CITATION: *Inquest into the death of Marlon Aidan Jordan Clancy*[2011] NTMC 009	
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0198/2009
DELIVERED ON:	13 May 2011
DELIVERED AT:	Darwin
HEARING DATE(s):	22 and 23 February 2011
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Infant death, suffocation, mother/infant co-sleeping**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Department of Health and Department of Children and Families	Ruth Brebner
Mother	Elisabeth Armitage

Judgment category classification:	B
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IN THE CORONER'S COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0198/2009

In the matter of an Inquest into the death of
MARLON AIDAN JORDAN CLANCY
ON 27 OCTOBER 2009
AT ROYAL DARWIN HOSPITAL,
DARWIN

FINDINGS

13 May 2011

Mr Greg Cavanagh SM

Introduction

1. Marlon Aidan Jordan Clancy ("Marlon") was an Aboriginal male born on 31 August 2009 at the Royal Darwin Hospital ("RDH") in the Northern Territory of Australia. Marlon was the only child to Sonia Hunt and Aidan Clancy.

2. Marlon died at approximately 5.12am on 27 October 2009 at the RDH after cardio pulmonary resuscitation (CPR) ceased. He was eight weeks of age at the time of his death. His death was unexpected and thus reportable to me pursuant to s12 of the *Coroners Act*. The holding of a public inquest is not mandatory but was held as a matter of my discretion pursuant to s15 of that Act.

3. Pursuant to s34 of the Act, I am required to make the following findings:

"(1) A Coroner investigating:

a. A death shall, if possible, find:

(i) The identity of the deceased person.

(ii) The time and place of death.

(iii) The cause of death.

(iv) Particulars required to register the death under the *Births Deaths and Marriages Registration Act*"

4. I note that section 34(2) of the Act also provides that I may comment on a matter including public health or safety connected with the death being investigated. Additionally, I may make recommendations pursuant to section 35 as follows:

"(1) A Coroner may report to the Attorney General on a death or disaster investigated by the Coroner.

(2) A Coroner may make recommendations to the Attorney General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the Coroner.

(3) A Coroner shall report to the Commissioner of police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the Coroner believes that a crime may have been committed in connection with a death or disaster investigated by the Coroner"

5. Counsel assisting me at this inquest was Ms Jodi Truman. Ms Ruth Brebner was granted leave to appear on behalf of both the Department of Health and the Department of Children and Families. Ms Elisabeth Armitage was granted leave to appear for the mother, Sonia Hunt. I thank each Counsel for their helpful assistance in this matter.

The Conduct of this Inquest

6. A total of four witnesses gave evidence before me. Those persons were:

6.1 Detective Senior Constable Christina O'Connor, the Officer in charge of the Coronial Investigation.

6.2 Mr Timothy Orwin, the boyfriend of mother of the deceased at the time of his death.

6.3 Mrs Joy Simpson, Manager of the Casuarina office of the Northern Territory Families and Children Child Protection Services.

6.4 Professor Roger Byard, Marks Professor of Pathology, Discipline of Anatomy and Pathology at the University of Adelaide.

7. A brief of evidence containing 17 civilian statutory declarations and nine statutory declarations from police officers, together with numerous other reports, photographs, police documentation, file from the Northern Territory Families and Children Child Protection Services, and medical records were tendered into evidence ("exhibit 1"). The death was investigated by Detective Senior Constable Christina O'Connor who prepared a thorough investigation brief and I thank her for her assistance.

Formal Findings

8. On the basis of the tendered material and oral evidence received at this Inquest I am able to make the following formal findings:

i. The identity of the deceased person was Marlon Aidan Jordan Clancy born 31 August 2009 at the Royal Darwin Hospital in Darwin in the Northern Territory of Australia.

ii. The time and place of death was approximately 5.12am on 27 October 2009 at the Royal Darwin Hospital.

iii. Particulars required to register the death:

a. The deceased was a male.

b. The deceased's name was Marlon Aidan Jordan Clancy.

c. The deceased was of Aboriginal descent.

d. The death was reported to the Coroner.

e. A post mortem examination was carried out by Dr Terence Sinton who investigated and discussed the possible causes of death.

f. The deceased's mother was Sonia Lorraine Hunt and his father was Aidan Leigh Clancy.

g. The deceased lived at 6 Wackett Street in Jingili in the Northern Territory of Australia.

9. The cause of death is a matter of particular controversy and was the subject of evidence. I will return to this issue later in these reasons, however, I do find that the cause of death was accidental suffocation.

