Legislative Scrutiny Committee
Committee Secretariat
GPO Box 3721
Darwin NT 0801
Email: LSC@nt.gov.au

Dear Legislative Scrutiny Committee,

I welcome the opportunity to make a submission to the inquiry into the *Attorney-General Legislation Amendment (Boards, Committees and Statutory Offices) Bill 2026* (the Bill).

Background
I am an independent statutory officer appointed in accordance with the *Children's Commissioner Act 2013* (the Act). The Act articulates the functions, powers and responsibilities of the Children's Commissioner, which include:

- to receive and investigate complaints about services to vulnerable children
- to undertake inquiries related to the care and protection of vulnerable children
- to monitor the administration of the *Care and Protection of Children Act 2007* (CAPC Act) as it relates to vulnerable children
- to promote and advocate for the rights, interests and wellbeing of vulnerable children and to consult with, advise and make recommendations to Ministers and others on the same.

Being appointed as the NT Children's Commissioner is an important responsibility and I feel the weight of this every day.

I care deeply about ensuring children' rights are promoted and protected; and that Government Agencies and service providers are fulfilling their responsibilities to vulnerable children entrusted to their care.

Context
In addition to my statutory functions, I was a member of the Northern Territory Child Deaths Review and Prevention Committee (CDRPC) appointed in accordance with section 209 of the CAPC Act.

I have observed first-hand its crucial role in the review and prevention of child deaths in the Northern Territory, through expert, multidisciplinary reviews of all child deaths, analysis and identification of emerging themes and trends, research and development of preventive strategies and provision of advice and recommendations to Coroners, government agencies and other stakeholders. Without the Committee, I am concerned the NT will lose a critical independent mechanism for identifying systemic risks and informing evidence-based policies, services and preventative responses aimed at reducing future child deaths.

This submission is made with reference to the Legislative Scrutiny Committee's Terms of Reference, particularly consideration of whether:
(a) the Assembly should pass the Bill;
(b) the Assembly should amend the Bill;

(c) the Bill has sufficient regard to the rights and liberties of individuals; and
(d) the Bill has sufficient regard to the institution of Parliament.

This submission will only focus on Part 2 of the Bill, in relation to proposed amendments to the CAPC Act clauses 3 through to 6 inclusive.

Role of the Committee
As is evident from the explanatory memorandum, the intent of Part 2, clauses 3 through to 6 inclusive is to abolish the Child Deaths Review and Prevention Committee (CDRPC) and the Child Death Register. I do not support these proposed amendments and submit the Legislative Assembly should decline to pass Part 2, clauses 3 through to 6 inclusive of the Bill.

The CDRPC plays a critical role in improving child safety and wellbeing in the NT. The Committee's statutory functions include maintaining the Child Death Register; conducting and sponsoring research into child deaths, diseases and accidents involving children; making recommendations arising from this research; monitoring implementation of recommendations; contributing to public awareness regarding child deaths and prevention; and contributing to national child death reporting and prevention initiatives.

These functions are not merely administrative in nature. They represent a coordinated, multidisciplinary, evidence-based mechanism designed to understand causal factors linked to child deaths in the NT and how future child deaths may be prevented.

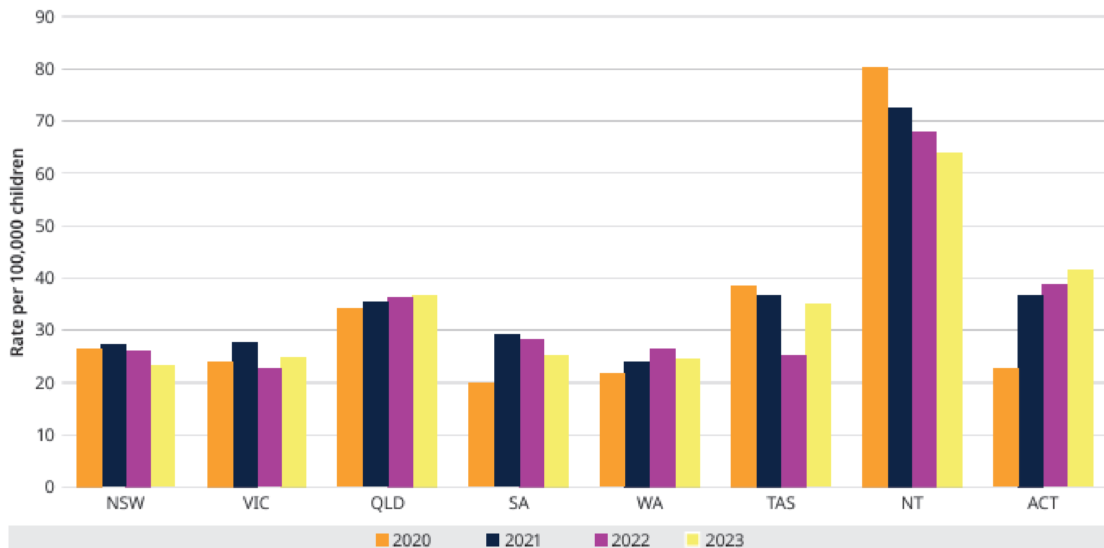
This reform is particularly troubling given the NT records the highest child mortality rates in Australia. Figure 1 below demonstrates the NT child mortality rate far exceeds all other jurisdictions, with mortality rates in 2023 reaching 63.8 per 100,000 children aged 0–17 years, compared with 23.2 in New South Wales.[1]

In addition, the Indigenous child mortality rate was disproportionately high at 114.5 per 100,000 children aged 10-17 years, in contrast to 29.4 per 100,000 for non-Indigenous children. The NT also experiences disproportionately high child mortality arising from disease, morbid conditions and external causes. The rates from diseases and morbid conditions per 100,000 ranged between 15.1 (Western Australia) and 41.5 (Northern Territory).[2]

---

[1] Child Death Review and Prevention Committee, Australian child death statistics 2023, 24-256 accessed via: https://qfcc.qlfd.gov.au/sites/default/files/data-australian-child-death-statistics-2023.pdf.
[2] Ibid, 7.

Figure 1: Rate of child deaths (aged 0–17 years) by jurisdiction 2020 to 2023



Notes. Refer to the methodology section for jurisdictional methodological differences and additional issues. Rates are calculated per 100,000 children aged 0–17 years in each jurisdiction and use as a denominator the ERP as at 30 June in the relevant year. Caution should be exercised when comparing rates between jurisdictions. Although the rates are based on a population rather than a sample, common practice is to consider death a random event; and hence, have an associated sampling error. This is particularly important when comparing rates from low numbers. Current methodology calculates the crude rates and should not be used to infer the general probability of death for specific cohorts.

Source: Queensland Family and Child Commission: , Australian and New Zealand Child Death Review and Prevention Group, (2023) Australian Child Death Statistics, accessed via webpage

In this context, dismantling the Territory's dedicated child death review mechanism raises serious concerns regarding the NT's capacity to identify systemic risks, monitor trends, and implement evidence-based prevention strategies. Abolishing the Committee would significantly weaken child death prevention oversight in the jurisdiction with the greatest demonstrated need for such oversight.

The proposed amendments would leave the NT as the only Australian jurisdiction without a multidisciplinary expert child death review body. All Australian jurisdictions currently maintain child death review and prevention systems that collect, analyse and contribute child mortality data to broader national frameworks. The CDRPC's participation in the Australian and New Zealand Child Death Review and Prevention Group ensures the NT contributes to and benefits from national and international best practice approaches to child safety and prevention.

I am not satisfied that the Bill sufficiently demonstrates that these functions can be adequately replicated through existing departmental structures or the Coroner's Office. While the explanatory memorandum suggests the Committee's functions may be delivered more efficiently through relevant government agencies and coronial processes, not all child deaths are reportable deaths under the *Coroners Act 1993* (NT), nor do all reportable deaths result in coronial inquests.

Australian Medical Association NT president Robert Parker, also a former member, recognised the different purposes and functions of the Committee from that of the Coroner. He explained that the coroner's office investigated "reportable deaths", which included deaths which were unexpected, unnatural or violent; resulted from accident or injury; took

place in custody or were of an unidentified person. In contrast the Committee focused more on health, public health as well as trends in child deaths nationally to find ways the NT could mitigate risks. [3]

The Northern Territory Coroner recently reflected on this distinction in the *Inquest into the deaths of Baby K, Baby B and Baby S [2026] NTCC 06,*[4] attached (*) to this submission. In her decision, the Coroner outlined the history, functions and importance of the Child Death Review and Prevention Committee and expressly recommended that "*the Northern Territory Government re-establish a comprehensive Child Death Review process with all necessary expertise and resources to complete the process*". The Coroner further recognised the importance of multidisciplinary expertise in identifying systemic issues and improving child death responses. This highlights a significant gap between the scope of coronial oversight and the broader preventative and systemic review functions undertaken by the Committee.

Importantly, the Committee's effectiveness derives from its multidisciplinary composition and ability to draw upon expertise from multiple sectors, disciplines and specialist fields. Committee members contribute insights regarding national and international best practice, emerging evidence-based interventions, research findings, policy reform and systemic risk factors affecting children. As a member of the Committee, I am concerned that these specialist collaborative functions cannot simply be absorbed administratively without substantial loss of independence, expertise and the Committee's unique preventative role in identifying systemic risks, emerging trends, and opportunities to prevent future child deaths.

Child Death Prevention and Review Committees nationally have informed significant child and adolescent health, wellbeing and safety reforms, including compulsory seatbelts and child restraints, public health responses to Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Death of an Infant (SUDI), and improved understanding of child and youth suicide prevention. An example of NT specific work supported by the CDPRC to address high rates of infant deaths while sleeping was the Bubba Basket Safer Sleeping Project which included components of health education, community and consumer awareness campaign and provision of a safe sleeping basket (Pedi Pod) for newborns in Tennant Creek.[5]

I am also concerned regarding the truncated timeframes for submissions and failure to engage, consult and seek advice from experts and key stakeholders, including members of the Committee on this significant reform. Best practice legislative reform requires transparency, early engagement and meaningful consultation with affected stakeholders. There has been no consultation with Committee members regarding the proposed abolition. Further, no alternative statutory framework, governance arrangement, membership structure or replacement mechanism has been identified to continue the Committee's core functions.

This raises significant concerns regarding whether the Bill has sufficient regard to the rights and liberties of individuals, including children who have special rights because of their

---

[3] Reported in the ABC news, 10 February 2026, accessed via https://www.abc.net.au/news/2026-02-10/nt-child-deaths-review-committee-disbanded-concerns-serious-gaps/106322560; DailyMotion link accessed via https://www.dailymotion.com/video/x9zm902.

[4] Inquest into the deaths of Baby K, Baby B and Baby S [2026] NTCC 06, 30 April 2026, 65-67 accessed via: https://agd.nt.gov.au/__data/assets/pdf_file/0004/1609456/Decision-Baby-S-Baby-K-Baby-B-Co-Sleeping.pdf

[5] Child Death Review and Prevention Committee, Annual Report 2023-2024, 24-256 accessed via: https://agd.nt.gov.au/media/docs/annual-reports/cdrpc-annual-reports/cdrpc-annual-report-2023-2024.pdf.

vulnerability. The main human rights treaty specific to children that set these and others out, is the Convention on the Rights of the Child (CRC), which Australia ratified in December 1990. Under the Convention, Australia Governments are required to undertake ‘all appropriate legislative, administrative and other measures for the implementation of child rights’.

Children's rights to life and safety are fundamental human rights—ensuring every child has the opportunity to survive, grow, and be protected from harm. Under international law and domestic frameworks, governments bear the primary duty to uphold, protect, and fulfill these rights by regulating systems, providing services, and intervening when necessary. Abolishing the Committee without establishing a clear, legislated alternative mechanism weakens the NT’s ability to uphold these obligations and safeguard Territory children.

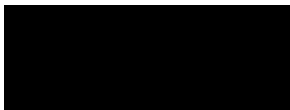
I am additionally concerned regarding the paucity of transitional arrangements. The Bill has not clearly addressed how the functions, responsibilities, research projects, data holdings, monitoring functions, reporting obligations or operation of the Child Death Register will be transferred and maintained following abolition of the Committee. This creates uncertainty regarding continuity, accountability and independent oversight.

For these reasons, that the portion of the Bill contained in Part 2, clauses 3 to 6 should not pass.

The current provisions of the CAPC Act that establish and empower the operation of the CDRPC should remain and be strengthened through adequate resourcing and support from the Northern Territory Government, to preserve the Committee’s critical child death prevention functions.

I request and support the publication of this submission and would welcome public hearings be listed on these reforms.

Yours sincerely,



Shahleena Musk
Children’s Commissioner
20 May 2026

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

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

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0075/2022 A0055/2023 A0064/2023
DELIVERED ON:	30 April 2026
DELIVERED AT:	Darwin
HEARING DATE(s):	14 – 18 July 2025 23 July 2025
FINDING OF:	Judge Elisabeth Armitage
CATCHWORDS:	**Sudden unexpected death of an infant (SUDI) in an unsafe sleeping environment; co-sleeping/family sleeping/bed sharing; cultural considerations; 'Triple Risk Model'; lack of culturally relevant education materials; no educational materials in Aboriginal languages; Pēpi-Pod®; Coolamon; classification of cause of death; Child Death Review and Prevention Committee; child death review; continuity of care.**

REPRESENTATION:

Counsel Assisting:	Giles O'Brien-Hartcher
Counsel for the families of Baby S, Baby B, Baby K:	Hannah Donaldson & Bryony Seignior
Counsel for Health:	Elizabeth Forbes (Clayton Utz)
Counsel for Children and Families:	Michael McCarthy (Hutton McCarthy)
Counsel assisting for MyMidwives P/L (Karen Hollindale, Bobbie McMinn and Rachael Ianni):	Ralph Bonig (Finlaysons Lawyers)

Judgment category classification:	A
Judgement ID number:	[2026] NTCC 06
Number of paragraphs:	214
Number of pages:	74

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0075/2022
A0055/2023
A0064/2023

In the matter of an Inquest into the deaths of

BABY K

ON: 8 December 2022
At: Tennant Creek Hospital

BABY B

ON: 22 OCTOBER 2023
AT: ALICE SPRING HOSPITAL

BABY S

ON: 6 DECEMBER 2023
AT: LARAPINTA, NT

FINDINGS

Judge Elisabeth Armitage

Introduction

1. These inquests examined the deaths of Baby B, Baby K, and Baby S. Each baby was young and small and the environment in which they co-slept was risky and likely caused their deaths. The risk of them dying could have been reduced and their deaths might have been prevented if their sleep environments were safe.[1]

2. The deaths of Baby B, Baby K and Baby S were devastating for their parents who loved them and who were trying to keep them safe. These babies were treasured by their families and their communities. The deaths of these babies

1 Evidence of Dr Marianne Tiemensma on 17 July 2025 at 291

touched many who gave evidence before me in this inquest. The tragic loss of these little babies has caused very deep pain, and I offer my sincere condolences to those who are grieving.

3. Tragically, in the Northern Territory (and across Australia) babies still do pass away in risky sleeping spaces. These inquests considered three deaths, but there are other babies who have similarly passed away. For example, in July 2017 in Darwin, a 9-week-old girl passed away sharing a bed with three siblings. In January 2018 in Darwin, a seven month-old baby boy was sleeping with his mother. He passed away when he rolled into a small gap between the wall and the mattress. In May 2018 in Yuendumu, a 3-week-old boy passed away in a bed shared with parents and a sibling. In October 2019 in Darwin, a 2-month-old boy passed away in bed with his mother. In June 2020, a 5-month-old passed away in Katherine, sleeping on a soft foam mattress with heavy covers, an intoxicated father, and a sibling. Also in June 2020, in Tennant Creek a 1-month-old boy passed away on a foam mattress shared with his parents and one sibling. He was found with a blanket over him. In December 2020, a 3-month-old baby boy passed away in Darwin, sleeping between his parents. In November 2021, in Borroloola, a 5-week-old baby girl passed away co-sleeping with other members of her family in circumstances where several mattresses were pushed together. In April 2022, a 4-month-old girl in Katherine passed away while co-sleeping on a blanket on the floor. In September 2022, a 5-day-old girl passed away co-sleeping with her mother in a hospital bed. These were all tragic and potentially avoidable deaths. These were loved babies who left behind devastated families.

4. These inquests were a snapshot into a bigger picture. Alarmingly, in the Northern Territory in the five-year period from 2017 to 2024,[2] Forensic Pathologist Dr Marianne Tiemensma "found that co-sleeping was a factor in about 40% of infant deaths."[3] The statistics are: from 2017 to 2024 there were 32 infant deaths in the Territory while co-sleeping. In 2017, co-sleeping was a factor in 3 deaths – all were Aboriginal babies. In 2018, 9 babies in the Territory died in this way, 7 of them Aboriginal. In 2019, 1 Aboriginal Territory baby died while co-sleeping. In 2020, 3 babies died while co-sleeping, 2 of them Aboriginal. 3 babies in the Territory died in 2021, 2 of them Aboriginal. There were 5 deaths in 2022, all Aboriginal. In 2023, 2 babies, both Aboriginal, died in the Territory while co-sleeping. 6

2 Evidence of Dr Tiemensma on 17 July 2025 at 277
3 Evidence of Dr Tiemensma on 17 July 2025 at 279

babies, 5 of them Aboriginal, died in the Northern Territory in 2024. In 2025, 2 babies died from what are suspected to be co-sleeping deaths.

5. All these babies were less than 1 year old; some were only a few days or weeks old. Many of these deaths occurred outside of Darwin – in Alice Springs, Tennant Creek, and remote communities in the Territory.

6. According to the latest ABS release[4] on deaths in Australia, the national infant mortality rate for all infants is 3.27 deaths per 1,000 live births. Nationally, for Aboriginal and Torres Strait Islander people it is almost twice that at 6.2 deaths per 1,000 live births. As shocking as that is, the infant death rate more than doubles again for Aboriginal and Torres Strait Islander babies born in the Northern Territory, with 13.3 deaths for every 1,000 live births.

7. It was accepted by the leading expert that while it is not reasonable to aim for the elimination of co-sleeping, there is a need to minimise the risks.[5] These inquests considered how co-sleeping risk minimisation might be done better for Aboriginal families, and families more generally, in the Northern Territory, with the aim of eliminating preventable infant deaths and saving lives.

