OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of A, a 6 year old child**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO(s):	2012/3510
DELIVERED ON:	27 May 2015
DELIVERED AT:	Cairns
HEARING DATE(s):	4 May 2015 to 8 May 2015
FINDINGS OF:	Jane Bentley, Coroner
CATCHWORDS:	Coroners: inquest, child in care, DOCS, drowning, pool, supervision, water safety, respite care, foster care

REPRESENTATION:

Counsel Assisting:	Ms S. Williams
Mother of A:	Ms L. Neil i/b Cuthbertson & Co, Lawyers

Integrated Family and Youth Services (IFYS):
Mr T. Collins i/b Sowden Lawyers

Department of Communities, Child Safety and Disability Services (DOCS):
Ms K. Carmody

Introduction

Section 45 of the *Coroners Act 2003* provides that when an inquest is held the coroner's written findings must be given to the family of the person in relation to whom the inquest has been held, each of the persons or organisations granted leave to appear at the inquest and to officials with responsibility over any areas the subject of recommendations. These are my findings in relation to the death of a child, A. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

These findings and comments:

1. confirm the identity of the deceased person, the time, place and medical cause of his death;
2. consider whether the actions or omissions of any third party contributed to his death; and
3. consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

Background

At the time of his death A was six years and five months old and lived with foster carers, Mr and Ms B. A was placed into the custody of the Chief Executive, Department of Communities, Child Safety and Disability Services (DOCS) on 21 November 2009.

Summary of events on 24 September 2012

At approximately 3.15pm on 24 September 2012, A was swimming in the pool in the backyard of his foster carers' residence with two other children. Ms B was sitting on the veranda overlooking the pool, having coffee with her friend, Ms P. She was facing the pool and observing the children.

A could not swim and was wearing a flotation device. A was seen to be floating face down in the water by the other children who removed him from the water and alerted Ms B.

Ms B commenced first aid and contacted the Queensland Ambulance Service. Paramedics arrived and provided CPR for 45 minutes. A was transported to Cairns Base Hospital where he received CPR for a further 45 minutes before regaining return of spontaneous circulation. He was transferred to Townsville Hospital and admitted to the intensive care unit at 12.15am on 25 September 2012. Despite treatment A remained unresponsive and a nuclear medicine brain blood flow scan performed on 27 September 2012 revealed a complete absence of cerebral perfusion. A was declared deceased at 5.18pm on 27 September 2012.

Autopsy results

An autopsy revealed that A died from hypoxic ischaemic encephalopathy due to drowning.

Reviews by DOCS

An internal review of the DOCS systems and practices relevant to A was carried out by DOCS, the culmination of which was a Child Death Case Review Report.

The Child Death Case Review Report was reviewed by the Child Death Case Review Committee.

The Child Death Case Review Committee found:

- A had a history of involvement with DOCS which included a number of short-term placements and two longer term placements, the last being with Mr and Ms B.
- Mr and Ms B demonstrated an ongoing commitment to improve the developmental and emotional needs of A who had been diagnosed with ADHD and had experienced developmental delay. At the time of his death A had shown noted improvements in his speech, was on track to commence grade 1 in 2013 (having had to repeat prep) and his attention span and emotional development were showing ongoing improvement.
- In January 2012 DOCS made the decision to apply for a long term guardianship order in relation to A.

The Committee found that no actions or inactions of DOCS were linked to A's death but considered that a lack of supervision was a risk factor which may have been relevant to A's death.

The Committee noted that at times Mr and Ms B had nine children in their care. On the day of A's death there were eight children in their care (one having left the house that morning). The Committee considered that the number of children approved to be in the care of Mr and Ms B was excessive and may have impacted on the level of supervision that Mr and Ms B were able to provide. After the death of A the number of children approved to be in the care of Mr and Ms B was reduced to six and the Committee considered that number appropriate.

The Committee did not explore the fact that there was a regional protocol that no more than six children be in one placement without specific approval by a manager and that protocol had not been followed at the time of A's death.

The Committee noted the following service systems issues which were present in the three years prior to A's death:

- Insufficient application of the Indigenous Child Placement Principle;
- Limited availability of indigenous carers;
- Lack of planning regarding meeting cultural needs;
- Lack of detail in case plans regarding cultural needs and outcomes;
- Limited support and information provided to non-indigenous carers to assist them to support A's cultural identity;
- Quality of engagement and limited availability of Recognised Entity;
- Lack of regular and timely case planning and case reviews;

- Family relationships not clearly recorded in Integrated Client Management System;
- Background information about child not provided to carers;
- Case plans not provided in a timely manner;
- Insufficient placement visits.

The Committee concluded that none of these systems issues had any adverse effect on A.

The Committee agreed to report on lack of supervision as a recurring risk factor in drowning cases in its 2012-2013 Annual Report.

Police investigation

Detective Sergeant Bamford who has 11 years' experience in the Child Protection Unit of the Queensland Police Service, submitted a comprehensive and helpful coronial report outlining the findings of the police investigation into A's death.

A, and his brother C, had been in the care of DOCS since 21 November 2009. On 23 August 2012, A and C were placed on an interim order which was to expire on 18 October 2012. A's mother was contesting DOCS' application for a short term order in relation to both boys.

A and C were placed with Mr and Ms B on a permanent basis on 7 August 2010. They had previously spent time in that household for respite care when they were with a previous carer.

On Monday 24 September 2012, there were nine children in the care of Mr and Ms B. They ranged in age from 3 years to 14 years. They had been with Mr and Ms B for various periods of time. The eldest had been with Mr and Ms B for nearly six years. Two of the children had only arrived on the Saturday morning prior and were there for short term respite. Seven of the children were permanently placed with Mr and Ms B.

Mr B took one of the children to the airport at 6.30am that day and he left Cairns for a family visit.

At 9am the remaining children were swimming in the pool under the supervision of Ms B who was sitting at the table in the pool enclosure. A was wearing his flotation device, as usual. A was not allowed into the pool enclosure unless he was wearing the vest and all the children were aware of that rule.

At about 1pm all the children left the pool to have lunch. After lunch Ms B and one of the girls who were there for respite care went to have a sleep. Ms B had been up during the night caring for the little girl who had been ill and they were both tired.

After lunch Mr B caught two of the older boys misbehaving (putting sticks into the pool pump) and they were sent to their room.

At about 3pm Ms B's friend, Ms P arrived to visit the family. Mr B woke Ms B and she came out to the veranda. They all sat there and chatted for some time. Three of the children including A and his brother C went back into the pool. Neither Mr B nor Ms B could recall placing the flotation device onto A but Ms P recalled that it was done by Mr B. A could not put it on by himself as the zip was difficult to fasten.

At about 2.15pm Mr B went to the shops with three of the children. Ms P and Ms B were sitting on the veranda, which is slightly elevated above the level of the pool, watching the children swim in the pool. They had a clear line of sight.