Evidence of the Circumstances Surrounding the Death

10. At the time of his death Marlon was eight weeks of age and living with his mother and sister, Faith, at 6 Wackett Street in Jingili ("the Jingili address"). Marlon's parents were no longer in a relationship and Marlon's father was in fact incarcerated at Berrimah Gaol at the time of his death, and had never met his son Marlon.

11. The house in which Marlon resided was a Territory Housing Commission home of basic living standards. Marlon shared the same room in which his mother and sister slept. They in fact all shared the same mattress on the floor. I heard evidence that in addition to his mother and sister, the mattress was in fact occupied by another adult on the evening of Marlon's death, namely Mr Timothy Orwin who was a boyfriend of Ms Hunt.

12. The medical records were tendered before me as part of exhibit 1. These records did not indicate that Marlon had any particular health concerns, or

that he had required regular attendances upon medical professionals. It appears from the material before me that he was a healthy child and this accords with the significant findings at autopsy.

13. As a result of investigations conducted by police it was also revealed that there had been a number of reports made about this family to what is now known as the Department of Children and Families ("DCF"), but was, at the relevant time known as the Northern Territory Family and Children's Services ("FACS"). A copy of the file held by DCF was also tendered as part of exhibit 1. I will, for the purpose of these reasons, refer to this as the DCF file given the current naming of the Department.

14. That file revealed nine reports to DCF. Ms Joy Simpson from DCF gave evidence in these proceedings and stated that whilst there were nine recordings; "there were 8 child protection reports and one intake event for information only". Ms Simpson gave evidence that a "child report" is one where "new information comes in" concerning a child and an intake event for information only is where "information is being added to a previous report". Ms Simpson stated this occurred where "the concerns are similar to a previous report". It was noted that only two (2) of the recordings related to Marlon, namely one that recorded his death and the other that recorded his birth. The birth of baby Marlon was reported and recorded as "for information only".

15. During the course of this inquest, the involvement of DCF and any action, or perhaps better termed "inaction" by them became a matter of some evidence and therefore consideration by me. Ms Joy Simpson gave evidence that whilst DCF had seven reports which referred to violence or abuse, drug abuse and alcohol misuse alleged to have been witnessed by the child, Faith Stevens, no such reports were received in relation to Marlon.

16. The last report that DCF had received in relation to this family, prior to the birth of baby Marlon, was on 22 May 2009. That report alleged (inter alia)

violence and abuse, and also possible drug and alcohol abuse that the child Faith was being exposed to. Ms Simpson gave evidence that the report was recommended to proceed to investigation as a "child of concern" report. Ms Simpson stated that as a "child of concern", DCF was then required (pursuant to its own policies and procedures) to conduct an investigation of the allegations and assessment of the family "within 5 days", ie by 27 May 2009. Ms Simpson admitted that this did not occur.

17. The next contact that was made with DCF about this family was a report to DCF on 1 September 2009 advising of the birth of baby Marlon on 31 August 2009. Concern was raised in that report about baby Marlon because of the "history of domestic violence" in the family. This report was simply attached to the earlier report of 27 May 2009 and no further action taken. Ms Simpson gave evidence that when such a report is attached to an earlier "child of concern" report:

> "What normally happens is the Casuarina office would read the information sent through from central intake which was received by email system and then that information is factored into the previous report. So an assessment is done on whether – if a response hasn't been done for a previous report then that information needs to be considered about whether we need to respond to that".

18. Ms Simpson admitted this further consideration did not occur. It is clear therefore that not only did the "child of concern" report in May 2009 not prompt DCF to take action in accordance with their own policies, but not even did the additional contact with DCF in September 2009 prompt them to take any action. This is all in spite of the fact that they would have then been aware that their own policy of five days to investigate and assess a child concern matter was not being complied with.

19. Ms Simpson gave evidence that post the death of baby Marlon the Casuarina office of DCF had been addressing its "backlog" of unallocated child concern cases and had reduced the backlog from "over 300" to "approximately 126". Ms Simpson however did give evidence that even if a

"child concern" case was received now, the Casuarina office would not be able to investigate and assess that report within the five days required under its policy.

20. As a result of the evidence before me, I am unable to determine whether compliance by DCF with their own policy of investigation and assessment of a "child of concern" matter within five days would have made a difference to the outcome for baby Marlon. However it is of real concern that almost 18 months after this death having occurred, that DCF would still be unable to comply with its own policies and procedures of investigating "child of concern" matters. That however is not a matter that I intend to comment further upon in these reasons, particularly given that I am aware that it is a matter of some investigation in another forum via the Office of the Ombudsman.