Cultural considerations

8. There is a long tradition in human history, and particularly in indigenous cultures, of co-sleeping (also referred to in these findings as bedsharing or family sleeping). In fact, according to the Australian Breastfeeding Association, 75% of *all* babies spend at least some time sharing the parent bed in the first three months of life, including unplanned sharing (for example, when the carer unintentionally falls asleep with baby).[6]

9. Dr Yasmine Musharbash, Associate Professor of Anthropology Australian National University, who is an expert in Warlpiri ‘everyday life’ provided an expert report on co-sleeping in Warlpiri culture.[7] She explained that in traditional Warlpiri culture (and in many cultures) co-sleeping was and

4 ABS ‘Deaths, Australia’, released 26/9/25; infant deaths are defined as deaths of children less than 1 year of age
5 Evidence of Professor Roger Byard on 17 July 2225 at 296
6 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
7 Anthropology of Indigenous Co-sleeping in Central Australia with a Specific Focus on Warlpiri Cultural Practices, Expert Report for the NT Coroner, Dr Yasmine Musharbash, PhD, Associate Professor of Anthropology, 13 April 2025, Folio 6.1

continues to be the norm. During the day, Dr Musharbash explained that Warlpiri people (like other people in Arnhem Land, and throughout the Territory) have used pods (traditionally made of bean tree wood) called parraja to carry infants "from time immemorial." However, when the community settled down to sleep, the baby was taken from the parraja and placed next to their carer to sleep. In Warlpiri culture a baby never sleeps on its own at night: when its mother lies down to sleep, she lies down with the baby in close physical contact, usually on its side for spiritual and cultural reasons. Physical contact during co-sleeping continues to be of the utmost cultural importance. Not to co-sleep would be seen, in Warlpiri culture, as neglect: it would be seen as cruelty and exposing the infant to danger.

10. Similarly, Andrew Walder, the Executive Director and institutional respondent for the Department of Children and Families in Central Australia, said in his experience parents were proud of the practice of co-sleeping, that it is intergenerational, and that keeping baby close provided safety and security for baby and promoted bonding with their parent/carer.[8] Midwife QM, trained in Victoria and currently works there and in Tasmania. However, from 2022 – August 2023 Midwife QM worked at Tennant Creek, Alice Springs, and Katherine. Compared to her experience elsewhere, she was shocked to see how common co-sleeping is in the Northern Territory.[9] Ms Fraser lived her whole life (26 years) in Tennant Creek and was working with Julalikari Council Aboriginal Corporation (**Julalikari**) which delivered a pilot safer sleeping initiative for infants, the Bubba Basket program, from about 2021-2023. Ms Fraser said that in her experience bed sharing was common in Tennant Creek: "Their families do it, they do it. It's just sort of something they have learned to do."[10] Aboriginal Health Practitioner (**AHP**) Sherrelle Khan, is a very experienced practitioner and she said, while many mothers from many cultures chose to co-sleep, for Aboriginal mother's "it is our way", because it forms an "emotional, physical and cultural bond" between mother and baby.[11] She said that it was important for health practitioners to respect a mother's decision about sleep practices.

11. The Western Australian Ombudsman investigated sleep related infant deaths and noted that in the research literature most infants in Indigenous communities co-sleep with parents. Aboriginal grandmothers described it as

8 Inquest evidence of Andrew Walder on 18 July 2025 at 389
9 Inquest evidence of Midwife QM on 16 July 2025 at 156
10 Inquest evidence of Mikeely Fraser 15 July 2025 at 133
11 Affidavit of Sherelle Kahn, 14 July 2025 at [77]

a natural part of family and cultural traditions.[12] Grandmothers, mothers, sisters, and aunties were considered credible sources of information about how to care for children, and their views were important for new Aboriginal mothers, perhaps more so than education from health practitioners.[13]

12. It must, therefore, be acknowledged, accepted, and respected that traditionally Warlpiri mothers, like mothers from many other Aboriginal communities and other cultures, have co-slept and continue to co-sleep with their babies.

How has co-sleeping changed?

13. While co-sleeping continues to be the norm in Aboriginal communities, in many other ways lifestyles have changed. The settings and conditions in which people live now are vastly different to the way Aboriginal people traditionally lived and slept. Dr Musharbash notes the following key changes in Warlpiri sleeping practices:[14]

    - The physical sleeping environment now (most often) is inside a house likely in artificially climate-controlled environments when possible, rather than outside in the open;
    - Warlpiri people now sleep with pillows and under blankets ("minkies") rather than relying solely on body warmth and fire or breeze for temperature regulation;
    - Warlpiri people now sleep on mattresses, swags, and beds when possible, rather than on the ground;
    - The soundscapes are vastly different (for example, the natural environmental sounds and sounds of a traditional camp have been replaced by contemporary sound scapes including artificial media and motorised noise); as well as interruptions by lights being turned on and off multiple times during the night, and potentially noises of fights;
    - These days, and never in the past, there is also the issue of intoxication; people may be drunk or affected by marijuana or other drugs.

12 Common Brief 2.7 Ombudsman Western Australia, Investigation into ways that State Government departments can prevent or reduce sleep related infant deaths, 2012 at p51
13 Common Brief 2.7 Ombudsman Western Australia, Investigation into ways that State Government departments can prevent or reduce sleep related infant deaths, 2012 at p64
14 Dr Musharbash's report, at 5

14. Of these changes Dr Musharbash considers that minky blankets and intoxication by alcohol or drugs are “perilous for infants.” Concerning ‘minkies’ she explained that Warlpiri people use significant numbers of minkies to keep warm, “even in summer people rarely use less than two or three and in winter often more than four,” noting that being 100% polyester minkies are not good insulation. Dr Musharbash states that “realistically speaking, minkies are the only bedding option” due to the prohibitive cost of alternatives. As to intoxication, Dr Musharbash claimed no expertise but assisted me by pointing to the likelihood that intoxication “potentially impact[s] the culturally embodied awareness of others while asleep.”

SUDI, SIDS, the research of Professor RW Byard and the ‘Triple Risk Model’

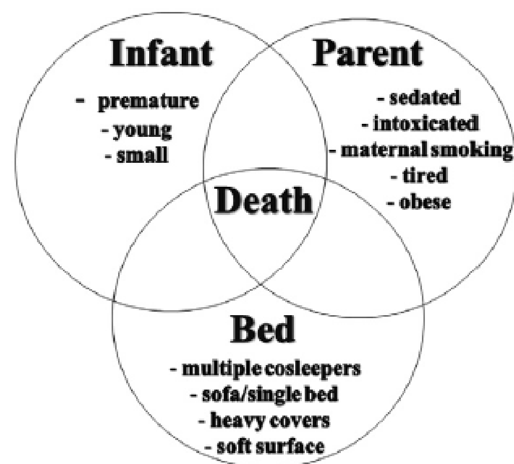
15. Sudden unexpected death in infancy (**SUDI**) is a broad term used to describe the sudden and unexpected death of an infant for which the cause is not obvious. An autopsy will be conducted in an attempt to find the cause of death or to exclude possible causes. Where no sufficient cause (illness, 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.

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

17. These inquests examined the deaths of three babies who died when sleeping with parents and in circumstances where other risk factors were also present. I acknowledge that those most vulnerable to SUDI in a co-sleeping environment are those who already experience significant disadvantage, including Aboriginal families, families already involved with the child-protection system, and low socio-economic groups. This phenomenon is noted nationally.[15]

15 see, for example, NSW Govt. Recommended Safe Sleep Practices for Babies, folio 2.1; QLD Child Death Review Board, folio 2.4; WA Ombudsman’s report, folio 2.7

18. Professor Roger Byard has been researching and publishing on the risks of co-sleeping since 1994.[16] 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.[17] 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:[18]



19. 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. He said that, while it must be recognized that many situations do not result in a lethal outcome, in certain infants the compounding effect of these risk factors may result in death.[19]

---

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

17 Inquest evidence of Professor Byard on 17 July 2025 at 278

18 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 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

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

20. I was fortunate to have Professor Byard give evidence in this series of inquests. Professor Byard acknowledged the importance of recognising and respecting cultural practices. However, similarly to Dr Musharbash, he noted the changes to the way Aboriginal (and other) people have traditionally slept and he is also concerned that those changes have significantly increased the risk to babies who co-sleep.[20]

21. This is not the first NT Inquest to have identified the risks for babies who co-sleep and the need for culturally aligned education. In the *Inquest into the death of Marlon Aidan Jordan Clancy* [2011] NTMC 009, Coroner Cavanagh said at [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."

22. It is clear from Dr Musharbash's work that in a traditional setting Aboriginal parents co-slept safely with their babies. Similarly, Professor Byard told me that in Asian countries many parents co-sleep safely with their babies: on a thin bamboo mat on the floor with non-intoxicated slim parents.[21] Ultimately, the evidence in these inquests was that while co-sleeping can be done more safely, it is not safe to co-sleep in an unsafe sleep environment, noting the risks identified in the triple risk model.

What has been recommended by the Child Death Review and Protection Committee to ensure safer sleeping environments for babies in the NT?

23. Back in 2012 a remote NT Study was conducted in NT Aboriginal communities which found that all infants slept with their parents in overcrowded conditions[22] and little has changed. The practice of co-sleeping and bed sharing was considered by the Child Death Review and Protection Committee (**the Committee**) which made the following recommendations:[23]

---

20 Inquest evidence of Professor Byard on 17 July 2025 at 294
21 Inquest evidence of Professor Byard on 17 July 2025 at 294
22 S. Kruske, S. Belton, M. Wardaguga and C. Narjic, Growing up our way: the first year of life in remote Aboriginal Australia, Qual Health Res 2012 22:777 published online 4 January 2012 and referred to in Common brief 1.5 SAF,T, SUDI and the practice of Co-Sleeping/Bed Sharing in the NT
23 Common brief 1.5 SAF,T, SUDI and the practice of Co-Sleeping/Bed Sharing in the NT

> “We recommend that more comprehensive, targeted research is undertaken to develop an evidence base that is relevant to the NT regarding the extent of the practice of co-sleeping and under what circumstances it occurs to establish and identify the extent and nature of the risk factors.
>
> Based on the outcomes of this research, we recommend the urgent development and introduction of a range of culturally appropriate, targeted measures to promote a "safe sleep environment" for Aboriginal infants who co-sleep/bed share with parents and other caregivers.”

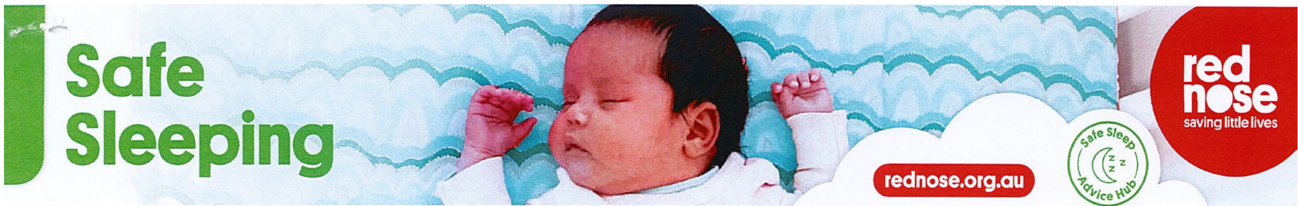
24. Accepting that this inquest may have missed materials available in the NT directed to educating Aboriginal families on safe sleeping and safer co-sleeping, there appears to have been only limited progress made on the Committees recommendations. Given that we are continuing to have babies passing away in unsafe sleeping environments, we must do more to educate all parents, but particularly Aboriginal parents, on how to create and ensure consistently safer sleeping environments for babies.

What information about safe sleep environments is currently available?

25. According to the national advice, it is safest for a baby to sleep on a separate surface to its parents, for example, in a cot. This is the Red Nose safe sleep space advice:[24]

24 Rednose.org.au/safesleep

26. However, while maintaining that a sperate sleep space is safest for a baby, Red Nose has a fact sheet on how to make co-sleeping safer and when it is dangerous to co-sleep. The factors Red Nose identifies as dangers are parental intoxication (alcohol or drugs), parental smoking, and small or premature baby. The co-sleeping information, adapted for Aboriginal consumers, is extracted below. Save for the addition of Aboriginal art, an acknowledgement, and referring to baby as 'bub' the information is presented very much in a western style format and in English. In particular, while some sleeping spaces are marked with a cross, the actual danger they create for baby is not specified. The main safety concern (asphyxiation/suffocation) appears to be assumed knowledge. Nowhere does it say that babies can pass away from suffocation/smothering.



red nose
saving little lives

Co-sleeping

Co-sleeping is when parents bring their bub into bed with them to sleep, or they sleep together somewhere else. Sometimes you plan to co-sleep and sometimes it happens unexpectedly.

The safest place to sleep bub is in their own safe space. We don't recommend co-sleeping, but if you choose to co-sleep you should understand how to make sleep safer.

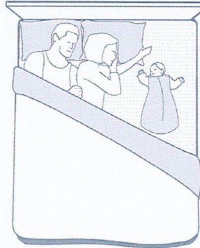
There are times when co-sleeping with your bub can be dangerous.

Co-sleeping is no good, if:

- You or your family were drinking alcohol
- You or your partner smoke – even if not around bub
- You or your partner have taken any drugs that may make you drowsy
  – this includes prescription drugs too
- Your bub is born early or is a small bub

Follow these tips for **safer co-sleeping**

- Always place bub on their back to sleep
- Tie up long hair and remove all jewellery including teething necklaces
- Place bub to the side of one parent – never in the middle of two adults or next to other children or pets
- Move the bed away from the wall – so bub can't get trapped between the bed and the wall
- Create a clear sleep space for bub to sleep
- Keep pillows away from bub's sleep space
- Make sure the mattress is firm and flat



- Make sure bub's face and head remain uncovered
- Make sure your bedding and sheets can't cover bub's face
- Make sure bub can't fall off the bed
- Use a safe sleeping bag with no hood and bub's arms out – don't wrap or swaddle bub

Unsafe sleeping spaces

We know that you always try to do your best by your bub! Hopefully these recommendations showed you some ways to keep bub safe during sleep times.

Red Nose acknowledges the Traditional Owners of the lands in which we work, live and visit.
This resource was co-designed with First Nations people.
When we listen, we learn. When we know better, we do better.
–Skye Stewart
Wergaia and Wemba Wemba woman from Mallee Victoria

Red Nose Safe Sleep Advice Hub
1300 998 698 (during business hours)
education@rednose.org.au
rednose.org.au/safesleep

© 2020, 2022 Red Nose Limited. All rights reserved.
For copyright enquiries contact: education@rednose.org.au

red nose
saving little lives

27. The Australian Breastfeeding Association recognises the benefits of co-sleeping for breastfeeding mothers; “they can respond more quickly” and they “tend to breastfeed for longer.” However, it also provides safety advice. It 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.” It includes this advice: “Make sure they have room to return to their back after the feed where their face will be clear of your breast and any bedding. It is particularly important to ensure babies have a clear face and head in shared sleep spaces to protect their airway. It is also important to avoid any objects or positions that may place baby in a chin-to-chest position which is likely to make it harder for a baby to breathe. Ensure pillows are removed from the baby's sleep space.” Similarly to other advice, the Australian Breastfeeding Association also identifies when it is *not* safe the share a bed with baby, which is if a parent is a smoker, or has

used alcohol, illegal drugs or sleep inducing medicines, if baby is small or premature, or if the parent is very tired.[25]

28. While acknowledging the quality of this advice, the Australian Breastfeeding Association advice is all in English, is word dense, assumes some understanding of SUDI and SIDS, refers to protecting airways but does not use the word suffocation/smothering/asphyxiation, and appears largely geared to a western audience.

29. In the Northern Territory, practitioners providing advice to parents rely heavily on these national resources. NT Health's Bed Sharing for Parent/Carer and Baby Guideline[26] directs NT Health staff to Red Nose downloadable resources and, rather regrettably as far as cultural safety is concerned, to a video produced in England by the Lullaby Trust. Royal Darwin Hospital (**RDH**) uses a Red Nose information sheet which includes some additional valuable information; specifically, it refers to the risks of "sudden infant death," "keeping airways clear," "suffocation, overheating and choking." However, the information sheet containing this advice is all in English.[27]

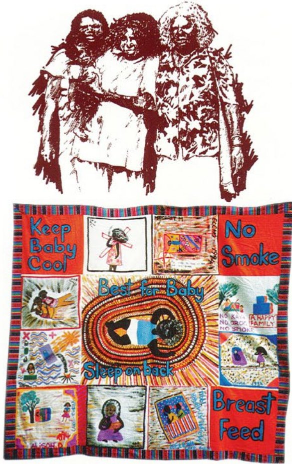
30. My Midwives and Alukura Women's Health Service (**Alukura**) also use Red Nose resources. The My Midwives and Alukura Care Schedule specifies that safe sleeping, co-sleeping and safe wrapping should be discussed at the 'week 34 of gestation' appointment and the mother is to be provided with "resources to take home". It is again scheduled to be discussed at visits on Days 1, 2 and 4 after the birth with the Midwives directed to "visualize sleep space if able."[28]

31. Gove Hospital, Palmerston Regional Hospital and Danila Dilba have a SIDS information sheet specific to their Aboriginal clients. I extract it in full:

25 Australian Breast Feeding Association – Bed-sharing your baby: the facts, June 2021, aba.asn.au/bed-sharing
26 Common Brief 1.10 NT Health Guideline Bed-sharing for Parent/Carer and Baby Guideline
27 Common brief 1.10 RDH Pamphlet
28 Common Brief 1.14 My Midwives/Alukura Care Schedule

Talk to these people about what is Best for Baby

- Community Care Nurse
- Health Worker
- Doctor
- Strong Women Workers



Best for Baby - This banner was created at Nungalinya College by the women of bi-cultural life studies.

SIDS offices all over Australia are also able to tell you more about Sudden Infant Death Syndrome.

GPO Box 3414 Darwin NT 0801
Ph: (08) 8948 5311 Fax: (08) 8948 5244

It's cool for fathers to love and care for their babies.

TAKING CARE OF YOUR BABY

About SIDS

SIDS means
Sudden Infant Death Syndrome
(also known as cot death)

SIDS

What is SIDS?

Sometimes babies die.

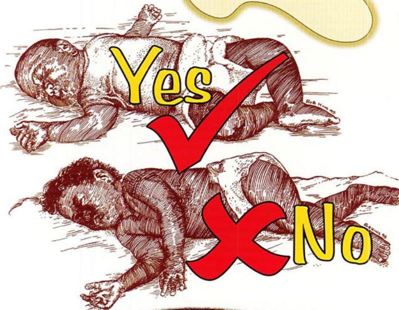
No one knows the reason why.

NO ONE IS TO BLAME.

To help keep baby safe

- Lie your baby on its back to sleep, in a clean flat place.

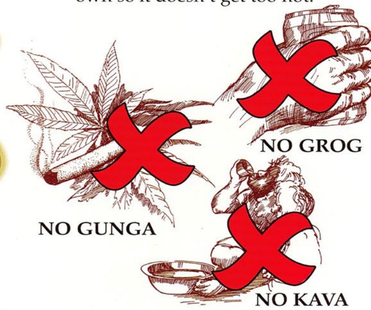
SLEEP ON BACK



Remember

- Do not let your baby get too hot.
- Don't wrap your baby too tightly.
- Make sure baby's head and arms are free to move.
- Baby needs to sleep in a place of its own so it doesn't get too hot.