C saw that A was out of the pool and he was not wearing his vest. He then saw him enter the pool at the shallow end and swim towards the middle of the pool. Shortly after that he saw him floating face down in the water in the middle of the pool. C swam underwater and looked up at A's face and saw that something was wrong. C and the other child pulled A over to the side of the pool and called out to Ms B and Ms P. They ran down to the pool and commenced CPR and called Queensland Ambulance Service. A had froth coming out of his nose and mouth. He was unresponsive.

A had been unable to swim when he was placed with Mr and Ms B. He was scared of the water and screamed the first time they tried to take him swimming. Mr and Ms B provided a flotation device for A and he gradually became less fearful. In the week before his death A was seen to dog paddle across the pool whilst wearing his vest. He sometimes wanted to remove his vest and swim like the other children but he was aware of the rule that he had to wear it at all times whilst in the enclosure. The other children were also aware of that rule and had been told that they were not allowed to assist A to remove his vest. A had never been observed to remove the vest by himself.

The flotation device was a vest which attached at the front by means of a zip. The zip was secured with a Velcro tag to prevent it coming loose. A strap attached to the back of the vest was placed between the legs of the wearer and secured by a clip at the base of the front of the vest so that the vest could not rise over the head of the wearer.

Detective Sergeant Bamford concluded that A's death was attributable to a lack of supervision of A whilst he was in the pool. He noted that Mr and Ms B had nine children in their care on the date of the accident and that there were five children in the house at the time that A drowned.

Detective Sergeant Bamford set out, in summary, the procedures in relation to placing children with foster carers:

- Potential foster carers submit an application and are assessed for suitability (by DOCS or the foster care agency e.g. IFYS) which includes information about:
    - Age and number of children they wish to care for;
    - An assessment of how many children and of what age, needs level, etc they are able to care for;

    - Household safety study.
- The assessment is provided to a Child Safety Officer (CSO) for approval;
- The carer and carer support agency prepare a foster care agreement which sets out the number of children that can be placed with those carers and which is reviewed annually.

Foster carers receive financial and other support in relation to the children under their care.

When DOCS has a child who requires a placement, the following occurs:

- The CSO contacts the Placement Support Services Unit of DOCS (PSSU) who notifies the foster care agencies in the relevant area;
- The foster care agency contacts potential carers;
- A carer advises that they are able to accept the placement;
- The information is provided to PSSU for approval;
- The service centre manager gives final approval for the placement.

All placements are recorded on the Integrated Client Management System (ICMS) so that DOCS can access all information at any time including how many children are in the placement.

Placement matching requires that the needs of the child are able to be addressed by the proposed carer. The purpose of the Placement Agreement is to ensure carers and services have access to relevant information about a child and support for the placement. It records the agreed support and services to be provided to the carer based on the assessed level of the child's needs.

Detective Bamford identified, as a matter of concern, that there is no legislation or policy provision in the Child Safety Practice Manual (CSPM) which identifies a limit on the number of children to be placed in a household.

Detective Bamford concluded that there were no suspicious circumstances in relation to the death of A. He concluded that there were short periods of time when Ms B was not observing A in the pool. He said that those periods were inadvertent and momentary.

The inquest

A pre inquest directions hearing was held on December 2014. At that time the parties were advised that the issue to be explored was the circumstances surrounding the death of A. Ms Neil, for the mother of the child, requested that a further issue be included i.e. the extent to which cultural values and beliefs were taken into account in the medical treatment of A in the period after his accident.

Prior to the hearing the issues were concluded as being:

1. The circumstances surrounding the death of A including whether any systemic issues within the Department of Communities, Child Safety and Disability Services and/or IFYS contributed to the death; and

2. The extent to which cultural values and beliefs were taken into account in the medical treatment of A in the period after his accident.

The inquest commenced on 4 May 2015. Counsel Assisting tendered a brief of evidence containing 51 exhibits. A further 12 exhibits were tendered during the inquest. Sixteen witnesses were called to give evidence.

No evidence was called in relation to the second issue and none of the parties made any submissions in relation to it and I do not propose to comment on it or make any findings about that issue.

The evidence

Mark Bamford

Detective Sergeant Bamford gave evidence that he was concerned, when he wrote the report, that the fact that Mr and Ms B had nine children in their care could have compromised the safety of the children. He later agreed, under cross examination, that when he came to that opinion, he did not know that the carers had been assessed and deemed appropriate to care for that number of children.

Detective Bamford agreed that it was probably a minute or two that passed between A last being observed and when he was pulled out of the pool. He could not come to any conclusion as to who removed the flotation device from A.

He said that if Ms B had been inside the pool enclosure at the time the risk to A would have been lessened.

Detective Bamford agreed that lack of foster carers was an ongoing problem in Far North Qld.

Mr B

Mr B gave evidence that he had been a foster carer for about eight years at the time of A's death. He remains a foster carer although he and Ms B have separated. He now solely cares for three children. He has cared for over 70 children over the years he has been a carer.

Mr B said that about a year before A died he and Ms B decided to change support agencies as they were unhappy with the level of support they were being provided. They changed to IFYS. They were always happy with the level of support they received from IFYS.

At the time of A's death Ms Beckman was the IFYS support worker for Mr and Ms B.

Mr B said that Ms Beckman conducted home visits irregularly – probably every 3 weeks. He would speak to her on the phone at least twice per week and correspond by email 3 to 4 times per week. Mr B said his support needs are

and were met very well. He is very happy with the level of support he has received from IFYS.

Mr B said that DOCS officers visited the house every 4 to 6 weeks and he was also happy with the level of support he received from DOCS.

Mr B could not recall being provided any information about A's swimming ability when A was placed in their care. However, it quickly became apparent that A could not swim and was very scared of the water. He couldn't recall IFYS or DOCS providing information about the swimming ability of children who came into their care.

Mr B said that prior to A's death neither he nor Ms B were given training about water safety or told by DOCS or IFYS what level of supervision would be appropriate for their children.

Mr B said that, at the time of A's death, if there were a number of children in the pool, he and/or Ms B would sit inside the pool enclosure and watch them. After A's death they were told by DOCS that no child was to be allowed in the pool area unless supervised by an adult present in the pool enclosure. They were also told that the children in their care were to attend swimming lessons. DOCS paid for those lessons. Mr B said prior to A's death he had not been given any training in relation to water safety and nobody had ever discussed with him the level of supervision required for the children. Mr B said it was never a problem for them to take children to lessons as it was just down the road.

Mr B said that during the period that they had been foster carers he and Ms B had gone on holidays without the children on one occasion – about five years ago they went to the Gold Coast for a week. Mr B said that he never wanted a break from the children. They all went on holidays together. Mr B said that he did not believe in respite and never wanted it. He considered that it was detrimental to the children to break their routine and to send them away. He said that on one occasion respite was organised and he had to drive the children to their respective respite carers and it was more trouble than it was worth.