21. Returning to the events of 26 October 2009, according to the evidence given before me, the residents of the Jingili address woke at about 7.00am. It appears from the evidence that in addition to Marlon, his mother Sonia, his sister Faith and Mr Orwin, the house was also occupied by the following persons that morning:

    21.1 David Collins – known as the step father of Sonia Hunt;

    21.2 Noelene Munyarryun – the partner to Mr Collins and Ms Hunt's aunty,

    21.3 Melissa Campbell – Ms Hunt's sister,

    21.4 Donna Wunungmurra – Ms Hunt's cousin, and

    21.5 Sandra Dhamarrandji – Ms Hunt's grandmother.

22. The evidence reveals that shortly after waking, Mr Orwin went to work and Mr Collins took Faith to school. Upon the return of Mr Collins it appears that the other occupants, including Marlon, then went as a group to

Casuarina Shopping Square. At about lunchtime the group returned to the Jingili address and thereafter it appears that the adults consumed alcohol for the remainder of the afternoon.

23. Later that afternoon, Mr Collins collected Faith from school and it appears that it was Mr Collins who also ensured that Marlon was fed throughout that day and that his needs were attended to.

24. During the course of the evening it appears that there were two calls made to police which resulted in them attending at the address:

    24.1 The first at around 6.26pm, being PROMIS 4398454. The records show police arrived and Ms Hunt was intoxicated and reported she had been assaulted by Donna Wunungmurra whilst she was holding Marlon. As a result of this complaint the police conveyed Donna Wunungmurra to 6 Moray St, Karama. It appears that all adults were intoxicated at this time.

    24.2 The second attendance at around 7.25pm, being PROMIS 4398481. The report received on that occasion was that Noelene Munyarryun had inflicted a cut to her own head through "sorry business" over the death of a relative. As a result Noelene Munyarryun was conveyed by ambulance to the RDH with David Collins accompanying her.

25. It appears that in between those two attendances, Mr Orwin also attended at the house after finishing work. Mr Orwin gave evidence that upon his arrival all persons present appeared to be drinking and under the influence of alcohol and that he also consumed a small amount of alcohol.

26. It appears from the evidence that after the police had taken Ms Munyarryun and Mr Collins to the RDH, Ms Wunungmurra also returned to the Jingili address and once again socialised with the group. At some stage a decision was made that Ms Hunt, Ms Campbell and Ms Dhamarrandji would go to the Casino. It appears that this occurred at about 9pm and that prior to her

departure Ms Hunt arranged for Ms Wunungmurra to care for Marlon in her absence. The three other women then left.

27. According to the evidence of Mr Orwin, he went to bed in the main bedroom and that sometime later he awoke to Faith coming in to the room to also go to sleep. They shared the mattress on the floor. Mr Orwin recalls there being two pillows on the bed and also a sheet or blanket of some sort. I note that the photographs of the scene depict the double mattress with two pillows and some bedding and other items on and around it.

28. Mr Orwin stated that the next thing he recalled was Ms Hunt returning to the house and entering the bedroom. At that time he was woken by the noise of her entering the bedroom. Mr Orwin did not know what time it was that Ms Hunt returned.

29. According to the statement given by Mr Collins to the police, he and Ms Munyarryun returned to the Jingili address from the RDH at about 1.30am. Mr Collins stated that when they returned, Ms Hunt was also arriving home in a taxi. Mr Collins noted that Ms Hunt was intoxicated and appeared to be having some sort of argument with the taxi driver. Mr Collins went inside the house with Ms Munyarryun.

30. Mr Collins recalled that inside the house he saw Ms Wunungmurra and the deceased. Mr Collins stated that Ms Wunungmurra did not appear intoxicated at that stage. He did not, at that time, know where any other persons were in the house. Mr Collins noted that Ms Wunungmurra was in the lounge room with the deceased and that shortly after he entered into the house, Ms Hunt also entered and lay down on the mattress in the lounge room and began kissing and cuddling the deceased. He saw the deceased's hands up, indicating to him that the deceased was awake, but that was all he noticed due to the lack of lighting on in the lounge room. Mr Collins then went to bed.

31. Ms Wunungmurra also gave a number of statements to police. She recalled Ms Hunt arriving home around the same time as Mr Collins and Ms Munyarryun. Ms Wunungmurra described Ms Hunt as appearing "very drunk" when she arrived home. Ms Wunungmurra recalled that Ms Hunt was "very drunk, falling over and she was mad". Ms Wunungmurra did not know what Ms Hunt was mad about, but Ms Hunt came and took the baby and went towards her bedroom.

32. Ms Wunungmurra set out in her statement that Ms Hunt was walking down to her bedroom and she was "zigzagging" and "drunk staggering". As a result Ms Wunungmurra said she was concerned for the baby due to Ms Hunt's level of intoxication and so she got up and took the baby to the bedroom with Ms Hunt following.