KEEP BABY COOL



These make you sleepy and you might roll on to baby.

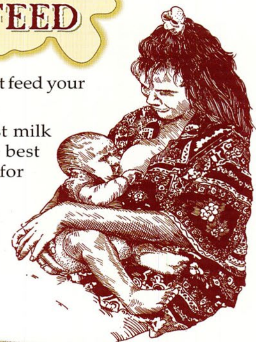
If you have been drinking grog or kava or have been smoking gunga put baby in a safe place to sleep.

- Don't let anybody smoke near your baby before or after it is born because your baby may get sick.
- Smoking mothers have small babies.

NO SMOKE

BREAST FEED

- Breast feed your baby.
- Breast milk is the best food for your baby.



32. This now appears to be somewhat dated, and I have concerns about some of the information and how it is presented. It is in English, it does not refer to suffocation/asphyxiation/smothering and it explains SIDS as 'cot death'. I heard disturbing evidence that this common terminology for SIDS resulted in a significant misunderstanding among Aboriginal families. This terminology led many Aboriginal families to misunderstand the safety provided by cots; instead, this language led them to believe cots were

dangerous for babies and babies died in cots. The term ‘cot death’ made Aboriginal parents more reluctant to use separate sleeping surfaces for babies.[29]

33. Katherine West provided and advised that they use this brochure:

34. This appeared to me to be one of the better adaptations I have seen of Red Nose information for Aboriginal families. It does not preference safe cot sleeping over safe forms of co-sleeping/bed sharing/family sleeping. However, it is in English and it does not specifically name the risk of suffocation/smothering/asphyxiation.

35. Some NT Health Services and Aboriginal Community Controlled Health Organisations (**ACCHOs**) referred me to the Women’s Business Manual, [30]

29 Common Brief 2.7 Ombudsman Western Australia, Investigation into ways that State Government departments can prevent or reduce sleep related infant deaths, 2012 at p64
30 Minymaku Kutju Tjukurpa Womens Business Manual 7th Ed. 2022,CC-BY-NC https://creative commons.org/licenses/by-nc/4.0/

a remote primary health pregnancy and birth care manual. Recognising this will be a lengthy visit as there is much to cover, it recommends a safe sleeping conversation occur at the first postpartum visit and provides the following advice:

Safe sleeping
- Sleep baby on their back
- Do not cover head and/or face
- Do not smoke near baby
- Use a firm, flat mattress and clean bedding
- If co-sleeping, adults should not drink, smoke or take drugs and baby should be between the edge of mattress and carer

36. There was a real scarcity of information on safe sleeping and safer co-sleeping culturally specific to Aboriginal communities, almost no community specific material and none produced in Aboriginal languages. Given the lack of educational materials that reflect the culture, country and language of Aboriginal people, there can really be little surprise if educational efforts with our Aboriginal mothers and families are not proving to be effective.

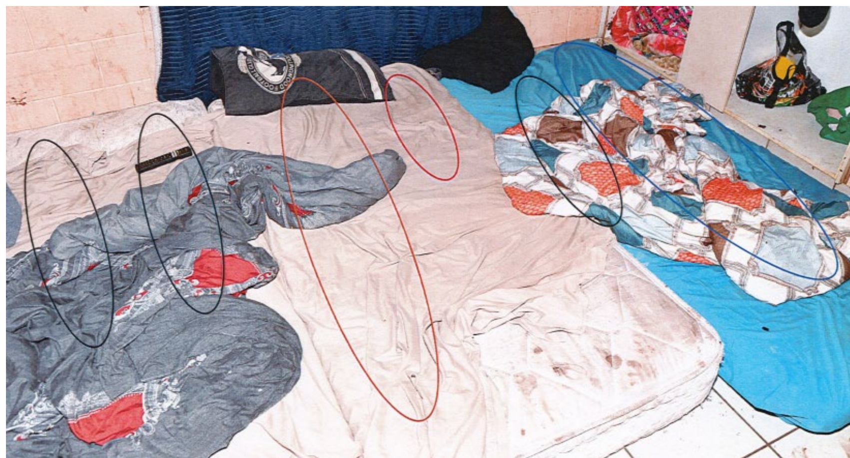
Unsafe sleep environments - what does the Coroner's Office see?

37. Accepting that representations of unsafe sleeping environments in diagrams are useful, I was still left wondering how a parent might understand those images in the context of their real-life sleep environments.

38. Not to shock or shame, but in a genuine effort to grapple with the issue, I now extract photos of some unsafe co-sleeping spaces that are held by the Coroner's Office.[31]

31 Baby K Additional documents Folio 14; none of these photos depict the unsafe sleeping spaces in these inquests

1
2
3



39. Invariably, these photos depict common sleeping environments across the NT which include soft mattresses (noting that cheap and widely available foam mattresses are particularly soft and dangerous for babies), multiple blankets (minky style but also other blankets and doonas being common), pillows, soft toys and occasionally sofas which are particularly dangerous.

40. Across the Territory families sleep in spaces like this every night but these places of shared rest are *dangerous* for small/premature babies. An adult on a soft mattress can create indentations in which a baby can roll and suffocate/smother. Blankets and pillows can be pulled up or moved during the night and inadvertently abut or overlay babies restricting their breathing. The same can happen with soft toys. Co-sleepers who are overly tired or intoxicated or overweight may accidentally, unknowingly, and unwittingly overlay babies causing suffocation or smothering, including by an arm or a breast coming to rest against a baby's face. Adult smoking adversely affects a baby's respiratory capacity. Mattresses or beds abutting walls or pushed up next to a second mattress create gaps and crevices in which babies can roll and suffocate/smother. More than one co-sleeper creates additional risks of overlaying due to overcrowding. The risk increases when baby is situated between co-sleepers. Many mattresses are simply too small for co-sleeping safely, for example, it is not recommended for a baby to co-sleep on a single mattress with one other adult. Many mattresses are simply too soft for a baby to sleep on safely.

41. What I discovered in these inquests was that in many cases the quality of existing mattresses was so poor/old/soiled/soft/small that they could never be adapted for safe co-sleeping. Mothers and babies needed a new, double or queen size *firm* mattress as a minimum first step to create a safer co-sleeping environment. I heard evidence that this was economically beyond the reach of many families and, even if available, such a purchase would not resolve risks when there is transience.

42. Alternatively, families needed to consider further adapting how they co-sleep; to introduce a safe sleep space/surface for baby, for example:

   - a separate mattress for baby (not directly abutting the parental mattress as depicted in the Katherine West brochure – and which I note may also not address issues of transience), or
   - a Pēpi-Pod® (left) or Coolamon (right) (or similar), discussed later in these findings but depicted below.[32]

32 Right - Additional material folio 2 Image from Bubba Basket Business Plan 2021-2023; Left – Image from Coolamon.org.au

43. Dr Musharbash pointed out the obvious: Aboriginal families, like everybody else, have already adapted/changed their sleeping environments - to incorporate soft mattresses, blankets, pillows, toys, parental alcohol use, and smoking. As identified by Professor Byard, these adaptations (and others such as increasing adult body weight) have *introduced* risks that did not previously exist, and these newly introduced risks have made co-sleeping dangerous for babies.

44. These findings will conclude that there should be a concerted effort to educate families in culturally appropriate and relevant ways, including in their own language, on safe sleeping and specifically on the need for a further adaptation/change specific for babies, to make co-sleeping safe again. As Professor Byard said, "you're getting a baby off a soft mattress, you're getting a baby out from under the covers, and you're getting a baby away from direct compression by a parent's body, and those are the things you need to do, and then that makes it safe."

45. In addition to education; hospital, health and community programs should make devices such as Pēpi-Pods® or Coolamons (safe sleeping devices) freely available to families who would benefit from them. The effectiveness of education, the uptake of safe sleep devices and the impact on baby mortality; should all be thoroughly evaluated. We cannot keep losing our precious babies to preventable deaths.

The story of Baby B

46. Baby B's mother did not give evidence and instead provided a statement. She can speak English and Arrernte but prefers Arrernte.

Antenatally

47. Baby B's mother lived in Alice Springs and attended appointments with midwives at Alukura.[33] In her statement she said that all the appointments were in English and any written information she received was in English.[34] She said that there was no interpreter at any of the appointments and that she would have accepted an interpreter if one was offered. Similarly, she said that she did not have access to Aboriginal support workers or Aboriginal Health Workers.[35] She said that her appointments checked up on her pregnancy and she was not given much information about how to look after her baby. Baby B's mother did not recall anyone telling her about how to sleep more safely with her baby.[36] She said that it would have helped her to get information about how to sleep safely with her baby, and it would have been best done with an interpreter.[37]

48. Baby B's mother's midwife, ES, worked with Alukura and My Midwives. Midwife ES said that Alukura tried to include Aboriginal Liaison Officers (**ALO**) in appointments with mothers[38] but many mothers preferred only to have the midwife present.[39] Similarly, the My Midwives mode of practice, in partnership with Central Australian Aboriginal Congress, is to pair midwives with an Aboriginal maternity support worker, those workers being described as a "very valuable resource".[40] Dr John Boffa, the Chief Medical Officer of Public Health at Congress, attested to the efficacy of this "bi-cultural pairing."[41] QM, a midwife employed by the Northern Territory Health Department (NT Health), said that it was beneficial to have an ALO in appointments and consultations if the mother consented to them being there.[42] In a similar vein, RA, a midwife employed by NT Health, told me that Aboriginal health workers are valuable resources in the midwifery department, and there are not enough of them.[43] A midwife employed by My

33 Baby B's mother's statement 13 July 2025, at [13]. This evidence is difficult to reconcile with the records of My Midwives, which indicate that she was first seen by Midwife ES on the date she was due to give birth.
34 Baby B's mother's statement 13 July 2025, at [19]
35 Baby B's mother's statement 13 July 2025, at [14]-[18]
36 Baby B's mother's statement 13 July 2025, at [21-22]
37 Baby B's mother's statement 13 July 2025, at [24]-[25]
38 Inquest evidence of Midwife ES on 15 July 2025 at 56
39 Inquest evidence of Midwife ES on 15 July 2025 at 58
40 Inquest evidence of Midwife ES on 15 July 2025 at 59
41 Inquest evidence of Dr John Boffa on 18 July 2025 at 349; 350; 351; 355
42 Inquest evidence of Midwife QM on 16 July 2025 at 166
43 Inquest evidence of Midwife RA on 16 July 2025 at 188; There is a single Aboriginal Health Practitioner working on the maternity ward at Alice Springs Hospital: Inquest evidence of Midwife RA on 16 July 2025 at 188

Midwives, BM (who cared for Baby S), also told me that the use of interpreters was vital for clear and proper communication between health care professionals and parents.[44]

49. There may be sound reasons why a patient might choose not to engage with an ALO or an Aboriginal Health Practitioner (**AHP**); privacy issues and continuity of care spring to mind.[45] However, there is no doubt in my mind that ALOs and AHPs are fundamental for the delivery of culturally safe pregnancy care.

50. Midwife ES said that it was difficult to find and engage with the mother of Baby B during her pregnancy. It was a common theme in the evidence that in 2022 and 2023 establishing regular contact with Aboriginal mothers was often difficult and there was no evidence to suggest that this had improved. The transitory lives of families in the context of insecure housing, domestic violence, distrust as to the safety of health services and other socio-economic difficulties faced by the most vulnerable women are the likely root causes for these difficulties.

51. Despite that difficulty, Midwife ES was diligent. Even when she could not find Baby B's mother, she was reviewing her records. She was increasingly concerned that the baby was due, and the mother had not seen a midwife. On Baby B's due date, Midwife ES went out actively searching for her. She found Baby B's mother who agreed to go to the hospital to discuss the delivery.[46]

52. Baby B was born on 21 August 2023 in Alice Springs Hospital (**ASH**), and his family was overjoyed at his birth. He was a healthy baby with a good birth weight and good APGAR scores, who grew well and was described as settled and contented. He was his mother's second child. He was a happy baby, he slept well, enjoyed warm interactions with his mother, and he brought joy to those who met him.

53. Midwife ES saw Baby B's mother on 25 August 2023 when Baby B was four days old. In her notes she wrote "SIDS," and in evidence she said that she discussed safe sleeping[47] and provided a "SIDS safe sleeping Indigenous

44 Inquest evidence of Midwife BM on 15 July 2025 at 110
45 Inquest evidence of Midwife RA on 16 July 2025 at 188. These include simply not wanting to; some women want the midwife to explain things to them; some women do not want people from their community knowing their business.
46 Inquest evidence of Midwife ES on 15 July 2025 at 63
47 Inquest evidence of Midwife ES on 15 July 2025 at 65-66

brochure that was in English" to help explain safe sleeping.[48] Later, Midwife ES said that on one occasion she took Baby B's mother to Centrelink and used that opportunity to discuss safe sleeping "because we had the time to actually do that then."[49]

54. On another occasion Midwife ES went to the house where Baby B and his mother were staying. She was not invited inside. She said that she was not generally invited inside when she made home visits and she would not insist on going inside to inspect, for example, sleeping arrangements, because that might embarrass or shame mothers.[50] As a result, Midwife ES did not look at Baby B's co-sleeping arrangements. When she was shown photos of the co-sleeping situation during the inquest, she said that if she had seen that at the time she would have recommended a container for the baby to sleep in next to the bed.[51]

55. Similarly, Midwife BM said that it would be difficult for midwives to enter and inspect sleeping arrangements because: a) there are likely to be several family members living or staying at the home who might wish to maintain their privacy, [52] b) there might be people sleeping inside, and c) it might not be safe for one person to enter a house without a co-worker being present. [53] It was her experience that families preferred to see midwives outside, rather than have them come into the house to see the sleeping area.[54] Similarly to Baby B's mother, when Midwife BM visited Baby S at home on 2 December 2023, Baby S's mother indicated that she would prefer to talk outside.[55] Midwife RA, one of Baby K's midwives, gave evidence consistent with the other midwives, and specifically mentioned overcrowding giving rise to safety and privacy issues which inhibited midwives entering houses.[56]

56. After hospital, checkups with Baby B recorded that he was healthy and well.

48 Inquest evidence of Midwife ES on 15 July 2025 at 65-66. This brochure is called 'Keeping Bub Safe'; the appropriateness of this brochure for Aboriginal parents is discussed later in these findings
49 Inquest evidence of Midwife ES on 15 July 2025 at 67
50 Inquest evidence of Midwife ES on 15 July 2025 at 66
51 Inquest evidence of Midwife ES on 15 July 2025 at 88
52 Inquest evidence of Midwife BM on 15 July 2025 at 128
53 Inquest evidence of Midwife BM on 15 July 2025 at 128
54 Inquest evidence of Midwife BM on 15 July 2025 at 128
55 Inquest evidence of Midwife BM on 15 July 2025 at 105
56 Inquest evidence of Midwife RA 16 July 2025 at 177-78

Baby B's passing

57. On 21 October 2023 Baby B was still *young and small*, he was only two months old. He was at Hidden Valley Camp in Alice Springs with his mother and father. During the evening, both his parents were *smoking and drinking* outside late into the night.[57] As discussed earlier in these findings, parental smoking and drinking are risks factors for co-sleeping. Tragically, Baby B's mother told me that she did not know about these risks.[58]

58. Baby B was put to bed before his parents went to bed. Baby B slept on the same *soft mattress* as his parents. *Heavy blankets* were on the mattress to keep them warm.[59] Later, at about midnight, his parents joined him in bed. His mother fed him before they all fell asleep. Baby B was *lying between his parents*, *on his side* and he had his own blanket.[60]

59. In the morning, his mother woke up and started her day. His father was still sleeping on the mattress with Baby B. When his mother came back at about 11.15 am to check on Baby B, she found him cold to touch and he was not breathing.[61] Her screams woke his father.

60. At 11.19 am on 22 October 2023 someone at the house made an emotional call to 000. After 3 minutes 50 seconds, the call ended. The operator tried to call back three times, but without success.

61. St John Ambulance arrived within minutes. Ambulance officers performed cardiopulmonary resuscitation (**CPR**) and tried to resuscitate Baby B for about 20 minutes at the location.[62] A large crowd grew and Baby B was transported to ASH where CPR and emergency care continued for another 50 minutes. Baby B could not be revived and at 12.05 pm a doctor pronounced that he had passed away.[63] His parents were devastated.

Autopsy

62. Forensic Pathologist Dr Tiemensma performed an autopsy. She found that Baby B was healthy and he had no injuries. In other words, she found that there were no other factors contributing to his death other than the manner

---

57 Folio 9, Baby B brief. Both parents were described as full drunk.
58 Statement of Baby B's mother, 13 July 2025, at [71]
59 Folio 1, Baby B brief (police investigation)
60 Folio 9, Baby B brief
61 folio 9, folio 11, Baby B brief
62 folio 6, Baby B brief
63 Folio 7, Baby B brief (p 91)

of his sleeping. Dr Tiemensma's findings are that Baby B's cause of death was a Sudden Unexplained Death of an Infant (SUDI) in an unsafe sleeping environment.

63. Dr Tiemensma explained that having a baby sleep in the same room as its parents but on a separate sleep surface, like a cot, is the best way to keep baby safe.[64] Conversely, in her post mortem report Dr Tiemensma explained that sharing a sleeping surface with another person was a known risk for sudden death in infants. Dr Tiemensma applied Professor Byard's triple risk model which, as noted earlier, identifies the risk factors for infant death in shared sleeping conditions[65] that arise from a) the baby, b) the parents, and c) the sleep environment.

64. Dr Tiemensma found:

a) Infant risk factors: Baby B was both young and small;
b) Parental risk factors: his parents were intoxicated and tired and there were multiple co-sleepers;
c) Bed/environmental risk factors: heavy covers, a soft sleeping surface.

65. The evidence at the inquest also revealed that it is likely that cigarettes were smoked in the bedroom, although exactly when that happened is not clear on the evidence.[66]

66. The evidence of Professor Byard and Dr Tiemensma was that together these combined risk factors markedly increased Baby B's risk of passing away even though he was otherwise healthy and well.[67]

Formal findings

67. For Baby B I find as follows:

(i) The identity of the deceased is Baby B, born on 21 August 2023, whose full details are known to the Office of the Coroner.

(ii) Baby B was pronounced dead on 22 October 2023 at 12:05 pm at the Alice Springs Hospital in the Northern Territory.

64 Inquest evidence of Dr Tiemensma on 17 July 2025 at 292
65 Professor RW Byard, Letter to the Editor (2012) 48 Journal of Paediatrics and Child Health 947, at 947-948
66 Inquest evidence of Midwife SM on 14 July 2025 at 45
67 Inquest evidence of Professor Byard & Dr Tiemensma on 17 July 2025, for example, at 286

(iii) Baby B's cause of death was Sudden Unexplained Death of an Infant (SUDI) in an unsafe sleeping environment.

(iv) The particulars required to register the death have been provided to the Office of Births, Deaths, and Marriages.