Mr B said that he recalled in the months before A's death there was discussion with Ms Beckman about DOCS organising a youth worker to come and babysit regularly so that he and Ms B could go out for a night. He said that over the last few years a youth worker has come regularly – about 8 or 10 times in total. That arrangement commenced after A's death.

He said that the support workers would prompt him to have the youth worker come so that he could have a break.

Mr B said that he knew there was a shortage of foster carers in Cairns so he took on as many children as he could manage to care for.

Mr B agreed that 2012 was a very busy year. They started off with 8 children in their care. At one time in that year they had 15 children but that was only for

three days. The number went back to 9 and then up to 11. They had 11 children for two months up until two weeks prior to A's death. Two weeks before A's death the number went down to 7. On the weekend prior to A's death they had been sent two children for emergency respite. One of their children had left Cairns for a short time on 24 September 2012 so they had 8 children in their care that day.

Mr B said A and C had originally come to them for respite care but their carer could not cope with them. He and Ms B had grown attached to the boys so when it was suggested that they permanently stay with them they agreed. They knew that there were no other placements available. Both of the boys had high support needs as did some of the other children in the household at that time. One of the boys who was in the house at that time (J) had very difficult behaviours. It had been discussed that he might have to be moved to another household but Mr B was reluctant to let him go as he thought he may be able to help him.

It was at this time, and in response to the challenging behaviour of J, that a community visitor commenced monthly visits.

Mr B said they were also having difficulties with the mother of two of the boys who were with them and who were transitioning back to her care.

Ms B

Ms B said that IFYS provided support in the form of weekly visits and regular contact. They offered her training. Ms B was happy with the support she was offered by IFYS.

After A's death they were provided with respite in the form of a youth worker who came to the house once every six weeks and looked after the children whilst they went out to dinner.

Ms B said that respite was not a frequent occurrence as they did not ask for it that often because they didn't want it. The lack of respite was not an issue for them.

Ms B said that they had one holiday away from the children over the 8 year period that they were foster carers – they went away for a week to the Gold Coast. Other than that week, when they went on holidays they took the children with them and they enjoyed doing that.

Ms B said that A's last carer told her that A was scared of the water and couldn't swim. She said that in regard to some of the children who came into her care she was given information about their swimming ability. She couldn't recall taking any of the children to swimming lessons prior to A's death but she did after that date. She would take them to lessons on Saturday mornings. She said that it wasn't a problem as she would take a number of children and they would all wait at the pool where the lessons were conducted.

Ms B said that A could not remove his swimming vest alone. At times he did not like wearing it. She had seen two of the children attempting to help him take it off on one occasion and they were chastised and told not to do it again. One of those children was in the pool with A the day he drowned but Ms B thought that the child understood that he was not to remove the vest from A.

Ms B agreed that in 2012 they had up to 15 children in their care. They always had more than 6 that year. Most of those children had behavioural issues and high support needs. One of the children that was in their care around the time of A's death was very troublesome (J) and she may have discussed with IFYS that they wouldn't be able to keep him at the house.

On 24 September 2012 they had 7 children permanently in their care and were providing respite for two others for the weekend.

Ms B said that, at the time of the accident, there were only three children in the pool. A could not swim but the other two children could. Although she was sitting on the veranda, rather than in the pool enclosure, she could see the whole of the pool. Ms B said that if there were a number of children in the pool she would sit inside the enclosure but if there were only a few she would sometimes sit on the veranda.

Ms B said that she last saw A lying on the pavers on a towel. He was not swimming at that time. The next time she saw A was when one of the other children called out to her to help. She said she was not looking at A when he drowned because she was engrossed in the conversation she was having with Ms P.

Ms B said that after A's death she was told by DOCS that the pool gate had to be key-locked (rather than only shut) at all times and that one of them had to be inside the pool enclosure when any of the children were in the pool. She was told to take two of the children to swimming lessons.

Ms P

Around 2012 Ms P, a good friend of Ms B, visited the house on a weekly basis. She can't recall Ms B ever saying that she was stressed or not coping with the children. It was always a well-run and organised household.

Ms P said that during her visit on 24 September 2012 she and Ms B were sitting on the veranda overlooking the pool. She saw Mr B put the vest on A before he went into the pool enclosure and they had some discussion about the fact that A could not swim and he had to wear a flotation device. Mr B took A down to the pool enclosure with the other children and then he went to the shops.

Ms P said that she and Ms B were sitting at the table talking about work and the kids and general chit chat. Ms P was watching the children as well as Ms B. She saw A swimming with his vest on. He was putting his head in and out of the water. Ms P didn't see how the vest came to be removed from A.

Pippa Beckman

Ms Beckman has a Certificate III in Child Services, a Diploma in Child Services, a Certificate IV in Child Protection and a Certificate IV in Family Intervention. She was the IFYS support worker for the B's at the time of A's death. Very shortly after that date she took up a new role in the organisation.

As support worker her role was to support foster carers by being available to them for advice, etc and to speak to DOCS on their behalf.

DOCS have the responsibility of approving persons as foster carers and to determine the number of children who could be placed with those carers. Matching of carers with children was conducted by IFYS support workers in consultation with DOCS officers who made the final decision.

Ms Beckman was the support worker for Mr and Ms B from early 2010. She was involved in the decision to place A and C with Mr and Ms B for respite care in August 2010 and the permanent placement of the boys with Mr and Ms B in October 2010 which was confirmed in March 2011.

Ms Beckman found Mr and Ms B to be likeable, caring, capable and competent carers who did an excellent job.

Ms Beckman, in accordance with IFYS policy, visited Mr and Ms B monthly, had fortnightly telephone calls with them and had email contact every few days.

Ms Beckman was trained by IFYS to carry out the role of support worker. During that training Ms Beckman was told that she should discuss respite with carers. Respite is a short break for carers. It is usually achieved by taking the children in their care to another carer for a short period e.g. a couple of days. Respite can be advantageous to carers and to children but it can also be detrimental to children in care who may feel they are not wanted or may have difficulties adapting to a new routine and new carers.

Ms Beckman told carers that they were entitled to respite and if they agreed she referred the request to DOCS. She was told that she should suggest respite to carers if she considered that they should have some.

Ms Beckman suggested to Mr and Ms B, on numerous occasions, that they should take respite. They were resistant to sending the children away to another carer for respite. They always said they were coping fine and they would take breaks separately from each other.