33. Ms Wunungmurra stated that Mr Orwin and Faith were in the room and she assisted Ms Hunt in putting the deceased into the bed. Ms Wunungmurra's memory was that the deceased was placed between his mother and his sister, Faith. She recalled his head being placed on a pillow, but that there were no covers put over the child. Ms Wunungmurra noted that there was a cover over the child, Faith.

34. Ms Wunungmurra described Ms Hunt as going to sleep very quickly. Ms Wunungmurra then left the room and returned to the lounge room and went to sleep. She stated that she heard the deceased crying for a little while but she thought it as a cry for feed, and "not a hurt cry".

35. Mr Orwin gave evidence that he recalled both Ms Hunt and Ms Wunungmurra entering the bedroom. When this occurred the lights came on in the room and, although he could not remember who was carrying the deceased, he recalled that the deceased was put into the bed in the middle of the mattress, between his mother and his sister. Mr Orwin recalled in his statement that baby Marlon was placed "up the top" of the mattress, "on the pillow bit".

36. Mr Orwin described Ms Hunt as "really drunk" at the time and that she in fact fell onto him on the mattress. Mr Orwin moved Ms Hunt on the bed and then he moved down to the bottom of the bed so that Ms Hunt was lying next to Marlon with Faith on the other side of the deceased. Mr Orwin stated in his statement that "there wasn't much room" on the mattress.

37. Mr Orwin also recalled Ms Hunt falling asleep almost immediately upon "falling" onto the mattress. Mr Orwin then saw Ms Wunungmurra leave the room. Mr Orwin stated that at that time he got up and went to the bathroom and when he returned, he turned off the light and got back onto the mattress.

38. Mr Orwin stated that he recalled Marlon was crying and Faith was still asleep. Mr Orwin noticed Ms Hunt appeared to be trying to remove her dress over her head and he assisted her in undressing. Mr Orwin then gave Ms Hunt a shirt and she lay back down and went to sleep. Mr Orwin recalled that Marlon was still crying and he saw Ms Hunt put her arm around Marlon "to try and comfort him". Mr Orwin also described this cry as a "whingey type cry", not one of "pain or anything", and he then went to sleep as well.

39. The next memory Mr Orwin has, is again, waking with Ms Hunt moving about on the mattress. Mr Orwin did not know how long he had been asleep but he looked at Ms Hunt and realised that she was attempting to get up from the mattress. Mr Orwin described Ms Hunt as "getting up to her hands and knees and becoming stable", however "as she would go further up to her feet she would fall back onto the mattress". Mr Orwin stated that he saw Ms Hunt fall back onto the mattress "at least three times", but noted it could have been more before he woke up. Mr Orwin asked Ms Hunt what she was doing and initially she spoke to him in her native language of Yolngu Matha, which he was unable to understand.

40. I should note at this point that the evidence given by Mr Orwin in his statement was a little different to his evidence in the witness box. I do not

consider Mr Orwin was intentionally making any changes in his evidence, I simply find that his memory was much better when he was spoken to by police closer to the events. It was also clear during the course of his evidence that Mr Orwin is still deeply upset about these events and I find that impacted upon his capacity to give evidence before me.

41. Mr Orwin stated that upon further questioning of Ms Hunt, she eventually stated she wanted to go to the toilet. As a result, Mr Orwin got up and helped Ms Hunt to her feet, and then escorted her to the door of the room. Mr Orwin stated that he then opened the door and the hallway was lit so he let Ms Hunt go and saw her heading to the toilet. Mr Orwin again described Ms Hunt as "really drunk".

42. Mr Orwin stated that when he returned to the mattress he left the door to the room open a little for Ms Hunt to return. At this time the light from the hallway was entering the room a little and he noticed that the deceased was lying across the mattress "with his head where Sonia was lying". As a result Mr Orwin decided to move the deceased so that when Ms Hunt returned she did not come back into the room and lay on the deceased.

43. Mr Orwin stated that when he moved the deceased he noticed that the deceased felt "all limp". Mr Orwin became "immediately worried" and looked at the deceased's chest to see if he was breathing. He did not notice any rising or falling of the chest and it was at this time that he saw something at the bottom of Marlon's nose. At this time Mr Orwin jumped up from the mattress and turned the light on in the bedroom. Mr Orwin saw that something around the nose was "white looking froth" and he also saw some blood around the bottom of the deceased's nose and mouth and on his chin. Mr Orwin noted it was not a lot of blood and appeared "diluted with saliva or something".