The story of Baby S

68. Baby S was a much-loved baby. She was born on 30 October 2023. Baby S's uncles and her aunt loved spending time with their niece. Baby S's maternal grandparents loved cuddling their granddaughter. Baby S was cherished by her parents. Baby S passed away on 6 December 2023 when she was only 5 weeks old. Her parents and family are stricken with grief. Her father was so sad he could not speak with investigators.[68] However, Baby S's mother helpfully provided a statement about Baby S.

69. Baby S now has a little sister and Baby S's mother has purchased a safe sleeping device for this child. Out of their tragedy, Baby S's parents now understand the real risks and the potential tragic consequences of unsafe co-sleeping. However, no parent should have to learn through experiencing their own tragedy.

70. When she was pregnant with Baby S, the mother went to Flinders Medical Centre because she had severe rheumatic heart disease and gestational diabetes.[69] Baby S was born prematurely at Flinders Medical Centre at 35 + 1 weeks. She was a small baby. She was well cared for, was breast fed, and put on weight consistently. Mother and baby were discharged back to ASH from Flinders Medical Centre a week later.

71. In Adelaide, the parents were given a Pēpi-Pod® (a plastic sleeping tub for babies to aid in safe sleeping, discussed in greater detail later in these findings). They were not able to bring the Pēpi-Pod® back to Alice Springs on the bus or the plane.[70] ASH has Pēpi-Pods® for use in the hospital, but they did not have Pēpi-Pods® that parents could take home.[71] Instead, Baby S's mother was told to buy a cot for baby.

---

68 Folio 1, Baby S brief, at 5

69 Baby S was diagnosed with a heart issue in utero, but it was not medically significant and did not contribute to her death.

70 This was owing to the workers at the hostel Baby S's parents were staying at erroneously telling the couple that they couldn't take the Pēpi-Pod® on the bus: Statement of Baby S's mother, 13 July 2025 at [35]

71 Inquest evidence of Midwife BM on 15 July 2025 at 107; see also inquest evidence of Midwife QM on 16 July 2025 at 154

72. Baby S's mother found her time at ASH more difficult than her time in Flinders Medical Centre. She said that at ASH there were no Aboriginal women or Walpiri interpreters to support her through her care and she was sometimes confused about what the doctors or nurses were saying.[72] When Baby S's mother compared her experience at ASH to hospital in Adelaide, the most significant difference was that her partner was with her all the time in Adelaide, but was not allowed to stay on the ward in Alice Springs.[73] Baby S's father was a good dad who wanted to support his partner and be involved in looking after Baby S.[74] When he could not stay, I can imagine that he felt excluded and the mother felt isolated. Being alone made it harder for the mother and she worried.[75] Baby S's mother also felt there was a lot less support at ASH compared to Flinders Medical Centre. She said that [one of the nurses in Adelaide] would come sit down with them and visit every day to make Baby S's parents feel comfortable to talk[76] but there was no-one like that at the ASH.

73. On 21 November 2023, when Baby S was 3 weeks old, she was discharged from ASH. Midwife BM visited Baby S and her family at home. The notes of that meeting indicate that safe sleeping was discussed and Midwife BM recorded, "[Baby S's mother] very aware, as has been discussed at Flinders and Alice Springs Hospital Neo Natal Unit."[77] Although there were no further details about the content of the discussion recorded in the notes,[78] Midwife BM was confident the safe sleeping information she provided was comprehensive and tailored to the client, in line with her normal practice.[79] Midwife BM said that it was her practice to discuss safe sleeping with parents antenatally and then again in the early postnatal period, often on a home visit, particularly if she saw where the baby was sleeping.[80]

74. Baby S's parents were familiar with the concepts of safe sleeping and bought a cot as instructed by ASH. [81] They tried very hard to do use the cot but found that Baby S would not settle alone in the cot, and would only settle if she was in bed with them.[82] They tried hard to create a separate space for Baby

---

72 Statement of Baby S's mother at [49]
73 Statement of Baby B's mother, 13 July 2025, at [29], [43]
74 Statement of Baby B's mother, 13 July 2025, at [29], [32], [40], [43]
75 Statement of Baby S's mother at [50]
76 Statement of Baby S's mother at [42]
77 Inquest evidence of Midwife BM 15 July 2025 at 104
78 Inquest evidence of Midwife BM on 15 July 2025 at 105
79 Inquest evidence of Midwife BM on 15 July 2025 at 104
80 Inquest evidence of Midwife BM 15 July 2025 at 108
81 Statement of Baby S's mother, 13 July 2025 at [40]
82 Statement of Baby B's mother, 13 July 2025, at [51]

S's in their bed, and after her passing bitterly regretted the loss of the Pēpi-Pod®.[83]

75. There were many family members living in the same house; it was overcrowded as is often the case. Baby S's parents had the only bedroom and everyone else slept in a single living space. Baby S's parents did not want Baby S to disturb everyone else. In those difficult circumstances, and where there were legitimate competing considerations, it can be well understood why they decided to have Baby S sleep in their bed (where she was settled) instead of in her own cot (where she was unsettled).[84]

Baby S's passing

76. Baby S spent the day with her parents. At about 11 pm they all went to the convenience store for tobacco and snacks. Both parents smoked, but told investigators that they did not smoke near Baby S.

77. When they got home, her mother put Baby S to sleep on the double bed in the bedroom. She was wearing a sleeveless body suit and socks. Both *parents smoked cannabis* outside the bedroom where Baby S was sleeping.[85]

78. At about 1:00 am, Baby S began to fret and cry. Her mother went in to feed her and after she was fed Baby S fell asleep. Her mother wrapped her in a baby blanket and put her on the far side of the bed. Both parents went to bed about 2am. Baby S's mother made sure that Baby S wasn't too close to her so that she wouldn't roll on her.[86] In addition to the blanket Baby S was wrapped in, her parents covered themselves and Baby S in 2 additional *blankets*, as it was cool due to the air conditioning being on. These blankets are visible in the evidence photos. During the night another family member turned off the air conditioning, so, by the time the parents woke in the morning, the room was heating up.

79. A member of the household looked in on them at about 9.45 am before she went to an appointment in town. At that stage everything seemed fine and it looked like the family was sleeping. Baby S's parents woke up shortly after 11 am. They looked to see whether Baby S was awake. They tried to wake her and noticed she was not breathing. This was at about 11.15 am.

83 Statement of Baby B's mother, 13 July 2025, at [52]
84 Inquest evidence of Midwife BM 15 July 2025 at 123-4
85 Audio Statement of Mother of Baby S, 30 January 2024
86 Audio Statement of Mother of Baby S, 30 January 2024

80. Her mother called 000 at 11.17 am[87] and an ambulance arrived within minutes. Baby S was in her mother's arms. The ambulance officers took Baby S, put her in the ambulance, and performed CPR for about 10 minutes. An intensive care paramedic arrived on the scene. At about 11.34 am it was noted that signs of rigor mortis were present and CPR was ceased. Baby S was declared deceased at 11.44 am on 6 December 2023.[88]

Autopsy

81. Dr Tiemensma performed the autopsy on 11 December 2023. The autopsy excluded other potential causes of death. After evaluating Baby S's history and her sleeping environment, Dr Tiemensma concluded that the unsafe sleeping environment likely contributed to the death, and accidental mechanical asphyxia as a likely cause of death should be considered.[89] Although she listed the direct cause of death as "unexplained", Dr Tiemensma, a highly experienced forensic pathologist, said at the inquest that Baby S's death was sudden and unexpected in an unsafe sleeping environment.[90]

82. In her report she referred to the known increased risk for sudden death in infants who share a sleeping surface with another.[91] Applying Professor Byard's triple risk model Dr Tiemensma identified the following co-sleeping risk factors:
    a) Infant risk factors - Baby S was premature, young, and small;
    b) Parental risk factors - intoxication (cannabis),[92] smoking (cannabis);
    c) Bed/environmental risk factors - multiple co-sleepers, a soft surface, bedding (heavy minky blankets[93] which also create an additional risk factor of overheating).[94]

87 Folio 11, Baby S brief
88 Folio 11 (St Johns Ambulance Records), Baby S brief
89 Folio 4 (Post mortem report, p 3), Baby S brief
90 Folio 4 (Post mortem report, p 2), Baby S brief
91 Folio 4 (Post mortem report, p 3), Baby S brief. Baby S was premature, and was co-sleeping with two adults who smoked prior to going to sleep, on a bed with soft bedding.
92 It appears that this finding relates to cannabis
93 a very soft, warm fabric made of polyester (an artificial material) that is thick and soft, with one side like short fur, and that is often used for making blankets, toys, and clothes, especially for children
94 Inquest evidence of Dr Tiemensma on 17 July 2025 at 283. The expert evidence was that high temperatures also increase the risk factors for infant death, which could have been a factor at that time of year: inquest evidence of Dr Tiemensma and Professor Byard on 17 July 2025 at 291-2.

Formal findings

83. Concerning Baby S I find:

(i) The identity of the deceased is Baby S, born on 30 October 2023, whose full details are known to the Office of the Coroner.

(ii) Baby S was pronounced dead on 6 December 2023 at 11:34 am at Larapinta in the Northern Territory.

(iii) Baby S's cause of death was Sudden Unexplained Death of an Infant (SUDI) in an unsafe sleeping environment.

(iv) The particulars required to register the death have been provided to the Office of Births, Deaths, and Marriages.

The story of Baby K

84. Baby K was born in Alice Springs Hospital on 8 September 2022, a bit beyond full term. His birth weight was within the normal range. He was dearly loved.

85. The Department of Children and Families (**DCF**, known as Territory Families at that time) knew of his family.[95] DCF's involvement with the family started 11 years before Baby K was born. There were ongoing concerns about neglect and exposure to domestic violence in the context of drug and alcohol abuse.

86. This is not to blame Baby K's mother. She was a victim of intimate partner and family violence. For some of Baby K's gestation, and at the time of his birth, Baby K's father was in prison for assaulting Baby K's mother. During the inquest concerns were raised about the history of domestic violence which had been perpetrated against her by Baby K's father. Non-publication orders to protect her identity are in place for her own safety. Baby K's mother is highly vulnerable. She is a young Aboriginal mother who, during her pregnancy and Baby K's brief life, was also caring for an older sibling.[96] She did not have stable accommodation, she moved between various locations, and sometimes she was drinking. At one point in her pregnancy,

95 Apparently one of these notifications resulted in a safety plan in which co-sleeping was discussed. This was in the context of family members agreeing that if the parents wanted to drink, the older sibling of Baby K was to be left in the care of a sober adult. Inquest evidence of Andrew Walder on 18 July 2025 at 396

96 Baby K's older sibling was only a young child at the time and still breast feeding when Baby K was born

Baby K's mother was living in a tin shed with no walls.[97] Despite these difficulties, she did her best to care for her children.

87. In late 2021, before Baby K was born, DCF initiated a Strengthening Families case for Baby K's family. Baby K's older sibling was about 6 months old at that time.[98] The Strengthening Families case continued until 14 October 2022, when Baby K was five weeks old. Whether it should have been kept open longer is discussed later in these findings.

88. Midwife QM provided antenatal care to Baby K's mother. Baby K's mother first called and asked to be seen in mid-May 2022. At that time, Baby K's mother said that there was too much drinking and temptation where she was staying and family were encouraging/forcing her to drink alcohol in her pregnancy. She wanted help in securing stable long-term housing, and a new phone so that she could stay in touch with service providers.[99] Midwife QM drove Baby K's mother to the women's refuge.[100] In other words, Baby K's mother knew she needed help and she was taking proactive steps to get it.

89. Midwife QM told me that during her pregnancy Baby K's mother was as engaged as she was able to be in circumstances where there was domestic violence, alcohol use, and housing instability.[101] Despite those challenges Baby K's mother accepted antenatal care and saw the midwives 7 times during her pregnancy, similar to other mothers experiencing less difficult circumstances.[102]

90. On 24 May 2022, Baby K's mother was assaulted by a family member because she refused to drink alcohol. Midwife QM made a referral to DCF because family were forcing Baby K's mother to drink.[103] It is possible that this coercion by family members was at the behest of Baby K's incarcerated father as part of an ongoing campaign of coercive control over Baby K's mother.[104]

91. On 27 June 2022, Baby K's mother asked Midwife QM for a referral to the alcohol rehabilitation service in Tennant Creek.[105] Midwife QM made this

---

97 Inquest evidence of a DCF Child Protection Practitioner on 18 July 2025 at 335
98 Inquest evidence of a DCF Child Protection Practitioner on 18 July 2025 at 324
99 Inquest evidence of Midwife QM on 16 July 2025 at 144
100 Inquest evidence of Midwife QM on 16 July 2025 at 145
101 Inquest evidence of Midwife QM on 16 July 2025 at 144
102 Inquest evidence of Midwife QM on 16 July 2025 at 144
103 Inquest evidence of Midwife QM on 16 July 2025 at 145-6
104 Inquest evidence of Andrew Walder on 18 July 2025 at 417
105 Inquest evidence of Midwife QM on 16 July 2025 at 146

referral, as well as other referrals to: CatholicCare for housing, the Social Worker at Tennant Creek Hospital, and to the women's refuge. Midwife QM said that she checked to ensure that the CatholicCare referral was "sent and followed up", but the referral to the social worker was not actioned to her knowledge.[106]

92. On 1 September 2022 a family meeting was organised by DCF with Baby K's mother and extended family: to encourage support for Baby K's mother to drink less, to ensure family looked after Baby K's older sibling if Baby K's mother was intoxicated, and for the sibling to be returned to Baby K's mother's care when she was sober again.[107]

93. The next day Baby K's mother asked DCF for a referral to BRADAAG, the alcohol rehabilitation service in Tennant Creek, so that she could address drinking issues, and, I infer, to get away from negative family influences including the coercive control of Baby K's father.[108] However, that referral was never made.[109] This was a significant lost opportunity to intervene to assist Baby K's mother. Less than one week later, Baby K was born.

94. The day after he was born, his mother discharged herself from ASH and caught a bus back to Tennant Creek. Midwife QM gave her a brochure about safe sleeping, which was all in English.[110] There was no evidence that any other sleeping education was provided. The 'vaginal birth clinical pathway' is a check list which nurses and midwives use to guide their conversations with parents after birth. At the time of Baby K's birth, it did not include a prompt for safe sleeping discussions/education on 'day one' after birth. I was told that it has been amended and now includes a prompt to discuss safe sleeping with parents.

95. Three days after Baby K was born, he was admitted into the Special Care Nursery, ASH, with signs of dehydration. He had lost more than 10 per cent of his body weight. He gained weight in hospital and was discharged a week later.

96. Two months later (on 21 November 22) Baby K went to hospital for a cough. A week after that he was back in Alice Springs Emergency with cold and

---

106 Inquest evidence of Midwife QM on 16 July 2025 at 145
107 Affidavit of Andrew Walder, 3 July 2025 at [153]
108 Affidavit of Andrew Walder, 3 July 2025 at [154]
109 This was acknowledged by Andrew Walder in his evidence (see, for example, his affidavit at [170])
110 Inquest evidence of Midwife QM on 16 July 2025 at 154

flu-like symptoms, which had persisted for some time. This respiratory illness likely made him more vulnerable, and it was determined to be a relevant factor in his death.

97. Two and a half weeks later, aged 3 months, Baby K passed away.

Baby K's passing

98. During the evening of 7 December 2022, Baby K was with his mother. She went to a family house to drink. There were lots of people there, and Baby K was held and cuddled by many of them. Baby K went home with his mother on the Night Patrol Bus at about 8.45 pm. He was cuddled by family on the bus ride home. There was no safe baby capsule available.

99. His mother took Baby K into the house and left him in the care of his grandfather. She then went outside to continue drinking and listen to music.

100. Baby K was unsettled for most of the evening. His grandfather gave him some milk, but then called a relative, a young teenage girl, to come in and look after the baby. Baby K's mother was drinking and smoking all evening. She said that she was too drunk, and she also asked the young teenage girl to hold Baby K and look after him.

101. The young teenager cared for the baby, both inside and outside the house, including making him milk, for several hours.

102. Sometime in the early morning, Baby K's *intoxicated mother* went to sleep on a *single bed mattress* inside the house. She was very drunk and *very tired* and baby K was *co-sleeping* in bed with her or being tended to by the young teenager. Perhaps as late as 6 am, the young teenager finally put Baby K back in bed with his mother who was under some *blankets*. She told Baby K's mother that she was going, and Baby K's mother asked her to come back later. The teenager left the house and went to her own home to sleep.

103. Baby K's mother woke up a bit before 7 am. She found Baby K lying face down and not responding. She was very distressed and started crying. She wanted her father to wake the baby.

104. At 6.51 am Baby K's grandfather called 000. He told the dispatcher that Baby K was not responding and not breathing. Police and ambulance were immediately dispatched. Police arrived first and commenced CPR at 7 am, and then paramedics took over. Attempts to revive the baby continued at the

scene, in the ambulance, and in the Emergency Department. Tragically, Baby K was declared deceased at 8.13 am on 8 December 2022.

Autopsy

105. An autopsy conducted by Dr Tiemensma found that the cause of death was "sudden death in the context of viral upper respiratory tract infection and an unsafe sleeping environment."[111]

106. Dr Tiemensma noted that the mild to moderately severe upper respiratory tract infection (which had been the cause of Baby K's hospitalisation shortly before his death) was not sufficient to cause death on its own.[112]

107. Applying Prof Byard's triple risk model, Dr Tiemensma found co-sleeping risks:
    d) Infant risk factors - Baby K was young and small;
    e) Parental risk factors - intoxicated and tired mother;
    f) Bed/environmental risk factors – single bed with a soft surface and heavy covers.

108. Although not noted by Dr Tiemensma, witnesses and Baby K's medical records provide evidence that his mother was also a smoker. Dr Tiemensma concluded that both the respiratory tract infection and the unsafe sleep environment were risk factors and both contributed to Baby K's passing.[113]

Formal findings

109. For Baby K I find as follows:

(i) The identity of the deceased is Baby K, born on 8 September 2022, whose full details are known to the Office of the Coroner.

(ii) Baby K was pronounced dead on 8 December 2022 at 8:13 am at Tennant Creek Hospital in the Northern Territory.

(iii) Baby K's cause of death was Sudden Unexplained Death of an Infant (SUDI) in the context of viral upper respiratory tract infection and an unsafe sleeping environment.

111 Baby K Coronial brief, Folio 4, at 2/20
112 Inquest evidence of Dr Tiemensma on 17 July 2025 at 290
113 Inquest evidence of Dr Tiemensma on 17 July 2025 at 290

(iv) The particulars required to register the death have been provided to the Office of Births, Deaths, and Marriages.

