QUEENSLAND COURTS

# CORONERS COURT OF QUEENSLAND

# FINDINGS OF INQUEST

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| CITATION: | | **Inquest into the death of Master Bailey Ezekiel PINI** |
| TITLE OF COURT : | | Coroners Court Queensland |
| JURISDICTION | : | Northern (Bowen) |
| FILE NO(s) | : | 2021/2548 |
| DELIVERED ON | : | 30 June 2022 |
| DELIVERED AT | : | CAIRNS |
| HEARING DATE(s): | | 16 May 2022, 15-16 June 2022 |
| LOCATION OF INQUEST | : | BOWEN |
| FINDINGS OF | : | Nerida Wilson, Northern Coroner |
| CATCHWORDS | : | Coroners: inquest, youth residential care; Sarina; voluntary placement 13 year old male child; in company with another; forcible entry into residential facility office, removed car keys belonging to staff member / carer; drove car to Bowen; single car collision; car ignited; cause of death effects of fire; passenger survived; key safe to be installed in facility office; consideration for additional staff or 'awake' staff on shift; consideration as to funding recommendations. |

**REPRESENTATION:**

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| Counsel Assisting | Mr J. Aberdeen |
| Co-Counsel Assisting | Ms M. Mahlouzarides |
| IFYS Limited | Mr T. Collins i/b Tony Snowden Lawyers |
| Dept. of Children, Youth Justice & Multicultural Affairs | Ms K. Carmody |

# Contents

## Publication

Section 45 of the *Coroners Act 2003* ('the Act') 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 38 page findings in relation to Bailey Ezekiel Pini. They will be distributed in accordance with the requirements of the Act and published on the website of the Coroners Court of Queensland.

### Standard of Proof

The particulars a Coroner must, if possible, find under section 45 (Coroners Act), need only be made to the civil standard but on the sliding Briginshaw scale. That may well result in different standards being necessary for the various matters a coroner is required to find. For example, the exact time and place of death may have little significance and could be made on the balance of probabilities. However, the gravity of a finding that the death was caused by the actions of a nominated person would mean that a standard approaching the criminal standard should be applied because even though no criminal charge or sanction necessarily flows from such a finding, the seriousness of it and the potential harm to the reputation of that person requires a greater degree of satisfaction before it can be safely made.

The paragraph above was specifically contemplated by the Court of Appeal with apparent approval. The Court went on to state:

> *"Two things must be kept in mind here. First, as Lord Lane CJ said in R v South London Coroner; ex parte Thompson, in a passage referred to with evident approval by Toohey J in Annetts v McCann: …an inquest is a fact finding exercise and not a method of apportioning guilt … In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use. Secondly, the application of the sliding scale of satisfaction test explained in Briginshaw v Briginshaw does not require a tribunal of fact to treat hypotheses that are*

*reasonably available on the evidence as precluding it from reaching the conclusion that a particular fact is more probable than not."*

## Relevant Legislation

Section 45(2) requires that a Coroner investigating a death must, if possible, ascertain the following facts –

(a) who the deceased person is; and
(b) how the person died; and
(c) when the person died; and
(d) where the person died, and in particular whether the person died in Queensland; and
(e) what caused the person to die.

I must not include within those findings any statement that a person is, or may be:

a) Guilty of an offence; or

b) Civilly liable for something

The expression "how" in section 45(2)(b) has been interpreted in Queensland to mean "by what means and in what circumstances" the death occurred. It is, therefore, capable of encompassing a broad range of circumstances.

The expression "cause of death" in subparagraph (e) is generally taken to refer to the medical cause of death, as determined following autopsy examination, or otherwise by way of certification by a medical practitioner.

The coronial investigation into Bailey's death has received evidence which enables the requirements of section 45(2) to be satisfied. I accept that, based upon the evidence, the appropriate findings would be as follows:

(a) the deceased person is Bailey Ezekiel PINI, aged 13 years (DOB: 30/11/2007);
(b) Bailey died when the motor car in which he was travelling collided with a tree, overturned, and caught fire;
(c) Bailey died on 9 June 2021;
(d) Bailey died at Queens Road, Bowen, in the State of Queensland;
(e) Bailey's death was caused by the effects of fire, as a result of a motor vehicle collision.

## Issues at Inquest

Draft Issues were prepared, which were published, and made available to persons appearing with a sufficient interest in the subject of the Inquest.

There was no application to amend or vary those Draft Issues at the Pre-Inquest Conference held on 16 May 2022, and the Draft Issues were thereafter accepted as the Issues for the Inquest.