44. Mr Orwin stated that he rang 000 and whilst he was doing that he ran down the hall and told Ms Hunt that the deceased was not breathing. Mr Orwin

then followed the directions of the 000 operator and commenced cardio pulmonary resuscitation ("CPR"). When he commenced CPR, Mr Orwin stated that Faith woke up and "began asking what was happening to her little brother". Mr Orwin did not see any injuries on the body of the deceased. As stated previously, it was clear to me from the evidence of Mr Orwin that he is still deeply affected by the death of baby Marlon. I accept he did all that he possibly could in the early hours of that morning to help the deceased.

45. As a result of Mr Orwin's call to 000, an ambulance was dispatched with paramedic officers, Alice Hageman and Adam Wylie on board. A copy of the St John Ambulance ("SJA") formed part of exhibit 1 and records the officers as "on the case" at 4.35am on 27 October 2009, and then arriving at the scene at 4.40am. The SJA officer's worked efficiently and are recorded as departing the scene at 4.43am and arriving at the RDH at 4.48am.

46. According to the statements of both officers, Ms Hageman entered the house first with Mr Wylie following behind after grabbing further equipment. Mr Wylie stated that when he entered the hallway of the house, he met Ms Hageman who had the deceased in her arms and had a "look on her face that this was a genuine job". Ms Hageman carried the deceased to the ambulance and Mr Wylie followed.

47. At the ambulance, in order to assess the deceased, the officers began to remove his singlet. Ms Hageman recorded in her statement that when she rolled the deceased to take off his singlet "a small amount of bright red blood came out of his mouth and trickled down the right side of his face and some of it went into his ear".

48. Mr Wylie recalled that the deceased was not breathing and had no pulse. A heart monitor was placed upon the deceased's chest and indicated that he was "asystole", which means that there were no signs of electrical or mechanical heart activity. In terms of his observations of the body of the

deceased, Mr Wylie stated that there were "no visible signs of trauma on the baby's body", but that his face was "cyanosed", meaning that it had a bluish/greyish discolouration. Mr Wylie also noted that the deceased's pupils were fixed and dilated, but that his body was still warm to the touch and there was no rigor mortis.

49. The SJA officers continued CPR. When a police officer arrived at the scene they asked the officer to drive the ambulance whilst they continued to work on the deceased. It is clear from the evidence that the SJA officers did all that they could to provide emergency assistance and to get the deceased to the RDH as quickly as possible.

50. As stated previously, the ambulance arrived at the RDH at 4.48am on 27 October 2009. The RDH file was tendered in evidence before me as part of exhibit 1. Those records note that upon his arrival the deceased was cyanosed (or blue) was unresponsive and cool to the touch. Again, a small amount of blood was noted around the nose/mouth area and ear, but there were no injuries seen on the body of the deceased.

51. At the hospital, CPR was continued by staff but unfortunately at no time was a rhythm found and the deceased was recorded as asystolic (ie no cardiac activity). Despite all the efforts of the RDH staff, CPR was eventually ceased at 5.12am and baby Marlon was declared deceased.

Cause of Death

52. As stated at the commencement of these findings, the cause of the death of the deceased was a matter of particular concern during the course of this inquest. Although it is a matter for all inquests, this was particularly so due to certain statements made at the RDH and also media reports concerning the appearance of the deceased upon his arrival at the RDH. As I stated at the conclusion of the evidence, had such statements not been made at the RDH, and such reports of a "bashing" not been alleged in the NT News, this

matter would never have proceeded to inquest. I will therefore address each of these matters in turn.

Events at the hospital

53. Exhibit 1 contained a number of statements about the events at the hospital and particularly a report made by the child, Faith, that she had seen someone come into the room and "bash" the deceased. As a result of those most serious statements, police fully investigated the allegation of a "bashing". It is clear from their investigations that there was absolutely no evidence at any stage that baby Marlon was bashed by anyone at any time. There were no injuries to his body and nothing at the scene to indicate an assault. I also note that Ms Wunungmurra, who was nominated as having been the person to assault baby Marlon denied ever hurting the child. I accept her evidence in this regard and accept she did not hurt baby Marlon at any time.

54. On day one of this inquest, a further statement from the mother was tendered into evidence before me. It became exhibit 3. That statement records at paragraph 30 that although Ms Hunt had accused Ms Wunungmurra (amongst others) of the death of baby Marlon, she could not "really remember what I was saying at the time". Importantly, at paragraph 31, Ms Hunt goes on to state:

> "I now know that nobody hurt Marlon".

55. As a result of that statement (and acknowledgement) by the mother, I do not intend to go any further into the allegations made and their context, except to say that Ms Hunt's acceptance that no one assaulted her baby is in accordance with the clear and overwhelming evidence in this regard. It was an appropriate concession for her to make.