Education and a Pēpi-Pod®

110. During her pregnancy Baby K's mother said that she was given very little if any education about safe sleeping[114] and, if any was given, she was not able to recall it.[115] Baby K's mother said that she learns best when either someone shows her how to do something, or she can watch a video about how to do it.[116] She said that she didn't understand all of what she was told, she cannot read English very well,[117] she did not remember having any Aboriginal Health Workers (**AHW**) or Aboriginal Liaison Officers (**ALO**) at any of her appointments, and she would have liked to have an AHW or ALO as it would have made her more comfortable and it might have emboldened her to ask questions about things she didn't understand.[118] Her main education on parenting and sleeping came from her mother, grandmothers and aunties.[119]

111. Midwife QM told me that "normally in the pregnancy, not much information about co-sleeping is ever provided, because there's a lot of information to be covered" on other things.[120] She told me that in her experience "normally, the majority of the co-sleeping or safe sleeping education is done once a baby's born on the ward, prior to the mother being discharged from the hospital."[121] She said that in the last few weeks of pregnancy (from 38 weeks onwards) questions such as "Do you have a place for the baby to sleep? Do you have a bassinet or a cot? Are you prepared for these things at home?" might be asked.[122] However, there was no prompt for such questions to be

114 Baby K's mother's statement, 21 July 2025 at [7]. I make this finding even though Ms Midwife RA, one of her midwives, gave evidence (at 173-4) that she had spoken to Baby K's mother at 14 weeks gestation about not smoking around the baby, which I accept is one of the factors relating to the overall safe sleeping picture.
115 Baby K's mother's statement, 21 July 2025 at [7]-[8]; DCF say that they discussed the risk of co-sleeping with Baby K's mother when they spoke to her about one of Baby K's older siblings: Affidavit of Andrew Walder, 3 July 2025 at [106]-[109]
116 Baby K's mother's statement, 21 July 2025 at [11]
117 Baby K's mother's statement, 21 July 2025 at [10]
118 Baby K's mother's statement, 21 July 2025 at [13]
119 Baby K's mother's statement, 21 July 2025 at [14]
120 Inquest evidence of Midwife QM on 16 July 2025 at 149; those other matters Midwife QM said, included for example, not drinking, not smoking, education on the woman sleeping on their side and monitoring the baby's movements, diets, when to present to hospital if they've got any pains or things, and a lot of information about the birth and labour process.
121 Inquest evidence of Midwife QM on 16 July 2025 at 150
122 Inquest evidence of Midwife QM on 16 July 2025 at 150

asked. She was not aware of any pre-birth education or discussions of safe sleeping with Baby K's mother.[123]

112. Midwife RA said that she provided Baby K's mother with both ante-natal care and post-natal care after she returned from giving birth in ASH.[124] Midwife RA confirmed that one reason for a lack of safe sleeping education during pregnancy is that women are focussed on the pregnancy and birth[125] but she told me that she did give Baby K's mother information and education about safe sleeping after Baby K was born. She confirmed that she knew of no document that prompted midwives or health providers to give this education.[126]

113. As discussed in greater detail later in these findings, the Tennant Creek midwives participated in a short lived program in Tennant Creek that distributed Pēpi-Pods®.[127] Although she was given a Pēpi-Pod, engagement between Baby K's mother and the program was very limited. Midwife RA said that Baby K's mother was given education on how to use the Pēpi-Pod®,[128] but as already noted, Baby K's mother said she did not remember anyone teaching her about how to co-sleep more safely; and the only information she received about the Pēpi-Pod® was when it was handed to her and she was "told it was for babies to sleep in".[129] Baby K's mother thought it looked too fragile for babies to sleep in and didn't trust it.[130] Earlier in these findings I raised the danger of referring to SIDS as 'cot death'.[131] Baby K's mother said that when one of her older children was born, family showed her a YouTube video where "babies were dying sleeping in the cot, so I did not want my babies to sleep in a cot".[132] Perhaps this fed into her suspicions about the safety of the Pēpi-Pod®.

114. Although the program is designed to give priority to babies less than 2 weeks old, Midwife RA said that there was not enough Pēpi-Pods® on hand to provide them before two weeks and when one batch had been "handed out," the midwives had to wait until another lot came along.[133] Baby K's mother

123 Inquest evidence of Midwife QM on 16 July 2025 at 150
124 Inquest evidence of Midwife RA on 16 July 2025 at 172
125 Inquest evidence of Midwife RA on 16 July 2025 at 175
126 Inquest evidence of Midwife RA on 16 July 2025 at 176
127 Inquest evidence of Midwife RA on 16 July 2025 at 177
128 Inquest evidence of Midwife RA on 16 July 2025 at 192
129 Baby K's mother's statement, 21 July 2025 at [18]
130 Baby K's mother's statement, 21 July 2025 at [19]
131 WA State Coroner, Finding upon inquest into the death of Nathaniel West (F/No: 384/06), January 2010
132 Baby K's mother's statement, 21 July 2025 at [23]
133 Inquest evidence of Midwife RA on 16 July 2025 at 177

did not receive one until 2 October 2023 when Baby K was more than 3 weeks old.[134] I infer the problems with delay are that the risk in the first two weeks is not ameliorated (when babies are at their most vulnerable due to size) and, after two weeks, sleeping arrangements and patterns will already have been established, and there may be a natural reluctance to change/disrupt those arrangements.

115. Baby K's mother was without stable housing, moving between houses, and dealing with domestic and family violence concerns.[135] As part of her postnatal appointments, midwives assisted her into the women's refuge on 7 October 2022 and at that time she brought no belongings, and certainly no Pēpi-Pod®.[136] Given her many difficulties, safe sleeping was potentially not the most pressing priority or at the forefront of her mind.

116. Neither Midwife RA nor Midwife QM went into any of the houses Baby K's mother was staying and so they did not see Baby K's sleeping arrangements.[137] There was no evidence that Baby K's mother ever used the Pēpi-Pod® as it was intended to be used. It was not used the night that Baby K passed away, and it was later located outside in the yard. It adds to the tragedy of Baby K's passing that there was a Pēpi-Pod® available, but it was not being used as a safe sleeping space for Baby K.

117. I acknowledge the incongruence between the midwives' assertions that safe sleep education was provided and baby K's mother's assertion that she recalled little or no such education. Given that AHWs, ALOs and interpreters were not used, the lack of culturally relevant educational material and the competing pressing unmet needs of the mother, this inconsistency is explicable. I accept that the midwives did attempt to explain safe sleeping, and I also accept that this was not effective for Baby K's mother for all the reasons just stated.

Access to and response of services to Baby K's mother's circumstances

118. On 23 December 2021, DCF opened a Strengthening Families case with Baby K's family. On 14 October 2022, DCF closed both a Child Protection Investigation (**CPI**) concerning Baby K's sibling and the Strengthening Families cases. The cases were closed because the exposure to domestic violence was temporarily resolved by the incarceration of Baby K's father,

134 Inquest evidence of Midwife RA on 16 July 2025 at 176
135 Inquest evidence of Midwife RA on 16 July 2025 at 179
136 Inquest evidence of Midwife RA on 16 July 2025 at 178-9
137 Inquest evidence of Midwife RA on 16 July 2025 at 178

the mother had been referred to an alcohol rehabilitation service, DCF had referred the family to a service to complete a housing application, and a safety plan was developed. Overall, the assessment was that the risks had been reduced.[138]

119. However, there was no follow up to ensure, for example, that the alcohol rehabilitation service had successfully engaged with the mother, and nor was there any follow up to ensure a housing application had been made. In fact, Baby K's mother did not attend alcohol rehabilitation, and no housing application was made on her behalf. An application for housing was not lodged for Baby K's mother until 17 March 2023.[139] On 23 and 27 October 2022, and then again on 17 November 2022, DCF received further notifications of concern about Baby K and his brother, indicative of a mother continuing to struggle and the children remaining at risk.

120. In November 2020 the Deputy Coroner made findings into the death of a child in Palmerston.[140] One of the issues raised was DCF (then Territory Families) closing a matter before closure was properly justified. The Deputy Coroner said this:

> "The Coroner sought a review from Territory Families along with a number of questions. The review provided on 29 September 2020 identified a number of issues and what had been done to mitigate the risks for the future. It was identified that the file relating to the notification should not have been closed and there should have been more persistence to ensure that the family was provided appropriate support. In that instance a referral had been made to a non-government provider that was not able to contact [child]'s mother. The provider returned the referral and the Territory Families file was closed. It was identified that referrals made by Territory Families need to be monitored. It was said that the system is being reformed to ensure that there are a number of required steps:
>
> - Acknowledgement of acceptance of the referral;
> - A shared case plan agreed between Territory Families and the provider;
> - Monthly progress reports from the provider to Territory Families;

138 Statement of DCF Child Protection Practitioner, 16 July 2025, at [140]
139 Inquest evidence of Andrew Walder on 18 July 2025 at 415; see also Exhibit 5 – email from Mr Ong to Mr Walmsley, 18 July 2025 at 9:44 am
140 Coroner's Findings in relation to the death of KDV (Rel No: D0148/2018)

- Three monthly case management meetings where mutual decisions are made on progress, case direction, and closure, including the rationale for closure, with a decision to close, continue or alternate referral or a Territory Families Strengthening Families case.

It was said that a referral to Strengthening Families should have been made in this case. If that had happened any referral would have been monitored.

Given that Territory Families has undertaken a thorough and objective review and made changes to strengthen their systems I consider the issues raised have been dealt with."

121. Despite that undertaking, similar issues arose for Baby K. Mr Andrew Walder, Executive Director Regional Services Central Australia with DCF, provided its institutional response and gave honest and forthright evidence. He told me that the Strengthening Families case should have remained open for longer because there was insufficient evidence of safety and insufficient enquiries had been made to ensure compliance with the Safety Plan.[141] If a risk is said to be mitigated by a referral, then DCF should ensure the referral has resulted in the delivery of the required support, or at a minimum, some form of actual connection. I was told this level of governance or scrutiny should occur during a network meeting and DCF cases should not be closed until there is evidence that there has been active engagement between the client and the service to which they have been referred.[142] However, no network meeting occurred in this case. Clearly more rigor is required and DCF should have in place a system that ensures network meetings are held before Strengthening Families cases are closed.

122. A DCF worker assessed one house where Baby K was staying on 11 October 2022. His assessment of the house was that it was in a "clear (sic) and tidy condition", and there were no risk factors in the house on that day.[143] The DCF worker later clarified that it would have been more accurate to say there were no significant identifiable hazards in the house as opposed to "clean and tidy".[144] I was informed that DCF expect their staff to complete objectively accurate Case Notes and provide staff with a Tip Sheet to this effect. Having seen photos of the dwelling I do not accept the assessment of "no significant identifiable hazards" in the house, particularly as it relates

141 Affidavit of Andrew Walder dated 3 July 2025 [176]-[177]
142 Inquest evidence of Andrew Walder on 18 July 2025 at 405-6
143 Inquest evidence of a DCF Child Protection Practitioner on 18 July 2025 at 329
144 Inquest evidence of a DCF Child Protection Practitioner on 18 July 2025 at 341

to safe baby sleeping in any of the bedrooms. If the safe sleeping of Baby K had been better considered, the risks in the sleeping environment could have been identified, education could have been provided and assistance offered to mitigate the risk.

123. I heard that DCF have now introduced a training module for staff, including a 'Safe Sleeping Advice Learning Moment' and scenario training, which addresses co-sleeping and sleeping risks and how to provide advice to parents and caregivers.[145] I was also told that discussing co-sleeping, and the risks of co-sleeping, is now part of safety planning.[146] Furthermore, DCF advises that it is committed to exploring the best means of providing safe sleeping devices to families, including through, for example, currently available 'preventative family care payments'.[147]

Recommendation 1

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 referrals have been made in Strengthening Families cases, the Strengthening Families case should not be closed until a) there is evidence that engagement is established between the referred service provider and the family, and b) a network meeting has been held where engagement and progress in service delivery is discussed and documented by DCF.

124. I accept that there were hurdles for Baby K's mother to engage with a residential alcohol rehabilitation program. She relied heavily on family supports and there are no alcohol rehabilitation facilities in Central Australia or the Barkly that offer placements for parents with children. The Council for Aboriginal Alcohol Program Services (**CAAPS**) is the only service in the whole of the Territory that will take a mother with a baby, and that is in Darwin. In other words, for Baby K's mother, and others like her, residential rehabilitation meant leaving all her family and support behind. It is not hard to appreciate why a new mother would find that difficult to do.

145 Inquest evidence of Andrew Walder on 18 July 2025 at 390; DCF Closing Submissions at [24]
146 Inquest evidence of Andrew Walder on 18 July 2025 at 392 -3; DCF Closing Submissions at [34]
147 DCF Closing Submissions at [27], [29]

125. Dr John Boffa, the Chief Medical Officer of Public Health at Central Australian Aboriginal Congress (**Congress**), said in evidence that if a mother with a serious alcohol problem was able to enter a residential rehabilitation facility for three months straight after birth, the baby's first three months would be alcohol free and wrap around parenting and support services could be offered to the mother.[148] For that to happen, the Central Australian Aboriginal Alcohol Programs Unit (**CAAAPU**) would need to receive funding to substantially expand its infrastructure and workforce. This is the kind of service that is clearly needed in Central Australia and would make a real difference to child and parental outcomes.

> **Recommendation 2**
>
> I recommend to the **Northern Territory Government** that, in consultation with NT Health, Central Australian Aboriginal Congress, other service providers who give antenatal, intrapartum and postnatal care to mothers and babies, Central Australian alcohol rehabilitation services, and research organisations such as Menzies School of Health Research, it identify and quantify the need for alcohol rehabilitation for pregnant and new mothers, and progress the provision of suitable alcohol rehabilitation services in Central Australia which can accommodate mothers and infants, including identifying funding for service infrastructure, programs and delivery.

Common Issues

126. The inquests identified several common issues. Not all were fully explored or investigated to the same degree of detail, and solutions were not always identified. However, whether it is dealt with in detail or not, I will discuss the common issues that arose to capture the information and to highlight the complexity of the challenges faced.

Education

Limitations with existing educational materials

127. Safe sleeping for babies is not intuitive. Best intentioned parents or family members caring for a baby may provide a soft, comfortable, warm, shared, sleeping surface that is the *opposite* of safe and in fact *introduces dangers*.[149]

148 Inquest evidence of Dr John Boffa on 18 July 2025 at 362
149 Inquest evidence of Professor Byard on 17 July 2025 at 287

Good intentions must be informed by good information and education. Education on safe sleeping is likely the key method by which further infant unsafe sleeping/co-sleeping deaths can be prevented.[150] But education to Indigenous mothers about safe sleeping for babies is lacking, piecemeal and rarely culturally appropriate. It was quite frankly shocking that no one attending the inquests produced any culturally appropriate educational materials in Aboriginal languages about safe sleeping.[151]

128. Every year in Alice Springs Hospital there is an average of 700-800 births. 60% of those are Aboriginal babies.[152] However, there was no educational literature (pamphlets, brochures, etc) used in the Tennant Creek or Alice Springs Hospitals in any Aboriginal language.[153] DCF also acknowledged that it did not have culturally appropriate resources to aid its discussions with Baby K's mother.[154]

129. In addition to being in English, most of the educational literature currently available requires a high level of literacy; whereas I heard that 40 to 70 percent of Aboriginal adults have low literacy skills, and this can rise to 90 percent in some remote communities in the Northern Territory. This is unlikely to change any time soon, given there are no adult literacy programs in the NT at a population level or even at an individual level; and workplace literacy programs have also been lost.[155] Whilst I accept that many Aboriginal people do not read in their own language, it is important that NT Health, other health organisations, and DCF ensure that the educational resources they are using are relevant and culturally appropriate for the population they are serving. Lose Mafi, who worked for the Anyinginyi Aboriginal Health Corporation and with the Maternal Early Childhood Sustained Home Visiting Program in Tennant Creek, said: [156]

> "I think it would have been great if it was community-led by some of the Elders in Tennant Creek. And if we had more resources that were… created from that particular community as well. So, I find that some of the brochures are quite wordy, and sometimes it's nice to have less words and more pictures."

150 Inquest evidence of Dr Tiemensma 17 July 2025 at 296
151 Although, Midwife QM 16 July 2025 at 158 described seeing a "safe sleeping SIDS video" used in Katherine Hospital, made by Aboriginal people, part of which was in Kriol.
152 Inquest evidence of Jane Napier on 17 July 2025 at 237
153 Inquest evidence of Jane Napier 17 July 2025 at 239
154 DCF submissions, 25 August 2025, at [8] and [13]
155 Inquest evidence of Dr Boffa on 18 July 2025 at 360
156 Inquest evidence of Losi Mafi on 16 July 2025 at 223-4

130. Education requires much more than just handing over a pamphlet, for a person to read in their third[157], fourth or fifth language. In the *Inquest into the death of Marlon Aidan Jordan Clancy* [2011] NTMC 009 Coroner Cavanagh SM, said at [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."

131. As identified by Coroner Cananagh, another difficulty present with the current literature is that it doesn't sufficiently name, explain, demonstrate or show the risks of unsafe sleeping or the potential consequences. Images with a red cross indicating "don't do this" do not explain the risk. There are no diagrams or images, for example, showing: a blanket/pillow over or next to a baby's face obstructing breathing; a baby rolling into an indentation in a mattress; a baby's breathing being obstructed by an arm or breast; a baby being overlaid. I was concerned that unless the risk was visually clear, the risks may not be understood by those who need to understand it.

132. I accept that midwives, such as Midwife QM, use the English pamphlets in the context of other education such as physical demonstrations.[158] All the midwives described how they attempted to explain or tailor education to the needs of the mothers they were speaking to. Even so, the evidence in these inquests demonstrated that interpreters, AHWs and ALOs were only sometimes used and I am not prepared to assume effective communication was achieved when these cultural supports were not used.[159]

---

157 Affidavit of Sherelle Kahn, 14 July 2025 at [41]. Ms Kahn says that patients often have English as their third, fourth or fifth language

158 Inquest evidence of Midwife QM 16 July 2025 at 157

159 See, for example, inquest evidence of Midwife RA 16 July 2025 at 187; inquest of Midwife BM on 15 July 2025 at 109-10

The Yellow Book or 'My Child Health Record'

133. During the inquests witnesses told me about a Yellow Book or My Child Health record[160] which is given to mothers at ASH to keep track of baby's records.[161] Witnesses confirmed that there was nothing in that Yellow Book to connect it with a young Aboriginal mother and there was little or no authentic consultation in relation to the development of the Yellow Book.[162] Applying a cultural lens, it was described as "awful", and only relevant for a certain demographic of mothers.[163] Midwife QM accepted that the women who were most vulnerable were least likely to use the book.[164] The information contained is beset with the same problems discussed elsewhere.

134. NT Health frankly acknowledged that the Yellow Book may not be useful for Aboriginal mothers, even so, it was submitted that they should not be excluded from receiving it.[165] So far as that goes I agree, but if there is to be a Yellow Book there should be an equivalent resource developed which is relevant to the 60% of mothers who are Aboriginal. All mothers should have material which is relevant to their culture, circumstances, and needs.