Ms Beckman also discussed the matter of respite with Keran Thomas and DOCS. She felt that Mr and Ms B needed a youth worker to visit their house once per month so that they could go out for an evening. At that time a number of the children in their care had high complex needs and she felt they needed some time off. Mr and Ms B were quite keen to have a youth worker come in regularly to care for the children so that they could go out for an evening. In June 2012 Ms Beckman had concerns about the placement breaking down

because of the stress that Mr and Ms B were under due to the behavioural issues and complex needs of a number of the children in their care.

In an attempt to address the support needs herself Ms Beckman increased her visits to fortnightly and had weekly phone contact with the family.

From 30 May 2012 until 21 September 2012 Ms Beckman raised the issue of providing a youth worker to Mr and Ms B with DOCS.

On 21 June 2012 at a meeting between the CSO, Ms Beckman and Ms Thomas in relation to supports to be offered to Mr and Ms B, Ms Thomas said that she needed funding for more sessions with certain children in the placement. Ms Beckman stated that she was commencing fortnightly, rather than monthly visits to the house and suggested the following supports be put in place:

- A youth worker to visit one weekend per month for a few hours;
- A youth worker or baby sitter to come to the home for 4 hours per fortnight so that Mr and Ms B could go to dinner;
- Assistance with funding for a removals company (Mr and Ms B were trying to find a new house at that time as they had to leave their current residence as it had been sold);
- Assistance with funding for a bond cleaner to clean their old house after they moved out.

The CSO agreed to speak to her manager about obtaining approval for the above.

On 18 July 2012 Ms Beckman spoke to Mr B about the above requests. In relation to the youth worker he told her that would “help a lot” as he and Ms B didn’t get a lot of time without the children.

On 21 August 2012 Mr B asked Ms Beckman about the youth worker. She told him that DOCS had said they would organise it by the end of the month.

On 21 September 2012 Ms Beckman told her manager that she was concerned about Mr and Ms B having the two girls for respite on the weekend as they already had 7 children in their care. Ms Beckman’s manager said that she should talk to DOCS about it. Ms Beckman spoke to Rhonda Wills, the Senior Team Leader, DOCS, and told her that Mr and Ms B would take the girls but IFYS was not happy with it and they could only stay a short time as IFYS had been trying to reduce the number of children in their care. Ms Wills spoke to her manager and advised that DOCS had approved the placement for two nights.

DOCS did not organise a youth worker to assist Mr and Ms B prior to A’s death. Ms Beckman was told that they had no staff or funding to provide such support.

After A’s death DOCS approved a youth worker to visit Mr and Ms B to provide respite once every 6 to 8 weeks.

Ms Beckman said that in 2012 there was pressure to find foster carer placements for children because of the number of children requiring placements and the lack of foster carers. A and C initially went to the B household for respite care but they developed a relationship and when A's carer could no longer care for him the brothers were placed permanently with Mr and Ms B.

Ms Beckman said that it is the responsibility of DOCS to make decisions re placements. IFYS can only make recommendations. Ms Beckman said that in the 12 months before A's death Mr and Ms B always had more than six children in their care and at one time they had 15 children – that was for a period of three days only. Ms Beckman agreed that for the two months leading up to the two weeks prior to A's death there were 11 children in the household.

Ms Beckman stated that she attempted to get the number of children in the placement down to six but it was very difficult. She recalls being advised by DOCS on one occasion that there were no other carers available and the only possible placement was the B household. She said that once DOCS made a placement decision it was her job to consider what supports could be offered to the carers so that they could cope with the placements.

It is IFYS best practice that no more than two sibling groups be placed in one household but that, too, was often exceeded because of the lack of available placements.

Ms Beckman said that Mr and Ms B lived in a house at Palm Cove when she first became their support worker. That house didn't have a pool. They moved to the Kewarra Beach house which did have a pool. When they moved there Ms Beckman carried out a house safety study. She knew that A couldn't swim. She checked that the pool was fenced and had appropriate signage. She had discussions about water safety with Mr and Ms B. She asked them questions such as whether they knew CPR and whether they understood the need for supervising the children in the pool.

On 18 September 2012 Ms Beckman visited the B household. A was swimming at the time and his brother may also have been in the pool. A was wearing his vest. Ms Beckman and Ms B were sitting at the table on the veranda overlooking the pool – the same place Ms B was sitting when A drowned. They were about 3 or 4 metres away from the pool. Ms Beckman considered that level of supervision to be appropriate.

Ms Beckman said that after A's death her manager, Ms Eakin, made the decision that IFYS would obtain pool certificates from carers with a pool and keep them on file.

Rhonda Wills

Ms Wills provided a statement in which she said that she approved respite care for the two girls on 21 September 2012 in her role of team leader of the CSO of those girls. Ms Wills cannot recall having any contact with Mr or Ms B at that time.

Ms Wills said she has a general understanding of the placement processes but she did not allude to the requirement for special approval for more than six children that was in place at the time nor did she state that such approval had been obtained prior to her approving the respite care. Ms Wills made no mention to having given any consideration as to the number of children in the placement or any other factors prior to approving the placement.

Ms Wills stated that her understanding was that all placements were organised by PSSU and then sent to the team leader for final approval.

Keran Thomas

Ms Thomas is a psychologist who assessed Mr and Ms B re the suitability as foster carers. She spent two and a half hours at their house in relation to that assessment. She thought they were managing well with the 8 children that they had at that time.

Ms Thomas said that she wouldn't have recommended that Mr and Ms B have more than 8 children in their care even though they were coping well with 8 children.

Ms Thomas said that in 2012 she attended a meeting with Ms Beckman who was going to recommend that Mr and Ms B be provided with a youth worker for respite. She did not know whether that eventuated.

Ms Thomas said that respite was particularly difficult where foster carers had a large number of children in their care. She said that Mr and Ms B were able to express any needs that they had and they did not want respite. They enjoyed taking the children on holidays with them.

Faith Strong

Ms Strong was the child support officer from DOCS for A and C from December 2011 to the time of A's death. She said that it is department policy that CSO's should visit foster carers monthly but she was seeing Mr and Ms B every two months and the visits were not always documented as they should have been. Ms Strong said that these omissions occurred because of her high case load – she was forced to prioritise matters as she was very busy. She was responsible for about 28 children at any one time.

Ms Strong had been to the Kewarra Beach house once or twice prior to A's death. The first visit was on 26 June 2012.

Ms Strong's file notes indicate that she conducted an introductory visit to the house of Mr and Ms B on 13 December 2011. The next recorded visited was on 27 June 2012 – that was at the Kewarra Beach house. The next recorded visit was on 12 September 2012. There are no other records of her having contact with Mr B or Ms B or A or C although it is possible that she may have spoken to Mr or Ms B in January, March and July in regards to contact visits with A's mother and father.

Ms Strong said that Mr B had facilitated and supervised contact between A and his father on a regular basis. Mr B was happy to do that even though it was normally the responsibility of the CSO.

