STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquests into the death MB and KB
Hearing dates:	20 November 2014
Date of findings:	20 November 2014
Place of findings:	State Coroner's Court, Glebe.
Findings of:	Magistrate Sharon Freund, Deputy State Coroner
File numbers:	2006/369142 and 2013/231521
Findings:	I find that MB died on 30 November 2006 at 24/20 Berrigan Crescent, Macquarie Fields as a result of Sudden Infant Death Syndrome Category II. I find that KB died on 29 July 2013 at 114 Gisborne Street, Wellington as a result of Sudden Infant Death Syndrome Category II.
Representation:	Ms D. Williamson as Sergeant Assisting the Coroner: Ms D. Ward instructed by Mr R. McLachlan, solicitor for and on behalf of the Secretary of the Department of Family and Community Services;

FINDINGS

MB was only 9 months old when he passed away on 30 November 2006. He was the third child of FB (mother) and PB (father).

His Sister, KB was only 24 days old when she passed away on 29 July 2013.

The deaths of MB and KB were reported to the Coroner pursuant to section 24(1)(b) and (c) of the Coroners Act 2009 because MB, KB and their siblings were the subject of risk of harm reports to the Department of Community Services.

On 30 August 2006 a risk of harm report was received with concerns that the family had run out of money to feed the children. Financial assistance was requested. The report indicated that MB had been sick since birth, suffering from whooping cough, which had diminished the family resources. The report stated that the family had been in crisis since the birth, that the home and children were dirty and that the family needed four beds.

As a result of this report, case workers purchased some groceries, nappies and formula to take to the home. The parents were interviewed and the children were noted to be happy, healthy and meeting their developmental milestones. Further financial assistance was also provided.

Subsequently, records indicate that Community Services worked with the family to assist in addressing the issues of neglect and offer practical assistance when required.

The children were referred to a paediatrician who ultimately advised that the children were well nourished and healthy for their age.

On 27 November 2006, records indicate that MB suffered a fall from the fourth step of the stairway at the premises at which the family then lived. As a result he suffered swelling and slight bruising just above his left eye. MB did not appear to suffer any complications as a result of the fall and no change in his behaviour or eating habits was observed in the ensuing days.

At 9:00pm on 29 November 2006 FB placed MB on his back on the lounge at the family residence at Macquarie Fields. At the time he was wearing a disposable nappy a shirt and a button up top. FB, DB and the other two children slept on a mattress at the bottom of the lounge where MB was placed. At about 11.44pm FB woke to go to the bathroom. She returned to the lounge room and lay down but does not remember checking on any of the children.

Around 3:00am on 30 November 2006, FB woke and found MB lying face down on the mattress to her left. She turned him over and observed that his face was blue and that he was cold to touch. She woke PB who has then commenced CPR. Ambulance were contacted and attended shortly after. They continued with CPR and transported MB to Liverpool Hospital. After further treatment, life was pronounced extinct at 5:30am.

The post mortem examination was conducted by Dr Neil Langlois.

The post mortem examination including the use of ancillary tests failed to reveal a cause of death. A bacterial infection was identified from culture of the left ear and blood.

The presence of a pure culture from both sites was regarded as a true result, but the significance of the finding was uncertain. The culture of the bacteria streptococcus pyogenes from the blood of the heart suggested that the infection had spread from the ear to infect the body (the condition of septicaemia). It was noted that the organism may be identified in cases of infant death and the significance of its presence was uncertain.

As MB had been sleeping on the lounge with his mother and father, the death was regarded as a case of sudden unexpected death in infancy in a child in an unsafe sleeping environment. (Sudden Infant Death Syndrome Category II).

KB was born on 05 July 2013 and was the eighth child to FB and PB.

In May 2009, prior to KB's birth, KB's siblings were assumed into the care of the Director- General by Ingleburn CSC. The reasons for assumption included the unhygienic state of the home environment, lack of supervision and domestic violence. In November 2009 Final Orders were made in the Children's Court granting Parental Responsibility to the Minister until the children reach the age of 18 years. All five children are placed together in a KARI placement in Mount Annan.

On 20 August 2010, prior to KB's birth FB and PB had another child. Between 2010 and 2012 that child was the subject of three Risk of Harm reports with KB (who was then prenatal) also being the subject of two of these reports. The children were the subject of five additional non Risk of Harm contacts. The reported issues included emotional state of carer, inadequate shelter or homelessness and drug abuse by carer.