The QR Code (https://linktr.ee/kate.uilisone?ltsid=c9e76249-838a-455f-a567-f10587de5a2f)

135. One of the things which has changed since Baby K passed away is the provision of a QR code on the ASH maternity ward for mothers to access information about many things, including safe sleeping.[166] I agree with Midwife RA that it is good for parents to have access to material on their phone (presuming that they have a smart phone, credit, internet connectivity, and the phone is charged) that they can continue to access after they leave hospital.

136. However, similarly to other currently available educational material, I have real concerns about how accessible this truly is for Aboriginal families. All the linked resources are in English and many are word dense and require high levels of literacy. The QR code contains a link entitled 'safe sleeping for newborns' which links to Red Nose documents in English.

160 Common Brief Folio 10, Affidavit of Sherelle Khan July 2025 Annexure 6
161 Inquest evidence of Midwife ES on 15 July 2025 at 90-91
162 Accepting that some of the hand drawn images depict persons of seemingly various ethnicities including Aboriginal persons; Inquest evidence of Midwife ES on 15 July 2025 at 90
163 Inquest evidence of Midwife BM on 15 July 2025 at 119
164 Inquest evidence of Midwife QM on 16 July 2025 at 159
165 NT Health written submissions 20 August 2025 at [65]
166 Inquest evidence of Midwife RA 16 July 2025 at 182

137. While there are some attempts in a generic way to make some information more culturally attuned, there is nothing specific to the communities that ASH services. In this vein, for safe sleeping the QR code links to a 'Keeping Bub Safe' pamphlet/fact sheet, produced by RROSIAC (Western Australia) and the Red Nose facts sheet 'Reducing the Risk of SIDS and Sleep Accidents in Aboriginal Communities'. While these fact sheets/pamphlets are directed at Aboriginal clientele, they are in English, they do not address co-sleeping and they are not designed with Central Australian Aboriginal families in mind.

138. Midwife RA conceded that, on a scale of 0 (not culturally appropriate) to 10 (for example, a demonstration video in language developed by an Aboriginal agency for a local community), the current resources that mothers are directed to through the QR code is "less than 3".[167] Ms Napier also accepted that, for the most vulnerable mothers – that is, whose babies are most at risk when co-sleeping – this resource is overall not culturally appropriate and does not meet their needs.[168]

139. NT Health submitted that the information available via the QR Code has been amended, for example, the terms 'antenatal' and 'postnatal' have been changed to 'before birth' and 'after birth', 'needles' has been added to 'vaccines', and 'drugs' has been added to 'substance use'. I am also told that the QR Code is currently being reviewed by the Aboriginal Health Worker team to ensure the sharing of information is more culturally safe.[169]

140. I acknowledge the value and intent behind these changes but the rectifications now being made are an afterthought. This is not the correct order of things. It is well overdue that Aboriginal clientele be afforded equal consideration when materials are developed and the information provided must be equally weighted to their needs, culture and language as it is to westernised or other multicultural needs. As a culturally appropriate resource for safe sleeping and co-sleeping, the resources linked to this QR code should be completely re-thought and re-formulated with the target audience for this material involved in the design and development of the educational material. As authentic, culturally appropriate material is developed it should be promptly made available on the QR code.

167 Inquest evidence of Midwife RA 16 July 2025 at 184
168 Inquest evidence of Jane Napier 17 July 2025 at 243
169 NT Health written submissions, 20 August 2025 at [71]-[72]

141. In passing I note that consideration could be given to adding a section on each of the Aboriginal Communities that ASH services. Each section could, for example, contains information about children and family services available in each community, including where and how to access a safe sleeping device (like a Coolamon or Pēpi-Pod®), if that service is available.

The potential for locally produced culturally appropriate educational material

142. None of the resources before me in this inquest were developed by NT Health[170] or DCF or Central Australian ACCHOs. I consider that the Department of Health, in collaboration with ACCHOs and DCF, should develop several resources – both in video and brochure form – which show parents how to make sleep spaces safer and, indeed, safe. There does not appear to be any obvious reason why real-life photos or scenarios cannot be used in this educational material. The material should be developed with and by local communities in local languages to ensure the materials are culturally sensitive and appropriate.

143. Midwife ES suggested that a video in language, demonstrating safe sleep practices, would be a powerful education tool. She thought that it would be helpful to have such a video available on iPads that midwives could show to mothers,[171] as an extension or advancement of the mobile medicine and outreach currently offered. But she cautioned that such a video should be made "by Aboriginal people for Aboriginal people."[172] She said that authentic consultation was imperative for efficacy and acceptance of the information; communities value ownership and educational material should be local or regional.[173] Midwife BM[174] agreed and Midwife QM[175] said,

> "[T]he local women are quite visual in their way of learning. So, I think, like, more video demonstrations and stuff, personally, I think would be more beneficial than a brochure, especially women like the mother of Baby K, who had insecure housing. I don't - like, a piece of paper would just be thrown away or lost immediately, whereas I think things like videos and stuff like that would probably be more beneficial for education."

---

170 Inquest evidence of Jane Napier 17 July 2025 at 257
171 Inquest evidence of Midwife ES on 15 July 2025 at 76
172 Inquest evidence of Midwife ES on 15 July 2025 at 76, 86
173 Inquest evidence of Midwife ES on 15 July 2025 at 86
174 Inquest evidence of Midwife BM on 15 July 2025 at 120, 121
175 Inquest evidence of Midwife QM 16 July 2025 at 158

144. The Acting Midwifery Unit Manager of the Maternity Unit ASH, Jane Napier, also considered that a demonstrational video about how to make co-sleeping safer in real life would be beneficial. A video could use real-life images to demonstrate risks: how a baby could be rolled on, how blankets might suffocate, or how a baby might fall off a bed.[176] A video could show how to make a safe space for baby such as: taking the mattress off the bed so there's not a long drop to the floor, taking heavy minky blankets off the bed, taking the pillows off the bed.[177] Such a video could also demonstrate how parents might use a Pēpi-Pod® or a Coolamon in the context of safe co-sleeping.

145. Ms Napier helpfully raised "Grandmother's Law."[178] She observed that grandmothers are very important in educating new mums about baby care and that an educational video depicting grandmothers as the safe sleeping 'educators' could be well received.[179]

146. Similarly, in its report the WA Ombudsman noted: [180]

> … that a culturally appropriate model, which understands Indigenous family dynamics, culture and beliefs, allows those in contact with Indigenous parents and carers to deliver messages that are more likely to be heard and put into action. For example, stakeholders noted that in some Indigenous families it may be more effective to inform grandmothers of the importance of safe sleeping, as they have great influence over the family and their practices when placing their infant to sleep.

147. Professor Byard agreed that it was important to find people who are respected in communities, like grandmothers, to demonstrate that safe sleeping is not about imposing outside ideas, but about actually engaging with the community to save lives.[181]

---

176 Inquest evidence of Jane Napier 17 July 2025 at 245
177 Inquest evidence of Jane Napier 17 July 2025 at 245
178 Grandmother's Law is one half of Land Law where men and women hold balanced positions with reciprocal responsibilities for maintaining societal equilibrium. Grandfathers look outwardly, protecting the camp. Grandmothers look inwardly, nurturing new generations of respectful, responsible and resilient youth who will 'look after country' to benefit both land and people: Ms Colleen Wall, 2017 National Native Title Conference presentation, 5 June 2017
179 Inquest evidence of Jane Napier 17 July 2025 at 246
180 Investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths, WA Ombudsman, November 2012, at 64
181 Inquest evidence of Professor Byard on 17 July 2025 at 296

148. Dr Boffa acknowledged the vital importance of grandmothers, noting: [182]

> "Alukura has got a grandmothers group … if you're going to change attitudes, … about what is traditional and what now might be a better way to do business, you've got to talk to the grandmothers. They have a huge influence. Everyone in every - in mainstream society, your grandmother, you know, has a bit [of] influence on - at what mothers do. They tend to listen to grandmothers, which is good. So, grandmothers will also have to be educated…"

149. While agreeing that older women had an important role to play, Midwife ES also pointed to the benefits of educating a wider circle of family.[183] It was suggested that a culturally appropriate safe sleeping video need not be exclusive to health professionals, it could also be placed on social media platforms (for example, YouTube or TikTok[184]) so that it was publicly accessible to all family members. Further, accepting there may be exceptions if there are safety concerns (for example domestic violence), DCF intends to amend its policies and guidelines to discuss safe sleeping with parents and family members in the child's primary place of residence. I was informed that DCF front line staff now have a learning package addressing safe sleeping and have introduced induction training for new staff about domestic violence, AOD and co-sleeping.[185]

150. As a proactive first step NT Health advised that it had identified funding to fast track culturally appropriate safe sleeping resources. NT Health intends to convert existing Red Nose educational materials into Central Australian languages, namely, Warlpiri, Eastern Arrernte, Luritja, Pitjntjatjara and Warumungu. Phase One, which was said to be already underway, includes the production of posters and slides with animations for a pilot program. Feedback is to be obtained on the pilot, with the intention of adapting educational content to 'real life' examples demonstrated by paid actors. NT Health anticipates being able to deliver the linguistically adapted material within 12 months.[186]

151. I acknowledge and encourage the development of these linguistically adapted educational materials. However, an important part of the evidence is that the new educational material should: a) address the limitations of the currently available material (particularly as to how it represents risk); b) be

182 Inquest evidence of Dr John Boffa on 18 July 2025 at 365
183 Inquest evidence of Midwife ES on 15 July 2025 at 72
184 Inquest evidence of Dr Marchant on 18 July 2025 at 367
185 DCF submissions, 25 August 2025, at [24]-[25]
186 NT Health written submissions, 20 August 2025 at [70]

developed in conjunction with the communities and people for whom they are intended; and c) be delivered by culturally respected members of the community (for example, grandmothers). If the process that NT Health has fast tracked results in materials that are not explicit as to risk and are not culturally authentic then it is likely there will still be more work to do. I would, therefore, encourage a thorough evaluation of any material developed to determine its effectiveness in improving the knowledge of new Aboriginal mothers (and families) and whether it actually results in changes in practice.

152. I note in passing that while I am considering safe sleeping in these inquests, similar culturally appropriate and sensitive resources should be available for all information about pregnancy, birth, and parenting. After the evidence concluded I learned that the Menzies School of Health Research has received an Avant Research Grant to develop the "Dungudbila app: a culturally safe pregnancy education tool." The lead researcher, Dr Kiarna Brown, recognising that Aboriginal women feel disconnected from standard antenatal care said, "It became clear that existing models weren't designed with Indigenous women's needs at their core." Dr Brown explains that she is motivated to create maternity care models that incorporate Indigenous knowledge and cultural practices and the project aims to deliver education that is evidence based and culturally respectful.[187] Given the seemingly close link between this work and the development of culturally appropriate safe sleeping materials, I have included Menzies School of Health Research as a possible collaborative partner in Recommendation 3.

Education is a shared responsibility and must extend to beyond the mother to the family

153. I acknowledge the evidence that many pregnant women are focussed on antenatal health[188] and labour, and that those topics may need to be prioritised in the antenatal period,[189] over broader parenting education.[190] Even so, Ms Napier said that it was important that education about safe sleeping started early, and was ongoing, so it wasn't something that mothers had to suddenly think about when they leave the hospital.[191]

---

187 https://avant.org.au/foundation/research-grant-recipients
188 Inquest evidence of Midwife BM 15 July 2025 at 127
189 For example, safe pregnancy education to minimise health complications during the pregnancy and minimise the risk of long term developmental impacts on the baby.
190 Inquest evidence of Jane Napier on 17 July 2025 at 238
191 Inquest evidence of Jane Napier on 17 July 2025 at 252

154. The midwives said they might discuss safe sleeping late in a pregnancy[192] but that most safe sleeping education and information was given to mothers, on the ward, prior to discharge.[193] I heard that the clinical pathways for discharging women at Alice Springs Hospital now include prompts to talk about safe sleeping, [194] and, since late 2023, the clinical pathways now require midwives to document that the safe sleeping education each day in hospital.

155. While highlighting this improvement, NT Health submitted that there are many factors outside the control of ASH Maternity Services that impact parental receptivity, such as the level of interest or engagement by the mother, the socio-economic issues facing the family, and drug and/or alcohol abuse. I acknowledge that service providers may be short staffed, find it difficult to engage parents as perfectly as they would like, and parents may struggle with information overload, but none of these circumstances or reasons diminish the need to provide culturally attuned safe sleeping education.

156. Having said that, I accept that educational responsibilities are not the preserve of health agencies, midwives or DCF but could be delivered more broadly in community, for example, in early childhood learning spaces and by services which engage with mothers or support families. NT Health and DCF indicated that they support a collaborative approach between them and other service providers in the development of educational materials. [195] Congress is willing to work with NT Health to prepare culturally appropriate educational material.[196] As culturally appropriate material is developed relevant to the communities where mothers reside, there should be a mechanism for ensuring that the materials are shared between agencies and services in that community.

157. Midwife BM reminded me that it is important to have fathers involved in education and information sharing so that everyone is aware of what to do, not just mothers. This extends to families more broadly, including grandmothers. As she pointed out, most Indigenous women live with extended families, and it is important that they know what to do as well.[197]

192 Inquest evidence of Midwife QM on 16 July 2025 at 149-50
193 Inquest evidence of Midwife QM on 16 July 2025 at 149
194 Inquest evidence of Midwife RA on 16 July 2025 at 186
195 Inquest evidence of Andrew Walder on 18 July 2025 at 391
196 Inquest evidence of Dr Marchant on 18 July 2025 at 370
197 Inquest evidence of Midwife BM 15 July 2025 at 113-14

As a general proposition, it is especially important that families be educated about ante- and post-natal matters, including safe sleeping.

158. As materials are developed, and a variety of education routes are identified, it is helpful to bear in mind the learnings from other jurisdictions. Other jurisdictions have recommended that:

a) carers should receive consistent, clear information about the recommended safe sleeping practices, routinely and opportunistically, in antenatal, postnatal, newborn care and community settings until the baby is 12 months of age (NSW);[198]

b) risk assessments are conducted at specified points in care for factors that may indicate a higher risk of SUDI (NSW);[199]

c) ongoing communication is the key, particularly having conversations at multiple points in time, starting before the 3rd trimester (QLD);[200]

d) services involve as many people as possible in education and discussions (QLD);[201]

e) strategies for safer infant sleep avoid lists of dos and don'ts, suggesting instead to aim for understanding of the 'why and how' of safer sleep messages so parents can apply that understanding to all infant sleep situations (QLD);[202]

f) at each conversation, services facilitate discussion and informed decision making (QLD)[203]; and

g) "gist" messaging be used instead of prescriptive lists. For example, gist messaging might be something along the lines of: easier to breathe, safer to sleep (QLD).[204]

159. All parties supported a recommendation to develop accurate, relevant, and culturally sensitive educational materials. Counsel for families emphasised that this should be done through authentic co-design which Aboriginal

198 NSW Health Guideline: Recommended Safe Sleep Practices for Babies, 27 July 2021
199 NSW Health Guideline: Recommended Safe Sleep Practices for Babies, 27 July 2021
200 Queensland Health Clinical Guidelines: Safer Infant Sleep, July 2022
201 Queensland Health Clinical Guidelines: Safer Infant Sleep, July 2022
202 Queensland Health Clinical Guidelines: Safer Infant Sleep, July 2022
203 Queensland Health Clinical Guidelines: Safer Infant Sleep, July 2022
204 Queensland Health Clinical Guidelines: Safer Infant Sleep, July 2022

stakeholders and Aboriginal controlled service providers from inception through to implementation.

Recommendation 3

I recommend that **NT Health** and the **Department of Children and Families**, in consultation with Central Australian Aboriginal Congress and other service providers who give antenatal, intrapartum and postnatal care to mothers and babies, and research agencies such as Menzies School of Health Research, develop accurate, relevant and culturally sensitive and appropriate educational materials about infant safe sleeping and safer co-sleeping, which meets the needs of parents with low literacy and/or of linguistically diverse backgrounds (especially Aboriginal language speakers). This should be done through authentic co-design with Aboriginal stakeholders and Aboriginal controlled service providers from inception through to implementation. Consideration should be given to developing:

a) educational material with realistic representations of the known risks of co-sleeping (and other unsafe sleep risks);
b) complementary educational tools such as videos in language, story-based resources, visual or practical aides; and
c) an educational awareness campaign directed at relevant groups such as Aboriginal community groups, early childhood services and Grandmothers, in recognition of their vital roles in engaging with and educating mothers.

Recommendation 4

I recommend that **NT Health, the Department of Children and Families, and Central Australian Aboriginal Congress** ensure they each have clear, up to date and comprehensive policies and guidelines addressing all aspects of infant safe sleeping and safer co-sleeping practices, with access to culturally relevant and appropriate educational materials (such as any materials created in accordance with recommendation (3)). 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).

Co-sleeping in hospitals

160. From January 2021 to August 2024 there was one co-sleeping death and four co-sleeping "near misses" in Territory hospitals.[205] Medical records show that Baby B was co-sleeping with his mother in hospital on at least one occasion and was noted to have settled next to her overnight on another.[206]

161. NT Health acknowledged that co-sleeping in hospitals was prevalent for cultural and resourcing reasons.[207] If a mother chooses to co-sleep in hospital, the NT Health Guideline on Safe Sleeping for Infants,[208] requires this to be escalated to the Team Leader, who must then reinforce education about risks and risk minimization strategies (safe sleeping devices) and document this in the medical records. If co-sleeping continues then hourly observations must be made by staff, who must also promote risk minimization strategies.[209] However, on the medical records available in these inquests there was little to no documentation concerning safe sleeping education being given in hospital.

162. I heard that a practice had developed whereby a baby mattress (from the cot) is pushed down between the mattress of a single hospital bed and the handrail of the bed, to prevent babies from falling out of the bed. This practice was observed by Midwife QM, at the Alice Springs and Tennant Creek Hospitals.[210] Professor Byard and Dr Tiemensma told me that this is not a safe prasafe and it should cease.[211] Furthermore, their evidence was that it is not safe to co-sleep on a single bed.