Reports in the media

56. A copy of the reports in the NT News about the death of the deceased formed part of the coronial brief (exhibit 1). That report was dated 28 October 2009 and formed the front page of the paper on that day entitled:

> "BABY BASHED TO DEATH
>
> Body 'bloodied and bruised' System in crisis"

57. The story in the NT News went on to report as follows:

> "The crumpled body of a six-week-old baby was rushed to Royal Darwin Hospital yesterday but he was declared dead on arrival.
>
> The bloodied little boy had been bashed."

58. As stated above, there was simply no evidence whatsoever of any of the above statements relating to the body or appearance of baby Marlon in the early hours of that morning. I would simply add that such reporting, when there is no evidence to substantiate the report, does not assist the community as a whole, or the family specifically, in coming to terms with the death of a child. Greater caution should be taken before reporting the death of any person, but particularly a child, by the media rather than simply seeking an attention grabbing headline.

The autopsy findings

59. Dr Terence Sinton, Forensic Pathologist at the RDH, conducted an autopsy upon the deceased at 10.45am on 28 October 2009. His report formed part of exhibit 1. Within his report Dr Sinton noted his findings following an extensive external and internal examination of the body of the deceased and of the musculoskeletal system, together with a "full body radiological examination, including the head, trunk and limbs".

60. As a result of that thorough and complete examination, Dr Sinton stated within his report that there were "nil" signs of any recent or old injury to the child, and that at autopsy:

> "The skull and remaining bony skeleton were intact, with no evidence for any recent bony trauma.
>
> Specific examination of the brain, eyes and upper part of the spinal cord showed no evidence for any recent haemorrhage or trauma".

61. Dr Sinton was unable to find "any scientifically supported cause" for the death of the deceased and therefore recorded the cause of death as "undetermined".

Professor Roger Byard

62. Professor Roger Byard also gave evidence before me. Professor Byard is the Marks Chair of Pathology at the University of Adelaide, as well as a Senior Forensic Pathologist at Forensic Science SA, also in Adelaide. Prior to that Professor Byard was a Senior Consultant Histopathologist at the Women's and Children's Hospital with a position of Visiting Consultant Pathologist at the Forensic Science Centre. He is also a Consultant Paediatric Forensic Pathologist to the Child Protection Unit at the Women's and Children's Hospital in Adelaide. I consider Professor Byard to be an eminently qualified specialist and his evidence was of great assistance to me during the course of this inquest.

63. Professor Byard provided a report dated 6 February 2011, which was tendered in evidence before me as exhibit 8. That report carefully reviewed all of the material tendered in evidence before me, including the statements of all relevant persons, the medical file and autopsy report, as well as all photographs taken of the deceased. Professor Byard was also provided with the additional exhibits that were produced during the course of the evidence, particularly the further statement of the mother (exhibit 3).

64. Professor Byard noted in particular in his report the autopsy report of Dr Sinton and the finding of the cause of death as "undetermined". Professor Byard noted that:

> "this case exemplifies difficulties that occur in making definitive diagnoses in infants and young children when there is little to find at autopsy".

65. Within his report Professor Byard confirmed the report of no evidence of any physical injury to the deceased either internally or externally. Professor Byard also noted the "small amount of blood" that was found and stated that this:

> "most likely arose during resuscitation as there was no evidence of any local injury such as an abrasion or laceration that could have caused it, or of skull fracture".

He noted that:

> "resuscitation is a well-recognised cause of bloody fluid or blood in the upper airway, mouth and nose related to physical forces used, and to the placing of plastic tubes in the airway".

66. Of the other potential causes of death, Professor Byard noted in particular whether this death could have been caused by Sudden Infant Death Syndrome ("SIDS"), or alternatively suffocation/asphyxia. In terms of SIDS as a possible cause, Professor Byard noted that this was a "term used when a previously well infant is found unexpectedly dead after sleeping, with no cause for the death being established". Professor Byard went on to note that:

> "Generally infants are well-nourished, with no evidence of injury except for occasional cases where there may be signs of medically-induced trauma from attempted resuscitation. Importantly there can be no significant underlying diseases present. Thus, SIDS represents a 'diagnosis' of exclusion with autopsy findings that may be identical to suffocation".

67. In relation to the possible cause of death being suffocation or asphyxia, Professor Byard considered the possibility of "overlaying", being the accidental suffocation of an infant by a sleeping adult. Professor Byard noted within his report that overlaying is:

> "an uncommon occurrence but is most likely to happen when an infant is placed to sleep under covers, on a soft mattress between two adults, or behind an adult on a couch. Parental fatigue, intoxication, and sedation also increase the risk of suffocation, and cases have been reported (including among hospital in-patients) where infants have died while being breastfed when their mother has fallen asleep".