Whilst she was the CSO for A Ms Strong was unaware of his swimming ability or whether he'd had swimming lessons. She said she would have arranged lessons if requested to do so by Mr and Ms B.

Since A's death Ms Strong has requested foster carers to arrange swimming lessons for children for whom she is responsible who can't swim.

Ms Strong says that when she visits any placement she looks for any hazards including inspecting pool fences and gates.

She said that the youth worker model of respite was not utilised very often. She said that she had not used it or considered it prior to A's death.

Carolina Williams

Ms Williams managed the Townsville and Cairns offices of IFYS. Ms Williams was an impressive witness who has 14 years' experience in the child protection sector.

Ms Williams said that she was advised of A's death. Prior to his death support workers were provided with no specific training in relation to talking to foster carers about the level of supervision required when children were in the pool. After A's death, she changed the policy so that all carers with a pool had to provide a pool safety certificate as part of the household safety study.

Ms Williams made the decision that support workers would be encouraged to advocate strongly to DOCS that there should not be more than six children in one household. She said that she was shocked to hear that Mr and Ms B had so many children in their house and she didn't deem that number appropriate.

Ms Williams said that even though some natural families have more than six children it is the case in those circumstances that the children have come into the family gradually and the family adjusts to the number. Here, there was a high number of children with complex needs and she considered that it was not in the interests of those children to be in a house with so many other children.

Ms Williams said that Mr and Ms B were considered to be exceptional, highly functional carers and they would not refuse a child if they felt that they had the capacity to care for him or her. They were highly organised carers. Ms Williams said that because of this DOCS often placed children with Mr and Ms B without prior consultation with IFYS.

Ms Williams acknowledged the lack of available carers and that some of the children were in the house at the time of A's death for short-term respite but maintained that the number was not appropriate.

Ms Williams said that after A's death IFYS gave more consideration to matching children with households that had pools. A broadcast was sent to all the support workers in regard to the changes that had been implemented.

Ms Williams said that it would be her expectation that, with a child like A who had developmental delays, the foster carer would be in the pool enclosure when the child was in the pool. She said the problem with mandating such an approach is whether it could be enforced. She agreed that training could be provided to carers around that topic.

Melissa Boulter

Ms Boulter was the CSO for A from before he went to live with Mr and Ms B – from September 2010 to August 2011. Ms Boulter states that she "engaged closely with the carers through frequent contact". She says her contact with Mr and Ms B was on a weekly basis through telephone calls and emails. She said she met with Mr B regularly as he would attend school meetings. Ms Boulter produced her file notes for the period which recorded no meetings at school, no telephone calls or emails with Mr B and no home visits.

In evidence Ms Boulter said that CSO's were supposed to visit carers monthly but she could not do it that often. She said she had regular phone and email contact with Mr and Ms B. Ms Boulter agreed that none of those visits were documented in the Department's records.

Ms Boulter said that A had some swimming lessons when he was with his previous carer and she organised for those lessons to be paid by DOCS.

Ms Boulter said that since A's death she was more mindful of recording information about a child's swimming ability in the Child Information Form which is available to all CSO's and support workers, as well as the Placement Agreements and Case Plans – recording that information in those documents would ensure that it was relayed to any foster carer. She has recently discussed with carers how they would supervise children in the pool.

Ms Boulter said that generally foster carers would not be funded to have a youth worker come to their house for respite but special approval could be given by a manager.

Ruth Anderson

Ms Anderson has been a support worker with IFYS since September 2012. She said as part of the household safety study she would ask all carers about where they would sit whilst supervising children in the pool and would recommend that they sat inside the pool enclosure.

Ms Anderson said that when she met with Mr and Ms B at their house in the week before A's death they sat on the veranda and watched A swim in the pool.

Ms Anderson is not aware of any training given to foster carers in relation to water safety.

Ms Anderson said that Mr and Ms B were keen to have a youth worker to their house for respite prior to A's death but that didn't occur. She didn't know why DOCS had not put that place. Ms Anderson said that after A's death Mr B and Ms B were told that they were to have respite and the youth worker model was put in place.

Simone Felix

Ms Felix is the Principal Service Advisor with Far Northern Region Placement and Support Services Unit of DOCS. She has been employed by DOCS since 2007 and has held many other positions in relation to child protection.

The role of the PSSU is to coordinate all out of home placements for children under the care of DOCS and to manage the region's use of funding allocated to out of home services.

Ms Felix first became involved in A's care in late 2010 when he was placed with his previous carer. Mr and Ms B were identified as possible respite carers for A and C whilst he was in that placement. When A and C went there for respite in August 2010 Mr and Ms B had four other children in their care. The respite was very successful and A and C visited there monthly and developed a good rapport with Mr and Ms B and the other children.

DOCS records indicate that there was some discussion, prior to the respite for A and C being approved by Pat Andersen, about the fact that Mr and Ms B already had 6 children in their care. Ms Andersen replied that if IFYS could put additional supports in place there was no reason why the respite could not continue but said that the file should be noted that if any of the primary placements leave no more children were to be placed with Mr and Ms B.

In January 2011 it was identified that the previous carer could no longer care for A and C. DOCS could not find an appropriate carer for the boys so Mr and Ms B were approached to provide emergency respite care. The boys stayed there for a month and then the respite arrangement was renegotiated as a primary placement.

Foster carers complete a Foster Care Agreement with their support agency that takes into consideration carer capacity and circumstances within the household. These are reviewed every 12 months and signed off by the DOCS manager. At the time of A's placement with Mr B and Ms B they were assessed as having capacity to care for up to 9 primary placements with up to an additional 3 placements for emergency respite reasons. That agreement was completed in August 2012.

Ms Felix said that the Far Northern Region has a regional directive in relation to limiting the number of children that can be placed within a foster carer's household and this directive is applicable regardless of how many children are indicated on the Foster Care Agreement. The directive states that written approval from either the Director, PSU or the Regional Director should be sought if a proposed placement exceeds 6 children. There is monthly reporting in place to monitor this.

Ms Felix said that Mr and Ms B were considered to be experienced, highly skilled carers who were held in very high regard and were one of the limited number of carer households who were permitted to exceed 6 placements and that had been done on a couple of occasions.

Ms Felix said that on 21 September 2012 (the Friday before A's death) there was a spike in the number of carers seeking respite care – that was usual for a Friday afternoon but it was also the weekend of the start of the school holidays.

The directive wasn't followed that day when the two girls were placed in the household for two nights respite care which brought the total number of children in the house to 9 for that period. Ms Felix said that she was aware, from conversations she had later, that approval would have been given for the respite care given the high level of Mr and Ms B's experience and the lack of any other options available as well as the short time period for the respite.

On Monday 24 September 2012 Ms Felix received a request to review how many children were placed within the household and it was then that it was realised that proper approval had not been given for the emergency respite.

