be obtained from the scene and during statement-taking, including information relevant to the sleeping environment and other factors that may have contributed to the death. The current guidance expressly recognises the need to balance compassionate support for parents, guardians, carers and family members with the requirements of a thorough investigation. Members are directed to

act discreetly in establishing and maintaining a scene, particularly where no obvious criminal circumstances are apparent, and to facilitate appropriate referrals to support services. The guidance also recognises the role of the Office of the Coroner and available support services, including Amber NT, for families affected by the death of an infant or child.

The Northern Territory Police Force thanks the Coroner for the opportunity to review and comment on the confidential draft findings.

The NTPF acknowledges the considered nature of the coronial inquiry and accepts the observations concerning police investigative practice as matters warranting careful consideration. The Force remains committed to conducting investigations into sudden infant and child deaths in a manner that is thorough, lawful, professional and compassionate, and to working with relevant government and non-government agencies to strengthen responses for vulnerable children and families across the Northern Territory.

Conclusion

Infant was beloved and her Mother devotedly cared for her. That she passed away is an immense and life altering tragedy for her family.

Mother had diligently attended antenatal care, gave birth at ASH, participated in postnatal care, was residing at premises designed to support new mothers, and Infant was the subject of investigations being conducted by the Department. Despite those opportunities, ***there is very limited documented evidence of Mother receiving safe sleep education throughout her pregnancy and post birth journey, she did not receive a safe sleeping device on exit from AAH and she was exited into homelessness without that being addressed or the associated risks being mitigated.***

This was a preventable death and more needed to be done to ensure safe sleeping was routinely discussed and promoted, that the risks of unsafe sleeping were clearly articulated, and that steps were taken to assist Mother to minimise or remove those risks to improve the safety of Infant, including by taking steps to ensure she and Infant had a safe place to sleep when exited from AAH.

Recommendations

1. I recommend to **NT Health** that it review and amend its Antenatal Care Pathways (and any similar pathways) to include a requirement to provide education on safe sleeping/safer co-sleeping and SIDS, with the support of Aboriginal Health Workers or Practitioners for indigenous clients/patients and using culturally appropriate educational material.
2. I recommend to **NT Health** that it develop a 'Safe Sleeping /Safer Co-sleeping/ SUDI Screen', to be completed with all mothers attending its antenatal/birth/postnatal services which clearly identifies that there is a risk of death from unsafe sleeping (including unsafe co-sleeping), the risk factors, and the steps that can be taken to minimise the risks.
3. I recommend to the **Department of Children and Families** that it review and amend all relevant policies, practices and procedures to ensure that investigations or engagements with families are not closed prematurely. By way of example only, where ongoing risks to a child are identified as likely, a Child Protection Investigation should not be closed until there is evidence of actual active engagement between the parent and appropriate service provider(s) to address and/or mitigate the risks to the child. In particular, the risks to an

infant experiencing homelessness should be identified and considered and active steps should be taken (and documented) to address homelessness and associated risks before closure.

4. I recommend to the **Department of Children and Families, Alice Springs Youth Accommodation and Support Services, the Ampe Akweke House program, and Alukura Maternity Group Practice** that each ensures it has 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. 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).

5. I recommend to the **Alice Springs Youth Accommodation and Support Services and the Ampe Akweke House Program** that they take all necessary steps to make available Pēpi-Pods®, coolamons (or similar) to mothers and babies (identified by staff as being at risk of unsafe sleeping). When a program of delivery is established, ASYASS and AAH should have in place a process that evaluates the efficacy of safe sleeping devices, the program of delivery and education materials.

6. I recommend to the **Northern Territory Government** that it:

    a) identify, quantify and map the level of homelessness experienced by expectant and new mothers across the Northern Territory;
    b) identify, fund and/or establish suitable accommodation and access pathways to suitable accommodation for expectant and new mothers;
        (i) in so doing, it should ensure that delays in access do not defeat the goal of infant safety noting that infants under 3 months of age are the most vulnerable; and
    c) prioritise the continuation of Aboriginal community-controlled service delivery.

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 and 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.