68. During the course of his evidence, Professor Byard went on to note that in terms of what was meant by "overlaying" this did not necessarily mean a particular part of a parent's body "laying" on the child, but rather those circumstances as outlined above.

69. In terms of features to be considered in relation to whether a death had resulted from suffocation or asphyxia, Professor Byard noted that the "usual" features of "swelling of the face, frothy fluid in the mouth, lividity of the extremities, engorgement of the genitals with involuntary discharge of urine and faeces, engorgement of the right side of the heart and venous system and fluidity of the blood" were not necessarily helpful as it was:

> "now accepted that there are no consistent histological, histochemical or biochemical markers for an acute asphyxial event at any age".

70. The Professor went on to note that:

> "In fact the markers that were once used to diagnose asphyxia have been referred to as an 'obsolescent diagnostic quintet'. The situation is even more complicated in the very young as their small size and reduced strength means that accidental or inflicted asphyxia can also occur with minimal signs of injuries such as abrasions or bruises. It is well-recognised that light pressure over the mouth and nose of infants with a hand, arm or pillow can occlude the upper airway but leave no markings".

71. During the course of his evidence, Professor Byard reported that when an infant was suffocating it would not necessarily "struggle", there may therefore be no outward sign that the child cannot breathe and is being suffocated as one might expect. Professor Byard in fact gave an example of a child suffocating whilst being breastfed when the mother became distracted by what she was watching outside a window. There was no struggle at that time. As was said by Professor Byard in terms of the issue of struggling, "some babies will but some babies won't".

72. In terms of this death, Professor Byard opined that in relation to the issue of the cause of death:

> "Relying solely on the pathological findings in this case I would agree with Dr Sinton that the cause of death could be deemed "undetermined", as there is no evidence of any underlying diseases or physical injuries that could have caused or contributed to the fatal episode. However, the circumstances surrounding Marlon's death are striking and are very suggestive of death due to "overlaying" or accidental asphyxia. A young infant of two months of age sleeping on a mattress with another child and two adults (at least one of whom was heavily intoxicated) is in a very dangerous situation. It was noted by a witness that Marlon was between his mother and sister and that his mother had her arm over him at one stage".

73. Professor Byard concluded that, whilst he acknowledged that he could not absolutely "exclude" SIDS or suffocation by some other mechanism, such as between the pillows (as was the given example by counsel for the mother), he was of the opinion that the most likely cause of death was suffocation from overlaying. Professor Byard stated that the reason for this was because of "disturbing circumstances of the family's sleeping arrangements". Professor Byard highlighted that the "disturbing circumstances" that he was referring to were:

73.1 The placement of baby Marlon between his young sister and his mother;

73.2 The sleeping surface being a "soft mattress" as described by the mother;

73.3 The placement of pillows on the bed near the deceased, whether he was on them or very close to them;

73.4 The fact that the mother was witnessed to place her arm over the deceased very shortly after she got onto the mattress herself; and

73.5 The serious intoxication of the mother at the time, but also her own self description of being extremely tired as well.

74. As Professor Byard simply put it in his evidence:

> "crowded beds, soft surfaces, soft mattresses, pillows, toys, that sort of thing are dangerous".

In addition

> "if the parent's really tired or if the parent is sedated or intoxicated they're not going to respond normally, so they're not perhaps going to be aware that they're close to their baby or then they have a limb over the baby's face of maybe pressing on the chest. … But a less than normally responsive adult, deep sleep and all these other issues really create a dangerous situation. Duvets and quilts as well are a problem".

75. Professor Byard acknowledged that there were a number of risk factors of children sharing their beds with their parents and the risk of death occurring that were in addition to those set out above, namely:

75.1 The fact that his mother smoked both during and after pregnancy;

75.2 That the deceased was most likely less than normal weight at the time of his death; and

75.3 That the child was not being breastfed.

76. However, Professor Byard maintained that despite those risk factors, he maintained his opinion that whilst there could be no "pathological exclusion", it was more likely than not that for the reasons outlined, baby Marlon died of suffocation. I do not consider that the strength and veracity

of Professor Byard's opinion in this regard was ever impacted upon as a result of any of the questions asked of him during the course of his evidence.

Decision

77. It appears on the evidence that there are two possible explanations for the cause of Marlon's death:

77.1 A mechanism causing Sudden Infant Death (ie SIDS); or

77.2 Suffocation from overlaying.

78. Counsel for the mother attempted through her cross examination of Professor Byard to suggest that SIDS could not be excluded and therefore the cause of death should remain "undetermined". I do not agree.