Ms Felix said that all of the staff of the PSU felt strongly that there should not be more than 6 children in a household unless it had been approved by the Director, PSU.

Ms Felix said that a child's swimming ability should be recorded on the Child Information Form.

Pat Andersen

Ms Andersen is the Manager of the Cairns North Child Safety Service Centre. She is responsible for approving applications for foster carers.

Ms Andersen met with Ms and Mr B in August 2011 when they were residing at the former residence. She visited their home for the purpose of assessing whether they were capable of caring for more than 6 children.

She was there for about two and a half hours. The house had a creek in the backyard and she had discussion with Mr and Ms B as to how they supervised the children around that creek. She didn't visit the Kewarra Beach house but the household safety study that was submitted satisfied her that the house was appropriate for the children.

Ms Andersen said that she was unaware that there were 15 children in the house of Mr and Ms B for 5 days in July 2012.

Ms Andersen visited the Kewarra Beach home after A's death and that was for the purpose of the investigation into the death carried out by her office (the Matter of Concern investigation).

Ms Andersen said that DOCS is continually trying to reduce case loads in the Cairns office.

Ms Andersen said that there is no DOCS policy which mandates that children in care have swimming lessons but she would consider approving such expenditure if the foster carer wanted a child to have lessons. Ms Andersen said that since A's death there has been more awareness on the part of DOCS officers in relation to pool safety and access to swimming lessons.

Ms Andersen said that if she had received requests to approve expenditure for a youth worker to visit the B household she would have approved it. She said that if such a request was made and she didn't receive it that must have been due to a breakdown in communications between the CSO, the team leader and her.

Ms Andersen agreed that information about the level of supervision required for specific children could be included in the foster care assessment process. If it was, that information would be regularly addressed rather than being considered only when the household safety study was done (i.e. when a foster carer moves to a new house).

Ms Andersen said that it is the case now that if more than 6 children are to be put in one placement that has to be approved by the Regional Director, rather than previously, when it could have been approved by the Manager, PSSU.

Corinne Porta

Ms Porta is the Director of Placement and Support Services Unit, Far North Qld region. Ms Porta is responsible for the operational and strategic oversight of out of home care in the region and leads a team of 24 staff who work in partnership with the CSO's and foster care agencies to negotiate all placements for the region. She reports to Arna Brosnan, Regional Director.

As at 30 June 2014 there were 500 registered foster carers in the region. Ms Porta said that the region is constantly attempting to cap placements at 6 per household but this is made difficult by the chronic shortage of foster carers. DOCS is constantly trying to recruit more foster carers. Currently there are recruitment campaigns across the region. These have had some success in that new foster carers have expressed interest and are being assessed.

Ms Porta said that to ensure appropriate consideration is given before placing more than 6 children with a foster carer, a procedure has been developed. Such a placement requires both her endorsement and the approval of the Regional Director. They take into account such matters as the size of the home, the needs and ages of the children, the experience and capacity of the carers and external supports that will be provided such as respite and training. The process is initiated through PSSU which obtains monthly reports for the purpose of monitoring those numbers.

Ms Porta said that although some families manage well with more than 6 children experience has shown that it can also be the case that when that

number is exceeded many families struggle in many ways, including properly housing that number, having sufficient money to provide for them adequately and dealing with behaviours that the children may display.

Ms Porta said that managing a child's swimming ability is an ever-increasing difficulty for DOCS as funding is always stretched as DOCS attempts to address all of the priorities with respect to the children in its care. Previously all children at primary school attended lessons at school but this is not always the case now. Also, not all foster carers are able to take children to swimming lessons.

Ms Porta has attempted to raise awareness of issues of water safety:

- In December 2014 she requested that a section be included in the monthly regional Foster Care Qld newsletter pertaining to water safety – that was sent to all foster carers in the region;
- In January 2015 she sent an email to all staff to advise them to include information pertaining to a child's swimming ability in the Child Information Form so that this could be discussed with the foster care agency and prospective foster carers at the time that a placement is proposed – she identified three key responsibilities in relation to water safety:
  - Record information in the Child Information Form for each child in relation to their swimming ability;
  - All children should be encouraged to learn to swim and this should be built into their case plan;
  - For all placements with a backyard pool (or other body of water) the placement agreement needs to clearly articulate the agreements in regard to how the risk will be managed. Issues such as the child's capacity to swim, supervision, swimming lessons, and any other risk management strategies or expectations of carers should be reflected in the document. Please ensure this component is built into all new placement agreements.
- In January 2015 she spoke at the regional foster care forum about the importance of ensuring water safety awareness and where relevant, swimming lessons for a child, forms part of the Placement Agreement and placement matching process.

Ms Porta said that the inclusion of such information in the documents noted at the second bullet point, above, is not mandated by policy or procedures but she could see no reason why it should not be included in the Child Safety Practice Manual.

Ms Porta said that water safety awareness should be part of the training provided to staff.

Ms Porta said that the Regional Action Plan for short breaks/respite mentions the importance of considering the in-house youth worker model but it has been difficult to utilise due to the high turnover and unavailability of youth workers.

Arna Brosnan

Ms Brosnan is the Regional Director, Far North Qld region of DOCS. Ms Brosnan has over twenty-five years' experience in the child protection sector. She is responsible for leading departmental strategic direction in the region and operational oversight of six child safety services centres and three specialist units which include the Regional Intake Service, the Placement and Support Services Unit and the Support and Investigation Unit which are all in Cairns.

As at 30 June 2014 FNQ region had the care of 950 children and there were 459 registered foster carers.

In 2010 Ms Brosnan made the decision to implement a local protocol whereby placements of children be limited to six per carer household. Any placement above that number could only proceed with the approval of the PSSU director or Ms Brosnan. That approval would only be given after a review of the household to ascertain the level of care needs, the needs of the children to be placed, whether any extra supports were needed for the carers and whether the carers had any specialist skills, capacity or demonstrated experience in managing the requirements of all the children involved.

Ms Brosnan said that, to her knowledge, Mr and Ms B were highly regarded carers who are acknowledged for the high level of care and commitment they provide to children in their care. All children placed with Mr and Ms B benefit from the placement and exhibit marked improvement in their behaviour and development.

Ms Brosnan said that although regional processes were not followed with regards to an assessment being completed prior to placement of additional children with Mr and Ms B on a respite basis on the weekend of A's death, it is highly likely that any assessment would have supported the placement.

Ms Brosnan said that Pat Andersen told her that Mr and Ms B were encouraged to take respite which could have been facilitated by DOCS but they did not want to send the children away and would prefer to make their own arrangements with friends and family.

Ms Brosnan said that the most important factor which was identified re A's death was supervision of children in the water. She said her office has pushed swimming lessons and is constantly raising awareness re water safety. The other factor identified was the importance of adequate support for carers.