The family after KB's birth, received home visits and assistance from Bernado's (brighter future program), the Probation and Parole Service and also the Local Area Health Service. A home visit conducted shortly after KB's birth indicated that she appeared clean and well cared for. FB did raise concerns that they did not have a cot however was advised to continue using the pram for the time being as it was clean and tidy. Arrangements were to be made to assist the family in obtaining a cot.

FB and PB usually slept in a queen bed in the main bedroom with KB sleeping in the pram next to the main bed.

On the evening of Sunday 28 July 2013, FB and KB had an argument resulting in FB lying down to watch TV in the lounge room with KB in her arms. It was the evidence of FB that she knew and understood the risks of co-sleeping and didn't intend to sleep on the lounge but she accidently fell asleep with KB in her arms. KB was wearing a pink jumpsuit and white t-shirt and was wrapped in a child's blanket.

About 3:50am the following morning FB woke up to find KB had slipped down between her and the back of the lounge. She pulled the blanket away and grabbed KB who was unresponsive and purple in colour. She screamed for PB who got up and saw FB in the lounge room crying and screaming. PB took KB and commenced CPR as FB rang triple zero.

Ambulance attended and conveyed KB to Hospital. Nil signs of life were evident during treatment at the residence or en route to the Hospital. Life was pronounced extinct at 4:30am.

The post mortem examination was conducted by Dr Allan David Cala. The cause of death is undetermined.

Post mortem examination showed a well-nourished uninjured female infant. There were no abnormalities on internal examination that could account for death. There were non-specific congestive changes in the major bodily organs. Toxicological analysis was negative for drugs and alcohol. No significant abnormalities were noted after microbiological cultures.

Dr Cala reported that deaths of young children have been encountered during sleep with a caregiver whilst on a lounge. In these situations, children can become “wedged” at the back of the lounge and may be accidentally suffocated, smothered or entrapped. Alternately, some other asphyxiating event such as being in a face down position could occur. Dr Cala was of the view that these scenarios were not necessarily what occurred in this case. He was not prepared to give a cause of death of Sudden Infant Death Syndrome (SIDS). SIDS is a diagnosis of exclusion of other conditions including trauma, accidents and natural disease. The cause of Matthew’s death was previously given as Sudden Infant Death Syndrome, although the details of that case were not known to Dr Cala at the time of conducting this post mortem examination. Dr Cala opined that there was no convincing evidence from the medical literature to indicate SIDS runs in families. The cause of KB’s death was therefore reported as undetermined.

The role of a Coroner as set out in s. 81 of the *Coroners Act 2009* (“**the Act**”) is to make findings as to:

1. the identity of the deceased;
2. the date and place of a person’s death;

3. the physical or medical cause of death; and
4. the manner of death, in other words, the circumstances surrounding the death.

A coroner, pursuant to s.82 of the Act, also has the power to make recommendations, concerning any public health or safety issues arising out of the death in question.

The purpose of this inquest was to determine whether there was any connection between the deaths of both MB and KB and if the deaths were suspicious.

On 29 July 2013, PB was electronically interviewed by police. In that interview he made reference to KB appearing different, similar to MB. It was inferred by PB that KB appeared a little “Downey” or may have suffered from Down Syndrome but investigations have since revealed this was never diagnosed. In that same interview PB also spoke about a line across the hand of KB being a sign of Down Syndrome.

Both parents gave evidence at the inquest. Both seemed genuinely affected by the loss of their children and could shed very little light on comments made about KB’s different appearance after her death. Neither really understood what a diagnosis of Down Syndrome was and what affect if any it would have on their family.

All evidence indicates there is nothing suspicious about either the death of MB or KB. Unfortunately unsafe sleeping practices seem to have played a major role in both deaths despite FB not intending to fall asleep with KB in her arms on the lounge that night.

Accordingly, I now turn to the findings I am required to make pursuant to section 81 of the Coroners Act 2009.

I find that MB died on 30 November 2006 at 24/20 Berrigan Crescent, Macquarie Fields as a result of Sudden Infant Death Syndrome Category II.

I find that KB died on 29 July 2013 at 114 Gisborne Street, Wellington as a result of Sudden Infant Death Syndrome Category II.

For the reasons set out in these findings I make the following recommendations pursuant to section 82 of the Coroners Act 2009:

20 November 2014

Magistrate Sharon Freund
Deputy State Coroner