79. In terms of the evidence, all that I have before me in relation to what happened to this child is the evidence relating to the surrounding circumstances leading up to his death. The medical, or what Professor Byard referred to as the "pathological", evidence is unable to definitively show what occurred. The surrounding circumstances therefore become of even greater significance.

80. Of real significance in this matter is the evidence associated with the mother's level of intoxication prior to her going to bed. Even by her own admission she was drinking that night. It is clear that the amount that she drank on that night had a significant effect upon her ability to recall events. I prefer the evidence given by Mr Orwin as to what was occurring in the room prior to the discovery of Marlon given the small amount he had to drink and particularly given the number of hours that had passed since he had stopped drinking.

81. It is also clear to me that Marlon was a very important and loved member of his family. I accept that his mother is very upset by his loss, as I anticipate is his whole family. The death of anyone, but particularly a child, is a very sad thing indeed.

82. The purpose of this coronial inquiry is to make every endeavour to obtain evidence to allow the inquiry to arrive at a positive finding in relation to the cause of Marlon's death. That finding, under the Act, can be made on the balance of probabilities. It is not a finding to the criminal standard of beyond reasonable doubt.

83. It is with these factors in mind that I am led to the conclusion that it is more likely than not that Marlon's death occurred as a result of suffocation. I note that Professor Byard has referred in his report to it being suffocation by overlaying; however I find that the cause of death was suffocation but by a mechanism unknown. By this I mean that I am unable to be satisfied on the balance of probabilities precisely what it was that caused Marlon to suffocate in the early hours of 27 October 2009.

84. I also find based on the evidence before me that it is more likely than not that such suffocation occurred by accident. Whilst I accept that the heavy intoxication of the mother would have increased the risk of suffocation occurring, I do not find that his death would necessarily have been foreseeable to the mother.

85. In this regard it is clear from the evidence that "some" information was provided to the mother in relation to the risk of sleeping with your baby. I refer specifically to exhibit 5 in this regard, being the pamphlets from "Karitane" and "SIDS and Kids". I do note however that there is no suggestion that the risks were specifically identified to the mother, other than to provide her with the pamphlets. I make comment that it is important that mothers, and parents for that matter, be advised in a much more obvious

way of the dangers of sleeping in the same bed as their child. Simply handing over a pamphlet is not sufficient.

86. I also note the evidence of Professor Byard that he found the mother's further statutory declaration (exhibit 3) "a little disturbing" as it referred to the mother being:

> "very exhausted after Marlon's birth yet he slept with her in the hospital bed that night. So it's indicating that it's presumably hospital practice to put babies in bed with their mother".

87. As Professor Byard stated, it is extremely important that if information is provided setting out the risk of children dying unexpectedly from sleeping in the same bed as their parent, then it is important that the hospital "leads by example" and not permit such behaviour to occur, whilst at the same time educating mothers as to the risks of such behaviour.

88. Given the large Aboriginal population I also consider it is important that such education be culturally appropriate as to why such shared sleeping is dangerous. In this regard I note that it is important that the changes in sleeping surfaces and particularly the dangers associated with the use, or abuse, of alcohol and drugs is one that must be highlighted.

89. As was stated by Professor Byard in his evidence, it is also not my intention as a result of these comments to say that no parent should ever sleep with their child. I know that many, many parents do. However it is extremely important that parents be educated as to the risks of sharing the same sleeping surface with their infant children, particularly given the heightened risk that one morning they may wake up to discover that their beloved child has died simply as a result of sharing the bed with their parent.

90. That is an experience that no parent should have to go through and whilst I understand the desire of parents to protect their children and to be able to respond to the needs of their children quickly, such concerns/desires can

easily be addressed by the child sharing the same room with their parent, ie in a cot, but not sharing the same sleeping surface with their parent.

91. I also note that during this inquest, counsel assisting inquired of Professor Byard as to whether there were any further tools that could have assisted police in terms of their investigation of this death. In this regard, I note that Professor Byard stated that in South Australia a doll or teddy bear is used by police to get parents to show where the baby was at the relevant time. Professor Byard indicated that:

> "sometimes this is too distressing but often it's actually not and it's a better way for them to show exactly where the baby was found or how they put the baby to bed".

92. I do not intend to make a specific recommendation in this regard to the police however I do highlight it in the hope that this may be useful to police and something they might consider as part of the tools available to them when investigating what are understandably very upsetting deaths associated with the passing of children.

93. I have no recommendations in relation to this death.

Dated this thirteenth day of May 2011.

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GREG CAVANAGH
TERRITORY CORONER