Ms Brosnan agreed that a child's swimming ability should be included in the Child Information Form and that water safety training could be given to CSO's.

Ms Brosnan said that although the internal Systems and Practice Review conducted following the death of A made no recommendations as to changes, the FNQ region has committed to:

1. Using a more tenacious approach to exploring kinship care options and ensuring cultural connections;

2. Working towards a better understanding of parallel planning, for example, in the case of A, the CSO was working towards a reunification plan with A's mother but should have been considering other placement options should that plan not progress;
3. Improving the approach to respite care with initiatives to source respite from within the child's own support system to reduce the use of "stranger care";
4. Improving carer and staff knowledge of children's culture and community or origin;
5. Improving time compliance with case planning and reviews and creation of placement agreements.

Louise Ryan

Ms Ryan is the Assistant Executive Director of Child and Family Programs and Investment for DOCS.

Ms Ryan set out the comprehensive procedures, as set out in the Child Safety Practice Manual, for placement of children in foster care:

1. CSO's assess the level of support the child needs and takes this into account when deciding the appropriate model of care and the support and services that may be required for the child including the particular skills and abilities that a carer may be required to have.
2. The placement matching process is informed by the case plan goal and a thorough assessment of the child's strengths and needs to assess the level of support that a placement will need to be able to provide adequate care for the child. There are four level of support needs:
    a. Moderate level – typical for most children in care as a result of harm and trauma they have experienced;
    b. High level – includes needs that indicate serious emotional, medical or behavioural issues that require additional professional or specialist input;
    c. Complex level – needs that significantly impact on the child's daily functioning usually characterised by health conditions, disabilities or challenging behaviours;
    d. Extreme level – needs that have a pervasive impact on a child's daily functioning, usually characterised by the presence of multiple, potentially life-threatening health or disability conditions, and extreme challenging behaviours that may necessitate a constant level of supervision and care.
3. The skills and abilities of a proposed carer to manage a new placement is taken into account before the proposed placement is discussed with the new carer, especially the structure of the household including the time the carers have available to care for the child.
4. The decision to place a child is also based on the following information:
    a. The placement agreement between the carer and DOCS in which the carers specify the number and characteristics of children that can be placed with them;
    b. The experience of the carers and their particular skills;
    c. The size of the carer's house;

d. An assessment of the carer's ability to meet the child's requirements;
e. The proximity of the carers to the child's school or other services;
f. The need to place children in accordance with their case plan and placement matching procedures;
g. The availability of carer support;
h. The demand for placements in that place and the capacity of the carer pool;
i. Kinship carer and cultural considerations;
j. The desirability of placing siblings together;
k. Proximity of family members.

The CSO or the foster care agency (in this case, IFYS), where the carer is associated with one, is responsible for developing the Foster Carer Agreement with a foster carer. It is a written agreement negotiated by the parties and setting out the terms, conditions and responsibilities between the foster carer, and the foster care agency. It includes agreements about the maximum number of children and the carer's ongoing development and support needs. The document has to be reviewed at key stages of carer approval and re-approval.

Ms Ryan, when asked about the inclusion in the CSPM of a policy regarding water safety and training, etc stated that there were already too many policies and procedures in the Manual and this was a concern identified by the Qld Child Protection Commission of Inquiry.

Submissions

Counsel Assisting submitted that I would consider making the following recommendations:

1. DOCS update the Child Safety Practice Manual to require staff to record the swimming ability of all children, where known, in the Child Information Form;
2. DOCS update the CSPM to encourage the provision of swimming lessons to all children residing in a placement where there is a pool or water hazard;
3. DOCS consider updating the CSPM to require that the Placement Agreement for all placements where a child is in residence with a pool or water hazard articulates:
    a. How the risk of drowning will be managed by both foster carers and DOCS, including how the child will be supervised;
    b. The child's ability to swim;
    c. Whether swimming lessons are required;
4. DOCS require foster care agencies to provide all support workers with training on identifying water hazards, water safety and appropriate levels of supervision of children around water hazards;
5. DOCS and foster care agencies provide all foster carers with training on identifying water hazards, water safety and appropriate levels of supervision of children around water hazards;
6. DOCS consider amending the Household Safety Study form to include a requirement that water safety and supervision is discussed with foster

carers and a handout on water safety be provided to foster carers at the time of completing the form.

Ms Neil supported all six of the above proposed recommendations. Ms Neil said that A's death was not an unpreventable accident and there were several factors which contributed to it being:

- A lack of appropriate supervision
    - A couldn't swim, he had been assisted out of his vest previously by the other children and the risk should have been apparent;
    - Mr or Ms B usually sat inside the pool enclosure but didn't on this occasion because they had a visitor;
    - Nobody knows how A came to be not wearing his vest as there was nobody watching him;
    - Ms B failed to supervise A for a significant time period which could have been up to 15 minutes based on the time intervals provided by the various witnesses.
- Neither the staff of DOCS nor of IFYS were trained in appropriate supervision standards in regards to water safety.

Ms Neil submitted that although DOCS has recently taken steps to make staff more aware of water safety issues the department still has no formal policies in that regard and Ms Brosnan and Ms Porta were supportive of such policy change.

Ms Neil submitted that the regional cap of 6 children per placement unless there is specific approval should be included in DOCS policy.

Although DOCS and IFYS officers were aware of the benefits to carers of respite Mr and Ms B were unaware and put the needs of the children ahead of their own when they refused respite. Ms Neil submitted that although the provision of respite to Mr and Ms B may not have averted A's death the lack of it cannot be ignored in the context of the drowning having occurred when Ms B was having a break i.e. a coffee and a chat with her friend.

Ms Neil submitted that I consider the following further proposed recommendations:

1. The cap on the number of children in one placement become statewide DOCS policy with a maximum number of children which cannot be exceeded;
2. Policies be implemented by DOCS with regard to minimum requirements for respite for carers;
3. Foster carers to be trained in relation to the need for respite and the models available to them;
4. A policy be implemented requiring active supervision of swimming and including the need for swimming lessons, information to be recorded in the Child Information Form and training for staff in that regard.

Ms Carmody stated that DOCS supported recommendations 5 and 6 proposed by Counsel Assisting. She submitted that there was no link between a lack of respite and A's death. Mr and Ms B were managing the children in their care and they were all well looked after. At the time of A's death the Foster Care Agreement set out that they were approved to care for 9 permanent placements and 3 respite placements.

Mr Collins submitted that there were no systemic failures on the part of IFYS which contributed to A's death.

Comments, recommendations and findings

The scope of the Coroner's inquiry and findings

An inquest is not a trial between opposing parties but an inquiry into a death. The scope of an inquest goes beyond merely establishing the medical cause of death.

The focus is on discovering what happened; not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred and, in appropriate cases, with a view to reducing the likelihood of similar deaths.

As a result, a coroner can make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.