205 Folio 1.2, common brief
206 Inquest evidence of Midwife BM 15 July 2025 at 117, referring to Baby B's brief, folio 1 and 2 in the Additional Documents
207 NT Health written submissions, 20 August 2025, at [26] ff.
208 Affidavit of Sherelle Kahn, 14 July 2025 at Annexure 7: NT Health Safe Sleeping for Infants Guideline
209 Affidavit of Sherelle Kahn, 14 July 2025 at Annexure 7: NT Health Safe Sleeping for Infants Guideline at p 4 of 6.
210 Inquest evidence of Midwife QM 16 July 2025 at 155. She also saw mothers sleeping with Pēpi-Pods with their babies in them whilst they were in their hospital beds as inpatients at Alice Springs Hospital (at 155)
211 Inquest evidence of Prof Byard and Dr Tiemensma on 17 July 2025 at 300-1

163. In her evidence, Midwife QM said that when she worked at Alice Springs and Tennant Creek Hospitals in 2021 she witnessed two babies co-sleeping with their mothers in hospital,[212] which she understood was permitted by the Department of Health.[213] She confirmed that if midwives saw co-sleeping "not being done correctly" they would "intervene and give education around that."[214] At that time ASH had Pēpi-Pods®, and the midwives encouraged mothers to use them if they wanted to co-sleep with their babies.[215] However, given the dimensions of a Pēpi-Pod® I can appreciate that it would not be easy to sleep with one in a raised single bed with rails.

164. An alternative to a Pēpi-Pod® is a 'side-sleeping' cot; a cot that fits next to the hospital bed without a barrier between the two, so that mother and baby can co-sleep, but baby is on its own sleep surface (a **Malvestio Cot**). Midwife RA told me that the Alice Springs Hospital maternity ward has nineteen beds[216] but only one Malvestio Cot. I think it likely that almost every mother would prefer this configuration to a separate cot or Pēpi-Pod® and, for those 'in the know,' I imagine this single Malvestio Cot is in high demand. Even if there are only eight beds normally occupied (described as a "busy day"[217]), one Malvestio Cot is clearly insufficient.

165. I accept that there are competing issues and concerns about safety, cultural imperatives, education relevant to both the hospital and the home sleep environment, and the financial viability of parents to implement what they have been taught. Accepting all these complexities, the evidence is clear, according to Professor Byard and Dr Tiemensma, it is not safe to co-sleep on a single bed, and it is not safe to use a cot mattress as a barrier in a single bed. Given that there is not really room for a mother and a Pēpi-Pod® in a single hospital bed, the only other options for safe hospital co-sleeping is to provide all mothers who choose to co-sleep in hospital with either a) a larger bed that accommodates a Pēpi-Pod® or similar, or b) a side cot. I consider that the NT Health Safe Sleeping Guidelines and the available physical resources in maternity wards should reflect this reality.

212 Inquest evidence of Midwife QM on 16 July 2025 at 141
213 Inquest evidence of Midwife QM on 16 July 2025 at 141
214 Inquest evidence of Midwife QM on 16 July 2025 at 156
215 Inquest evidence of Midwife QM on 16 July 2025 at 154
216 Inquest evidence of Midwife RA on 16 July 2025 at 181
217 Inquest evidence of Midwife RA on 16 July 2025 at 181

Recommendation 5.

I recommend that **NT Health** within 12 months amends the NT Health Safe Sleeping Guideline to permit in hospital co-sleeping only when:

a) a side cot is provided to a mother; or
b) another safe sleeping device (such as a Pēpi-Pod®, Coolamon or similar) and a larger style bed is provided; and
c) safe sleeping education in a culturally appropriate format is provided to the mother.

Practices not consistent with Red Nose recommendations such as wedging a baby cot mattress between the bed frame and mattress in a single hospital bed are to cease. NT Health will take all steps available to ensure there are sufficient physical resources (safe sleeping devices, side cots, larger beds and culturally appropriate educational resources) for implementation of the updated guideline.

Safe sleep spaces for babies: Pēpi-Pods®, Coolamons, Finnish cardboard boxes and cots

166. Examples of Pēpi (Mauri for baby)-Pods® and Coolamons were in evidence before me. Each is designed to provide a safe sleeping surface for baby to be used when co-sleeping. An important part of each program which provide these devices is ongoing education and support to families to ensure the success of the initiatives.

167. Pēpi-Pods® originated in New Zealand in response to infant mortality in unsafe sleeping spaces and 'took off' in 2011 following the Christchurch earthquake.[218] A Queensland program was initiated by Apunipima Cape York Health Council in 2014, which was subsequently expanded. A Final Research Report concluded that the Pēpi-Pod® Program was "accepted and used appropriately by parents in Queensland indigenous communities and reduced the risk of SUDI in the context of co-sleeping with known risk factors."[219]

168. The Pēpi-Pod® program is not just about handing out a Pod, instead it relies on strong engagement between providers and recipients which consists of three core components:

218 Common Brief 3.1 Pēpi-Pod® Program, Materials for Registered Distributors 2015, Australia
219 Common brief 3.2 Final Research report for the Department of Child Safety, Youth and Women on The Queensland Pēpi-Pod® Program: A strategy to promote safe sleeping environments and reduce the risk of Sudden Infant Deaths in Infancy In Aboriginal and Torres Strait Islander communities, 30 July 2018

a) The provision of a safe sleep enabler (the Pēpi-Pod®) that provides for unobstructed infant airways consisting of a polypropylene box, and a 3cm fabric covered tight fitting mattress and bedding.
b) Safe sleep education delivered by an officer or health service professional who has completed a training package.
c) Family commitment to participating in the program, using the Pēpi-Pod®, and educating others.

169. There is significant research behind the way the Pēpi-Pod® is intended to be distributed and used. A vital part of the Pēpi-Pod® program's success in reducing co-sleeping deaths is educating and engaging with families about safe sleeping more generally and then about how the Pod should be used. In the program, safe sleep education must be delivered by a known health care professional, a family must be committed to using the Pēpi-Pod® in the way it is intended as a safe sleep space, and there must be follow up with parents about their experiences. Distributors are expected to uphold processes, standards, accountabilities and evaluation on program delivery. This includes the collection and entry of data for every Pēpi-Pod® issued. It does not meet the program's aims to just hand out Pēpi-Pod's® and hope for the best.

170. When Baby K passed away co-sleeping was common in Tennant Creek.[220] It was how mothers had been brought up, and the risks were not well understood.[221] But for a short period between 2021 and 2023, in conjunction with Julalikari [222] and the Children and Family Centre, the Tennant Creek Hospital midwives participated in the Bubba Basket program which promoted the use of Pēpi-Pods® for safe sleeping. The program was intended to provide outreach to mothers and families at home, with the aim of sharing information about safe sleeping, in the ante natal period and in the 12 months post birth.[223] The program was funded by DCF. The average number of births in the Barkly was said to be between 96-100 each year. One hundred Pēpi-Pods® were purchased over the course of the program and approximately fifty were distributed.

171. Baby K's mother was given a Pēpi-Pod®, however, as there was very little engagement between her and the program providers, she did not receive the

220 Inquest evidence of Mikeely Fraser 15 July 2025 at 133
221 Inquest evidence of Mikeely Fraser 15 July 2025 at 133
222 The program was run by the Julalikari Council Aboriginal Corporation; Baby K Additional documents Folio 2
223 Inquest evidence of Mikeely Fraser 15 July 2025 at 132

lead-up education and ongoing support envisaged by the program,[224] and Baby K passed away when the Pēpi-Pod® was not being used. There was no evidence that it was ever used. Baby K's mother did not think it looked safe.

172. To be clear, I am not overly critical of the program providers who were doing their best with the resources (staff and vehicles) available to them. Engagement was difficult to achieve because of Baby K's mother's circumstances (especially her homelessness and transience). Sadly, mothers (and their babies) in these difficult circumstances are the ones most in need and the most difficult to successfully engage.

173. Despite the tragedy of Baby K, I heard that the Bubba Basket/Pēpi-Pod® program in Tennant Creek distributed 50 safe sleeping devices and engaged well with many mothers who reported using the Pēpi-Pod® at least sometimes. Midwife RA said that in her experience the Bubba Basket program was generally well received and had a positive impact when the Pēpi-Pods® were used correctly.

174. Although DCF evaluated the program positively, after the pilot no further funding was sourced and the program ceased. I was told that there are now *no* specific safe sleeping programs in Tennant Creek.[225] It is clear that safe sleeping education is needed in the Barkly region. A program such as this, which was positively received and evaluated, is exactly the type of program that should receive continued grant funding and evaluation.

175. Pēpi-Pods® are available to mothers for use in ASH but not to take home.[226] Midwife QM occasionally saw mothers co-sleeping in hospital with Pēpi-Pods® in 2022.[227] However, Ms Kahn said in her experience mothers rarely use Pēpi-Pods® in hospital (and she extrapolated to a wider setting) because the construction of the device separated mother from baby; made breast feeding more difficult; are too bulky to put in bed; and decrease skin-to-skin contact between mother and baby.[228] It is these very qualms that the education and support components of the Pēpi-Pod® program hope to overcome and introducing Pēpi-Pods® after birth, in hospital, may not be conducive to the level of ongoing engagement and support the program recognises as necessary to encourage uptake.

224 Inquest evidence of Midwife RA 16 July 2025 at 199; Baby K Additional Documents Folio 6
225 Evidence of M. Fraser 15 July 2025 pp 132-137
226 Inquest evidence of Midwife QM on 16 July 2025 at 154-5
227 Inquest evidence of Midwife QM on 16 July 2025 at 155
228 Affidavit of Sherelle Kahn, 14 July 2025, at [93]

176. After the evidence concluded I learned that Flinders University is conducting and evaluating a Pēpi-Pod® Program in South Australia with funding from a Medical Research Future Fund (MRFF) Rapid Applied Translation Impact Grant. According to its website, the Pēpi-Pod® Program "offered Aboriginal families in South Australia the opportunity to provide a safe sleep environment for their new-born babies and increased family awareness and knowledge of safe sleeping behaviours. Recruitment to trial the program has ended. We are now in the final phase of the project, asking health professionals about the feasibility and acceptability of the program."[229] The program appears to have developed resources for Aboriginal families including a video on how to settle a baby in a Pēpi-Pod®. I take this opportunity to bring this initiative to the attention of DCF, Congress and NT Health.

177. Miwatj Health Aboriginal Corporation (**Miwatj**) partnered with the Coolamon Community Inc.[230] as part of its maternity and midwifery program in late 2024.[231] Coolamon Community Inc. promotes and provides Coolamons to Aboriginal mothers across Australia. Laura Hinds, the Maternal & Women's Health Program Lead at Miwatj, explained that Miwatj chose to promote and provide Coolamons as safe sleeping devices over Pēpi-Pods® following consultation in the communities they service.[232] The Coolamons now being supplied are ACCC compliant and have changed a little from the one exhibited in court. They are handmade from recycled paper rope, now over a wire frame, so it has stiff sides to prevent adults rolling onto baby and the mattress has a surface that can now be wiped clean.[233] The Coolamons also contain well selected and beautifully presented items for mothers and babies. The consultation process included feedback from parents about these items and the contents were changed to reflect community needs.[234] (The picture below is from Miwatj and the Coolamon depicted does not show the improved Coolamon following 2026 ACCC compliance.)

---

229 https://sites.flinders.edu.au/ssabsa/
230 A First-Nations -led registered charity. According to their website they commenced in 2022 and have supported 1400 First Nations mums and babies across Australia
231 See material at Common Brief Folio
232 Inquest evidence of Laura Hinds 16 July 2025 at 209. One of the reasons given for choosing the Coolamon over the Pēpi-Pod® was that some families thought that the Pēpi-Pod® would be too tempting to use as a storage area, for example, as a durable box to take hunting.
233 Coolamon community .org.au, Is the Coolamon Safe Sleep Space compliant with ACCC regulations; When Professor Byard examined the Coolamon, he was concerned that it was too soft and thought it needed more rigid sides, these concerns appear to have been addressed by the new construction.
234 Inquest evidence of Laura Hinds 16 July 2025 at 212

178. The Miwatj Coolamon Project includes education and engagement between midwives or a member of the Miwatj Health Early Childhood Team and families, including safe sleep education.[235] Both Coolamons and education are provided to mothers at about the 36th week of gestation.[236] Miwatj, similarly to many other health services, relies on Red Nose resources for written information, however, recognises the "importance of providing culturally appropriate literature in language," which was said to be "in the pipeline."[237] Ms Hind reminded me that it is important to keep front of mind that there are cultural and language differences from one community to another, even in the same region.[238]

179. These findings are not intended to suggest in any way that Coolamon's are better than Pēpi-Pods® or vice versa. As Midwife BM said, parents should have choice.[239] Communities should have a choice. This is not a case of one-size-fits-all. In line with the evidence I heard, community consultation about these portable safe sleeping space options is central to their success. It may be that a community chooses a different option; for example, Midwife BM gave evidence of a Scandinavian experience: [240]

> "The ones that they issue in Sweden, which was very helpful in reducing their co-sleeping death rate, are actually government standard issue, and they're cardboard boxes, and then they've got a flat surface mattress and an initial appropriate sleeping outfit."

---

235 Inquest evidence of Laura Hinds 16 July 2025 at 213. Miwatj Health's antenatal care includes discussions with mothers about domestic violence, household composition and overcrowding, water supply, cleanliness, hygiene, animal welfare and keeping animals away from baby's sleeping spaces,
236 Inquest evidence of Laura Hinds on 16 July 2025 at 212
237 Inquest evidence of Laura Hinds on 16 July 2025 at 214
238 Inquest evidence of Laura Hinds on 16 July 2025 at 214
239 Inquest evidence of Midwife BM 15 July 2025 at 114 and 122
240 Inquest evidence of Midwife BM 15 July 2025 at 115

180. I learned that for 75 years the Finnish government has provided all Finnish mothers with a cardboard box for baby to sleep in. It includes clothes, sheets, bodysuits, a sleeping bag, outdoor gear, bathing products for the baby, as well as nappies, bedding and a small mattress. Finland's infant mortality rates dropped markedly since the cardboard box scheme was introduced in in the first half of the 20th century.

181. Unlike the Scandinavian responses, neither DCF nor NT Health could identify any current Territory-wide program that is directed at providing safe sleeping devices to new mothers who display risk factors for unsafe sleeping. It appears to me that DCF and NT Health share responsibility for delivering or funding these types of programs.

182. I heard evidence that DCF would consider purchasing a safe sleeping device for a family it was working with if sleep risks were identified. No doubt NT Health could also consider providing devices to mothers in hospital to take home, however, in both cases there needs to be someone in the community delivering the ongoing education and support. In this regard I heard that DCF has provided funding to Congress and to the Gurindji Aboriginal Corporation to progress safe sleeping programs in Alice Springs and Kalkarindji. Congress has also committed to purchasing a large number of Pēpi-Pods® to trial their acceptability and use.[241] This was positive and welcome information.

183. Given that concerns about the strength of the sides of the Coolamon have now been addressed, I would encourage DCF, NT Health and Congress to explore the viability of engaging with Coolamon Community Inc. with a view to offering choice and exploring which device might be more culturally acceptable, and ultimately, used by families in the communities that are serviced.

Recommendation 6

I recommend to **NT Health, the Department of Children and Families, and Central Australian Aboriginal Congress** that they form a working group (which may include other relevant organisations such as AMSANT or Menzies School of Health Research) to initiate pathways to promote the availability of Pēpi-Pods®, Coolamons (or similar), evaluate efficacy of safe sleeping devices and education materials, and share information. If it is identified that approaches are lacking in efficacy, to continue to work together to identify new, innovative and culturally appropriate solutions.

241 Inquest evidence of Dr Boffa on 18 July 2025 at 358

The Importance of Aboriginal Health Workers (AHW), Aboriginal Liaison Officers (ALOs) and Interpreters

184. AHWs and ALOs are valuable resources in the midwifery department at the ASH[242] and in outreach midwifery services such as Alukura and My Midwives. They are vital to providing culturally safe health services to Aboriginal clients. They are conduits of authentic communication and culturally appropriate education.

185. Sharelle Kahn, an experienced Aboriginal Health Practitioner who works in the maternity ward in Alice Springs Hospital, was praised by many of the witnesses, including midwives and hospital workers, as being an excellent AHP. She explained: [243]

> "When educating Aboriginal mothers and their families, I will often include my own lived experience and knowledge, or that of an ALO, to supplement the materials that I provide. This allows Aboriginal people to have a much more personal way of interacting with the materials and understanding the reasons behind why I am providing this education."

186. Ms Kahn's evidence demonstrates the issue: it is her knowledge and cultural understanding which imparts the requisite education to the parents. She is an experienced AHP and uses her own cultural knowledge to appropriately educate parents about safe sleeping or safer co-sleeping. Ms Kahn said that in her experience it is easiest to offer safe sleeping education opportunistically and explained how that education was delivered with demonstrations. [244]

187. For opportunistic education to reliably occur there must be sufficient AHWs or ALOs available to reach every Aboriginal mother. However, I heard evidence that there are not enough to go around, for example, Ms Khan does not work weekends and may be allocated to other duties when she is rostered on. Two of the mothers in these inquests discharged very shortly after giving birth and where there are fast turnarounds there will not necessarily be AHOs or ALOs available to those mothers.

242 Inquest evidence of Midwife RA on 16 July 2025 at 188
243 Affidavit of Sherelle Kahn, 14 July 2025 at [57]
244 Affidavit of Sherelle Kahn, 14 July 2025 at [67] ff.

188. It would be better if there were more of AHOs and ALOs, and if policies and procedures like Congress's bicultural pairing approach were more widely adopted and practiced.

> **Recommendation 7**
>
> I recommend to **NT Health** that it review and amend its antenatal, intrapartum and postnatal care policy, guidelines and procedures to emphasise the importance of and increase the use of Aboriginal Health Workers, Aboriginal Liaison Officers and/or Aboriginal interpreters in the provision of all services to Aboriginal expectant/new mothers. Patient documentation should always record when an AHW/ALO/Interpreter is present. Consideration should be given to implementing a "bi-cultural pairing" approach as practised by the Central Australian Aboriginal Congress Midwifery Group Practice.

Individual Health Identifiers (IHI)

189. Congress's evaluation of the Australian Nurse Family Partnership Program found that the greatest indicator of disadvantage for families was the frequency of change of address. [245] A mother, such as Baby K's mother, who was effectively 'couch surfing' even when pregnant, is a significant risk factor for fractured and missed care and for poorer outcomes. Continuity of health information is important for the safety of patients and efficacy of care. However, I heard that when mothers move between services, between towns and remote communities, or between hospital-based and community-based care, critical information is often not shared.

190. Australian eHealth records, specifically known as My Health Record, are secure digital summaries of an individual's health information. They allow both patients and healthcare providers to access important health data, such as medical history, medications, and immunisations, to improve healthcare delivery and outcomes. An Individual Healthcare Identifier (**IHI**) is a unique 16-digit number used in the Australian healthcare system to identify individuals. It helps healthcare providers access My Health Records and improves communication between them regarding health information.

245 Inquest evidence of Dr Boffa on 18 July 2025 at 373

191. While best practice would involve every organisation providing health services using the My Health Record, this is not occurring. I heard for example, that the IT system used by My Midwives did not upload to the shared record whereas Alukura's IT system did. Dr Boffa said, "as for the rest of Congress we've got to make sure that's the toll everyone uses, antenatally as well. And the days when you used to send documents between services…that should be over."[246] I was told that ASH was failing to identify and enter patients IHI into the hospital IT records. This meant that hospital information could not be uploaded into the patient's My Health Record and, despite this concern being raised with NT Health, there appeared to be little will to rectify the issue.[247]

192. Counsel for the families also identified that communication between ASH and primary health providers would be improved if ASH (and other hospitals with maternity services) provided a thorough documented handover, which should include details of any education proved to the mother.