1) The information required by s.45(2) of the Coroners Act 2003, namely:

    a) When the deceased person died;
    b) Where the deceased person died;
    c) How (ie by what means, and in what circumstances) the deceased person died;
    d) The cause of death

2) What caused Toyota sedan Reg No 517-NBX to leave the carriageway and collide with a tree, on Queen's Road, Bowen, on 9 June 2021

3) Should security at youth residential care facilities be reviewed with respect to:

    a) Reducing the potential for access by unauthorized persons to motor vehicles, or keys to motor vehicles, then located at residential care facilities;

    b) Are the existing security measures in respect of motor vehicles at youth residential care facilities sufficient;

    c) Is it desirable that specific security measures, eg key-safes, should be installed at such facilities to reduce potential access to car keys and vehicles.

4) With respect to supervision of young persons residing in youth residential care facilities:

a) Were there, as at 9 June 2021, guidelines or instructions given by the department to providers of residential care facilities, as to (i) the number of supervisors to be in attendance at a facility at particular times; (ii) the duties of such supervisors; and (iii) the qualifications of such supervisors;

b) Have there been any changes made to such guidelines or instructions since 9 June 2001; and if so, what were the changes;

c) What were the arrangements, as at 9 June 2021, for the supervision of young persons at such facilities during the hours of night, with respect to (i) the number of supervisors on the premises during the night-time; and (ii) any requirements that a supervisor should be awake at all times during the night-time, to monitor the residents;

d) Have there been any changes made to such arrangements or requirements since 9 June 2021.

5) Whether it may be desirable, and reasonable, to review the policy underlying placement of young persons in residential care facilities, with a view to more effectively protecting young and vulnerable persons who are to be placed in a facility which also houses youths with greater experience within the Youth Justice System.

## Material relied on at Inquest

A coronial brief of evidence was tendered into evidence comprising all relevant material (Index to Brief A1 – F1 inclusive); statements and investigation reports. I have particular regard to the Queensland Police Forensic Crash Unit Report; all information provided by the Department of Children, Youth Justice and Multicultural Affairs (Child Safety) hereinafter referred to as 'the department' or DCYJMA; all information provided by Integrated Family and Youth Services (IFYS Limited); the statements of Ms Heather Jones and the statements and oral evidence of those witnesses nominated below.

## Witnesses required to give evidence

The following persons were called to give oral evidence at inquest:

i Cheryl Williams (family friend and temporary in person)

ii Constable Jason Kreymborg (Police Officer in person)

iii Constable Callam Moriarty (Police Officer in person)

iv Steven Wilson (first on scene after collision in person)

v Noel Bartlett (first on scene after collision in person)

vi Ian Patchett (Senior Firefighter on scene after collision in person)

vii Kristal Hannan (via video link)

viii Sergeant Michael Hollett (Police Crash Unit Investigator via telephone)

ix Detective Senior Constable Cindy Searle (Mackay CPIU officer via video link)

x Barbara Shaw (Department of Children and Youth via video link)

xi Dimitra Fotinos (local Child Safety Manager via video link)

xii Timothy Eyre (IFYS residential in person)

## Non Publication Order

*Pursuant to section 41 of the Coroners Act 2003, publication of the name of any child, or any information which might identify any child (other than the deceased child), or identify the location of any Youth Residential Care facility where any child may have resided from time to time is prohibited.* (It is recommended that the relevant residential care facility be reported as located at Sarina).

## Introduction and Background

1. Bailey was born on 30 November 2007 and died at Bowen on 9 June 2021 aged 13 years. Bowen is Bailey's home. (He also lived for a short period of time in Proserpine, and at a location near Sarina).

2. Bailey died from fatal injuries in a road accident which occurred at about 6:45am, on Queens Road, Bowen, Queensland. He was then the driver of a Toyota Echo motor vehicle Queensland Registration 517-MBX.

3. At the time of his death Bailey was housed in a youth residential facility (for a period of 4 weeks prior) located in Sarina, some 235 kilometres from his home.

4. The vehicle driven by him on 9 June 2021 was the personal vehicle of Ms Heather Jones. Ms Jones was a residential carer at a youth residential facility located in Sarina. Access to Ms Jones' vehicle was gained by Bailey and another male child in the hours prior by way of forcing entry into the youth residential office, removing the keys and then departing in Ms Jones's Toyota Echo vehicle without her knowledge or consent.