A coroner must not include in the findings or any comments or recommendations, statements that a person is or may be guilty of an offence or is or may be civilly liable.

Proceedings in a coroner's court are not bound by the rules of evidence. That does not mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

A coroner should apply the civil standard of proof, namely the balance of probabilities. However the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, then the clearer and more persuasive the evidence needs to be for a coroner to be sufficiently satisfied it has been proven.

If, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to the Director of Public Prosecutions in the case of an indictable offence and, in the case of any other offence, the relevant department. A coroner may also refer a matter to the Criminal Misconduct Commission or a relevant disciplinary body.

Comments

It is clear that Mr and Ms B were excellent foster carers. They devoted their lives to caring for children in need. They took in as many children as they felt they could care for and their goal was always to keep those children in their care for as long as possible in order to provide them with a stable and loving home. They were aware, as is everyone involved in foster care, that there was (and still is) a chronic shortage of carers in this region and were reluctant, therefore, to refuse any child a place in their home. They knew and had been told on occasion by DOCS that there were no other placements available.

In 2012 Mr and Ms B were approved by DOCS and had agreed, to have up to 9 children permanently in their care and to have up to 3 more children for short term respite. Some of the children in their care during that year were children who had been classified as having high needs.

Mr and Ms B were supported in their role as foster carers by IFYS and more specifically, by Ms Beckman.

IFYS is to be commended for the support it provided to Mr and Ms B. The agency fulfilled its role in the provision of such support and advocated to DOCS on behalf of Mr and Ms B in regard to their support needs.

Ms Beckman was an impressive witness who gave her evidence in a forthright and professional manner. She was very concerned about the welfare of her carers and did her best to support them with the resources she had available to her.

Although Ms Beckman was concerned in June 2012 that the placements with Mr and Ms B would break down and raised with DOCS that they required more support in the form of visits from a youth worker, nobody from DOCS progressed this request. Ms Andersen said that she would have approved such expenditure but she was not asked to do so and that must have been a breakdown in communications. Such a breakdown may have been attributable to large workloads in the office at that time but it is unfortunate that the request made on behalf of Mr and Ms B, who were taking on a large number of high needs children as well as other tasks, such as supervising parental contact, was given such low priority by DOCS staff.

Ms Andersen was unaware that Mr and Ms B had up to 15 children in their care for periods in 2012. She was unaware of the approval given for respite care on 21 September 2012 which resulted in the placement of 9 children with Mr and Ms B from that date. It seems that Ms Wills, the team leader who approved the respite care, was unaware of the protocol in relation to placing more than six children in a placement or the need for any consideration to be given as to the appropriateness of placements by her and remained so as at April 2015 when she provided her statement to this inquest.

It is to the credit of the staff of DOCS and IFYS that following the death of A, they reviewed their procedures and implemented changes that they considered might help to avert the death of another child in care.

Ms Williams changed the procedures of IFYS in relation to placing children in houses with pools. The CSO's and support workers became more aware of water safety, included more information in the Child Information Forms and other documentation about a child's swimming ability and discussed water safety and swimming lessons with carers where appropriate.

Ms Porta implemented a number of measures designed to promote awareness of water safety.

However, those changes were made only in this region and only in relation to IFYS and not the other foster care agencies associated with foster carers and DOCS. There is the danger that the lessons learned have not been recognised in all parts of the State and across all foster care agencies. Amendments to the CSPM would ensure that all persons involved in foster care have a heightened awareness of the need for water safety and appropriate supervision of children in the water.

It is clear that the other children in the pool enclosure and swimming pool with A at the time he drowned, including his brother C, are in no way responsible for the death of A. C was only 8 years old at the time. A's death is in no way attributable to C or the other child who both acted responsibly and maturely for their years, when they identified that he was in need of assistance and immediately took him to the side of the pool and called for Ms B. They did all they could to help A.

Ms B failed to supervise A when he was in the pool and her inattention was more than momentary – she was not watching him for at least 1 to 2 minutes. There is no doubt that she was somewhat comforted by fact that A was wearing his flotation device and she believed that he couldn't remove it. Further, Ms Beckman and Ms Anderson had visited the house and observed A swimming from the veranda where Ms B sat on the day of his death. Nobody had raised any concerns that such supervision was insufficient.

Ms B wished only the best for A and did her best to care for him. What happened to A in her care could have occurred in any household.

It cannot be concluded that the death of A can be directly attributed to number of children in the household or the lack of respite, however, when a tragedy such as this occurs, it is an opportunity to examine procedures and policies with a view to any amendments which may go towards averting a similar tragedy.

It is possible that, had Mr and Ms B been spoken to about pool supervision in greater detail and given more advice about the necessity of strict and constant supervision, they may have decided that it was appropriate to sit inside the pool enclosure at all times. It is possible that, had Ms B been in the enclosure she would have been more likely to notice that A's vest had been removed before he went back into the water.

As stated above, Ms Carmody advised that DOCS approved of the recommendations 5 and 6 proposed by Counsel Assisting. I propose to make those recommendations, however, the making of those recommendations, in my view, necessitates the making of recommendations that support workers and CSO's be trained in water safety. Without such training they could not be expected to discuss appropriate water safety measures and supervision with foster carers.

All of the witnesses involved in the placement procedure, including Ms Brosnan and Ms Andersen, agreed that information about a child's swimming ability should be included in the Child Information Form, as set out in Counsel Assisting's proposed recommendation 1.

I do not make any further recommendations as to the mandating of supervision methods or the documentation of same taking into account the difficulty of identifying appropriate procedures for every child in every placement. Training of CSO's, support workers and foster carers will, hopefully, have the effect of a raised awareness of issues of water safety and the need for appropriate supervision of children in the water.

Recommendations

I recommend that DOCS consider:

1. Updating the Child Safety Practice Manual to require CSO's to record information pertaining to a child's swimming ability in the Child Information Form;
2. Providing training to all CSO's in relation to the identification of water hazards, water safety and appropriate levels of supervision of children around water hazards;
3. Requiring all foster care agencies to provide support workers and foster carers with training on the identification of water hazards, water safety and appropriate levels of supervision of children around water hazards;
4. Amending the Household Safety Study form to include a requirement that water safety and supervision is discussed with foster carers and an appropriate publication (such as "The ABC of Pool Safety" published by the Department of Housing and Public Works) is provided to them at the time of completing the Study.

Findings required by s. 45

Identity of the deceased – a child, A

How he died – Hypoxic ischaemic encephalopathy due to drowning.

Place of death – The Townsville Hospital TOWNSVILLE QLD 4810 AUSTRALIA

Date of death– 27 September 2012

Cause of death –	A died after drowning in the pool in the backyard of his foster carers' residence due to a lack of appropriate supervision.

I close the inquest.

Jane Bentley
Coroner
Cairns
27 May 2015