193. For the best health care in a remote and transient population, it is important for Aboriginal people to have an IHI which can be accessed anywhere they access medical care.[248] It appears that currently NT Health-run facilities and Congress-run facilities are not working together on this. That must be rectified.

Recommendation 8

I recommend to **NT Health** that it improve its health information-sharing systems by ensuring the use of "Individual Health Identifiers" for all mothers and babies accessing NT Health antenatal, intrapartum and postnatal care.

Classification of cause of death - we do not know the extent of the problem

194. Dr Tiemensma reviewed SUDI in the Northern Territory in her five years as the Chief Forensic Pathologist and found that 40 per cent of deaths occurred in an unsafe sleeping environment. However, there is no national uniform classification for 'SUDI in an unsafe sleeping environment' (noting that unsafe sleeping includes co-sleeping) and a 'SUDI death in an unsafe

246 Inquest evidence of Dr Boffa on 18 July 2025 at 379
247 Inquest evidence of Dr Colin Marchant on 18 July 2025 at 379
248 Inquest evidence of Dr Marchant on 18 July 2025 at 379

sleeping environment', is not currently recognised as a classification for a cause of death. Dr Tiemensma said: [249]

> "If you look around Australia, pathologists and coroners may decide to classify these things as unascertained, undetermined, possible suffocation, SIDS, sudden unexpected death in an unsafe sleeping environment. So, we don't know the exact size of the problem."

195. Because there is no nationally recognised classification, I was told that in Tasmania, for example, a 'SUDI in an unsafe sleeping environment' is more likely to be classified as suffocation whereas in Western Australia a death in similar circumstances is more likely to be classified as unascertained.

196. Without consistency of classification, it is impossible to understand the frequency, spread, or even the raw numbers of 'SUDI in an unsafe sleeping environment'. The data necessary to drive funding allocations for public health, education and any other necessary reforms to reduce the number and frequency of these tragic and preventable deaths is missing. Both Dr Tiemensma and Professor Byard were firmly of the view that a national uniform classification is a primary and fundamental step towards understanding and then reducing the risks and, ultimately, deaths.

197. Both Professor Byard and Dr Tiemensma[250] gave evidence that after a thorough investigation (excluding other sufficient causes), if risk factors listed in the triple risk model are identified, these should be documented in the post mortem report. Further, if other sufficient causes of the death are not identified, and the death occurred in an unsafe sleeping environment, then the cause of death classification should be 'SUDI in an unsafe sleeping environment' (not SIDS).

Child Deaths Review and Prevention Committee (the Committee)

198. The Committee was established in 2008, by s 209 of the *Care and Protection of Children Act 2007*. This followed recommendations in the Territory Parliament's Board of Inquiry into the protection of Aboriginal children from sexual abuse report 'Little Children are Sacred'. The Committee conducted a child death review process which considered all child deaths in the Northern Territory. The purpose of the child death review process was to understand child deaths in order to prevent and reduce them. The work

---

249 Inquest evidence of Dr Tiemensma on 17 July 2025 at 280
250 Inquest evidence of Professor Byard and Dr Tiemensma on 17 July 2025 at 280-2

included maintaining a child deaths register, conducting research about child deaths, and input into the development of appropriate policy responses to address child deaths and their causes. The Committee's membership was qualified and diverse with representatives from NT Health (with Paediatric and Psychiatric expertise), the Department of Education, NT Police, NT Correctional Services, the Department of Children and Families, the Coroner's Office, Menzies School of Health Research, Forensic Pathologist, Aboriginal Peak and the Children's Commissioner. Its work was vital as a mechanism for the Northern Territory to understand why children died, and then to respond to reduce the incidence of child mortality.

199. In furtherance of this work, on 17 June 2024 the Committee wrote to the Chair of the RCPA[251] Forensic Pathology Advisory Group about the inconsistent terminology on death certificates and autopsy reports involving SUDI, noting that misclassified deaths resulted in limited learning and prevention strategies. The Committee noted that unsafe sleeping environments were considered to be a major factor in over 40% of SUDI cases in the Northern Territory over the last five years and of these deaths77% were First Nation children. The RCPA was invited to consider producing guidelines to develop a uniform approach to ensure the accurate reporting of SUDI events. The Committee said:[252]

> "We believe there is a need for invigoration of the public health campaigns with a need to broaden education to include safer co-sleeping environments with a focus on the risk factors, emphasising that co-sleeping is not safe. There is a need for thorough consultation with First nations population to allow development of an appropriate education/public health campaign for this cohort."

200. Documents tendered as Exhibit 7 reveal that during 2024 Committee members were not appointed or reappointed as required. Since October 2024 the Committee could not meet its statutory requirements for a quorum and effectively ceased to operate. I am informed the Committee was disbanded in February 2026 and there was no evidence before me that this important submission has since been actioned or progressed.

201. Currently it appears that a comprehensive child death review process is no longer being conducted in the Northern Territory, which consistently reports the highest child mortality rates in Australia at 67.9 per 100,000 when the

---

251 Royal College of Pathologists Australia
252 Common Brief 1.4

national average sits at 28.2.[253] As at 17 June 2025 there were thirteen child deaths that had not been subject to a child death review process and the numbers would be much larger now. The Inquest did not receive any evidence to indicate that the work of the Committee, in particular the child death review process, was continuing in some other format. I note that the Coroner's Office considers reportable deaths under the *Coroner's Act 1993* and these deaths do not correspond to *all* child deaths which were considered by the Committee. In addition, the Coroner's Office does not have access to most of the experts who comprised the Committee membership. In those circumstances I will make a recommendation with a view to ensuring that the comprehensive child death review process be reinvigorated.

Recommendation 9

I recommend to the **Northern Territory Government** that it re-establish a comprehensive Child Death Review Process with all necessary expertise and resources to complete the process, to make recommendations and publicly report on deaths, findings, recommendations and outcomes. Those engaged to complete the Child Death Review Process should also be tasked to consider how best to progress the implementation of a uniform and consistent classification for cause of death for SUDI, SIDS and unsafe sleeping environments, for example, as recommended by the Child Death Review and Prevention Committee to the RCAP Forensic Pathology Advisory Committee by letter dated 17 June 2024 or as recommended in the evidence of Professor Byard and Dr Tiemensma on 18 July 2025.

Communication with parents about SUDI

202. In each case before me in these inquests, Police were sensitive to the grief of the parents. It is understandable that police are reluctant to take statements from parents when grief is raw and acute. However, it is vital to obtain statements from parents or care givers about what happened in the leadup to the death, how the child was found and what was done when the child was discovered. We were fortunate to have statements from the mothers in these inquests, although they were only provided years after the incidents themselves, and were obtained specifically for the inquests. Inquests for these deaths were not mandatory and most unsafe sleeping deaths do not go to inquest. Therefore, investigating police should comply with the General

253 As reported, ABC News, Reporters T. Colling, L. Stimpson, "NT Child Deaths Review Committee disbanded by government, with concerns it will result in 'serious gaps'", 10 February 2026

Orders and obtain statements from parents in a sensitive way as soon as possible after the death for investigative purposes. Well-structured and comprehensive conversations captured on body worn video may be effective for this purpose.

203. During immediate grief, attending police may be tempted to tell parents, "It's not your fault." In the case of unsafe sleeping deaths, this may be neither accurate nor truthful and police should be trained to avoid using this or similar phrases. They could be trained, for example, to simply reassure parents that the cause of death will be thoroughly investigated, and they will be advised of the cause of death as soon as the investigation is completed. However, I also heard evidence that parents were regrettably not being informed in a timely way about the cause of death. At least one of the mothers in these inquests did not know how her baby had died until the week before the inquest.[254] It may be that police are not best placed to have these conversations.

204. Parents (and families) are naturally devastated if they experience the loss of a child from SUDI. It is challenging to inform parents that their child died in an unsafe sleeping environment. While it might seem easier to tell parents that their child died of SIDS[255] inaccurate classifications and not telling the truth perpetuates the problem. Without honest information parents (and indeed other family and community members) might continue to expose subsequent babies to the same unsafe sleeping environments, putting subsequent babies at similar risk.[256]

205. Issues of informing families accurately, sensitively and in a timely way about the cause of their child's death were considered by NSW Coroner O'Sullivan in the *Inquest into the deaths of Kayla Ewin and Iziah O'Sullivan*.[257] To improve investigation practices and communication with families that inquest heard that NSW Health were implementing an early interagency clinical review meeting for every SUDI. The meeting was to: take place within one week of the death; include the forensic pathologist, the investigating police and a paediatrician or medical professional; identify what further investigation was required; progress identifying the cause of

254 Inquest evidence of Dr Tiemensma on 17 July 2025 at 310; see also Baby K's mother's statement, 21 July 2025 at [28]
255 Inquest evidence of Dr Tiemensma on 17 July 2025 at 297
256 Inquest evidence of Dr Tiemensma on 17 July 2025 at 297
257 Exhibit 8

death; and address how the needs of the family were being met (including for accurate information).

Recommendation 10

I recommend to **NT Health** that the Territory forensic pathologists, in consultation with Northern Territory Police, the Coroner's Grief Counsellor, and a suitable representative from a Central Australian and/or Top End ACCHO and/or AMSANT, establish a process and practice for explaining SUDI, SIDS and/or unsafe sleeping infant deaths to a deceased infant's parents or caregivers, ensuring that Aboriginal cultural values, traditions and sensitivities are identified, respected and embedded in the process.

Housing

206. Housing conditions and overcrowding are chronic problems in remote communities. Witnesses saw photos of the living conditions of the babies in this inquest. They described housing conditions, particularly overcrowding, as "less than third world conditions", and "completely insufficient". One description of the sleeping conditions in those houses was "not even remotely acceptable to try to make a life with."

207. Baby K's mother was moving from house to house in response to family violence and overcrowding. She was referred to CatholicCare by midwives to get on the waitlist for public housing. Whether a person is on the general waiting list or priority waiting list for public housing depends on their level of need.[258] Baby K's mother's multiple vulnerabilities meant she should "very much" have been on the high priority list to receive public housing.[259] Counsel for the families questioning revealed that wait times in Tennant Creek, even for priority housing, are impossibly long: for a one bedroom house it is 8-10 years; for a 2-3 bedroom house it is 4-6 years.[260] Even if a homeless pregnant woman gets onto the priority list, the wait is too long to assist her baby.[261]

258 Inquest evidence of Ashley Ubrihein, Senior Regional Manager for CatholicCare NT, on 17 July 2025 at 235
259 Inquest evidence of Ashley Ubrihein on 17 July 2025 at 236
260 Inquest evidence of Ashley Ubrihein on 17 July 2025 at 236
261 Inquest evidence of Dr Boffa on 18 July 2025 at 361

208. Ms Mafi filled in forms and gathered supporting documentation for housing applications in Tennant Creek. She said she did referral after referral. She could only remember one person who got a house in the years that she worked in Tennant Creek, and that one took two years.[262] She said it was difficult to engage families in Tennant Creek who did not have secure housing, and were very transient, and there were geographical limitations to the service provided that did not reflect the reality of transient families. [263]

209. For the delivery of services to pregnant and new mothers' engagement is key and transience is a barrier to engagement. It was suggested that the creation of a central, accessible drop-in hub in Alice Springs for mothers and children to obtain antenatal and postnatal care could improve engagement with transient and homeless pregnant women and new mothers. To be successful, ideally, such a space would meet basic needs first, such as meals and hygiene facilities, and then additional needs could be identified and addressed by co-locating holistic supports or case managers. While I consider this to be a positive and achievable suggestion, it was not explored in sufficient detail for me to make it a recommendation. However, I commend it to NT Health , DCF and Congress for further consideration.

Continuity of care

210. A continuity of care model in antenatal and postnatal care involves the same midwife or a small team of midwives providing support to a woman throughout her pregnancy, during birth, and in the postpartum period. This approach aims to enhance the quality of care and improve outcomes for both mothers and babies by ensuring consistent support and communication.

211. In that context, I note that the work being undertaken by Alukura, Congress, and My Midwives. Congress has implemented a midwifery group practice (**MGP**) continuity of care model, which has resulted in improved birth outcomes, fewer interventions, better birth weights, and cost savings.[264] The MGP pairs an Aboriginal maternity support worker with every midwife, and provides access to wraparound services, such as nurse educators, diabetes educators, psychologists, and social workers.[265] The bi-cultural pairing assists in cross-cultural communication.[266] This model is recent and must be sustained by long term funding.

262 Inquest evidence of Losi Mafi 16 July 2025 at 226
263 Inquest evidence of Losi Mafi 16 July 2025 at 223
264 Inquest evidence of Dr Boffa on 18 July 2025 at 347-8
265 Inquest evidence of Dr John Boffa on 18 July 2025 at 350
266 Inquest evidence of Dr John Boffa on 18 July 2025 at 350 and Dr Marchant at 355

212. The continuity of care model was embraced by all witnesses who spoke about it.[267] Midwife BM explained that she supported a continuity of care model because it develops relationships and trust between the mother and midwife, women are heard, care is nuanced around their needs, and clients engage in their own health care.[268] She also recognised the importance of maternity support workers working alongside midwives to deliver the best care to mothers antenatally and postnatally.[269]

213. This model was not operational when each of these mothers were pregnant. Had the MGP model been in place for the mother of Baby B specifically, the extra outreach of Aboriginal maternity workers could have made a difference in locating and engaging Baby B's mother before the birth. This may have resulted in further opportunities for education to be provided, including about safe sleeping.

Recommendations

214. I make the following recommendations:

(1) 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 referrals have been made in Strengthening Families cases, the Strengthening Families case should not be closed until a) there is evidence that engagement is established between the referred service provider and the family, and b) a network meeting has been held where engagement and progress in service delivery is discussed and documented by DCF.

(2) I recommend to the **Northern Territory Government** that, in consultation with NT Health, Central Australian Aboriginal Congress, other service providers who give antenatal, intrapartum and postnatal care to mothers and babies, Central Australian alcohol rehabilitation services, and research organisations such as Menzies School of Health Research, it identify and quantify the need for alcohol rehabilitation for pregnant and new mothers, and progress the provision of suitable

267 For example, Midwife ES at 78; Midwife BM at 97, 114
268 Inquest evidence of Midwife BM on 15 July 2025 at 128-9
269 Inquest evidence of Midwife BM on 15 July 2025 at 114

alcohol rehabilitation services in Central Australia which can accommodate mothers and infants, including identifying funding for service infrastructure, programs and delivery.

(3) I recommend that **NT Health and the Department of Children and Families**, in consultation with Central Australian Aboriginal Congress and other service providers who give antenatal, intrapartum and postnatal care to mothers and babies, and research agencies such as Menzies School of Health Research, develop accurate, relevant and culturally sensitive and appropriate educational materials about infant safe sleeping and safer co-sleeping, which meets the needs of parents with low literacy and/or of linguistically diverse backgrounds (especially Aboriginal language speakers). This should be done through authentic co-design with Aboriginal stakeholders and Aboriginal controlled service providers from inception through to implementation. Consideration should be given to developing:

a) educational material with realistic representations of the known risks of co-sleeping (and other unsafe sleep risks);
b) complementary educational tools such as videos in language, story-based resources, visual or practical aides; and
c) an educational awareness campaign directed at relevant groups such as Aboriginal community groups, early childhood services and Grandmothers, in recognition of their vital roles in engaging with and educating mothers.

(4) I recommend that **NT Health, the Department of Children and Families, and Central Australian Aboriginal Congress** ensure they each have clear, up to date and comprehensive policies and guidelines addressing all aspects of infant safe sleeping and safer co-sleeping practices, with access to culturally relevant and appropriate educational materials (such as any materials created in accordance with recommendation (3)). 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 that **NT Health** within 12 months amends the NT Health Safe Sleeping Guideline to permit in-hospital co-sleeping only when:
a) a side cot is provided to a mother; or
b) another safe sleeping device (such as a Pēpi-Pod®, Coolamon or similar) and a larger style bed is provided; and
c) safe sleeping education in a culturally appropriate format is provided to the mother.

Practices not consistent with Red Nose recommendations such as wedging a baby cot mattress between the bed frame and mattress in a single hospital bed are to cease. NT Health will take all steps available to ensure there are sufficient physical resources (safe sleeping devices, side cots, larger beds and culturally appropriate educational resources) for implementation of the updated guideline.

(6) I recommend to **NT Health, the Department of Children and Families, and Central Australian Aboriginal Congress** that they form a working group (which may include other relevant organisations such as AMSANT or Menzies School of Health Research) to initiate pathways to promote the availability of Pēpi-Pods®, Coolamons (or similar), evaluate efficacy of safe sleeping devices and education materials, and share information. If it is identified that approaches are lacking in efficacy, to continue to work together to identify new, innovative and culturally appropriate solutions.

(7) I recommend to **NT Health** that it review and amend its antenatal, intrapartum and postnatal care policy, guidelines and procedures to emphasise the importance of and increase the use of Aboriginal Health Workers, Aboriginal Liaison Officers and/or Aboriginal interpreters in the provision of all services to Aboriginal expectant/new mothers. Patient documentation should always record when an AHW/ALO/Interpreter is present. Consideration should be given to

implementing a "bi-cultural pairing" approach as practised by the Central Australian Aboriginal Congress Midwifery Group Practice.

(8) I recommend to **NT Health** that it improve its health information-sharing systems by ensuring the use of "Individual Health Identifiers" for all mothers and babies accessing NT Health antenatal, intrapartum and postnatal care.

(9) I recommend to the **Northern Territory Government** that it re-establish a comprehensive Child Death Review Process with sufficient access to all necessary expertise and resources to complete the process, to make recommendations and publicly report on deaths, findings, recommendations and outcomes. Those engaged to complete the Child Death Review Process should also be tasked to consider how best to progress the implementation of a uniform and consistent classification for cause of death for SUDI, SIDS and co-sleeping/unsafe sleeping environments, for example, as recommended by the Child Death Review and Prevention Committee to the RCAP Forensic Pathology Advisory Committee by letter dated 17 June 2024 or as recommended in the evidence of Professor Byard and Dr Tiemensma on 18 July 2025.

(10) I recommend to **NT Health** that the Territory forensic pathologists, in consultation with Northern Territory Police, the Coroner's Grief Counsellor, and a suitable representative from a Central Australian and/or Top End ACCHO and/or AMSANT, establish a process and practice for explaining SUDI, SIDS and/or unsafe sleeping infant deaths to a deceased infant's parents or caregivers, ensuring that Aboriginal cultural values, traditions and sensitivities are identified, respected and embedded in the process.