5. The Inquest investigated the means by which Bailey came into possession of the car keys and how to prevent access to residential workers car keys in the future.

## Police Forensic Crash Unit Investigation

6. Both Mr Wilson and Mr Bartlett, civilian witnesses and residents of Bowen, were first on scene and provided statements and gave evidence at inquest.

7. Mr Wilson's account is *I had just entered onto Queens Road and a little white or grey car overtook me. It surprised me because I hadn't seen it. I didn't see where it came from. The first I knew it was overtaking me. It pulled back onto our side of the road, but it was swerving and driving erratically. I just thought it was someone late for work or maybe drunk. It was obviously speeding, but I know we were in a 70km/h zone. I did see it when it first hit the bend, I saw brake lights so I thought they must have realised they were going too fast. I know it goes to a 50km/h zone around there because of the bends and the houses. I drive this way all the time but usually a bit later. I lost sight of the car because of the bends and when I came around the bend there was a large pile of what I thought was rubbish in the middle of the road. I wondered how the rubbish got on the road but then realised as I got closer it was a terrible car accident.*
8. Mr Bartlett's account is *I was travelling at 60km/h and it went past me as if I was standing still. It would have being doing at least 120km/h. The car then sped through the roundabout at Soldiers Road and carried on along Queens Road heading into town. I then saw the car overtake another car a white dual cab ute and I lost sight of it after this. I then came across the car on Queens Road only 2minutes later, it had been involved in a crash and was on fire. I saw*

*other people trying to pull people out of the car. As I was driving along Queens Road I remember that the road was wet, and it was still raining lightly.*

9. It was obvious that they and all who attended the scene including emergency responders, remain traumatised by the events of that day. A number of people came either upon or to the scene at the time both boys were clearly still alive. Mr Wilson frantically tried to prise open the car doors to extricate Bailey and his companion, ultimately only his companion could be saved before flames engulfed the car. Bailey remained suspended upside down, his legs crushed within the front cabin of the car due to the damage to the front end from the impact with the tree. Mr Bartlett heard Bailey's companion yelling "*no no I killed him*".

10. Mr Patchett, a senior fire officer also provided a statement and gave evidence at Inquest. He was on duty that day at the Bowen Fire Station. It took two minutes to get the fire crew into the truck from the time of notification and three minutes to deploy under lights and sirens to Queens Road. By the time he and his crew arrived he knew that there was no way of saving anyone in the vehicle. The situation was not survivable. The jaws of life were used to remove the doors and extricate Bailey. Officer Patchett concluded that nothing could have been done differently, or better to save Bailey.

## Issue 2 - What caused Toyota sedan Reg No 517-NBX to leave the carriageway and collide with a tree, on Queen's Road, Bowen, on 9 June 2021?

11. The incident was investigated by Sergeant Michael HOLLETT of the Mackay Forensic Crash Investigation Unit. The officer provided a comprehensive report on the circumstances

12. After considering all of the circumstances, Sergeant Hollett expressed the opinion that a number of factors may have contributed to this incident:

    (i) Speed – the eyewitnesses gave evidence that the Toyota was exceeding the speed limit when it overtook them. The extent of

the damage to the vehicle, and the movement (flipping over) after the impact with the tree, also indicated a substantial speed.

(ii) Driver inexperience – Bailey was 13 years old with little or no experience in driving motor vehicles. Ms Williams, who cared for Bailey for some weeks prior to his placement in the residential facility, advised the Court that Bailey was keen to learn to drive; but when the subject was raised with her, she advised him that he had to wait until he could obtain a learner's permit (i.e. at 16 years of age).

(iii) Wet road surface – it had been raining lightly in Bowen on the morning of the incident. The rain had ceased by the time of the incident, but the roadway was still wet in places. When considered against the issues of speed, and driver experience, the wet road may have contributed to the impact and rollover.

13. A further possible contributing factor, not referred to by Sergeant Hollett, but which he conceded, at Inquest, may well have contributed to the event, was the fact that the tyres of the Toyota were low in tread. (see vehicle history report from Torrisi's garage dated 13 August 2020 exhibit B14.1) The report indicated that 'front tyres on wear limits, rear tyres mismatched'. Recommend replacing front tyres. A photograph of the vehicle taken after the fire had been extinguished confirms this. Ms Heather Jones, the owner of the vehicle, was able to advise the court that on 15 January 2021, when she last had the vehicle serviced, the mechanic advised her that her tyres were down to the wear limit and would soon require replacement.

14. As she only had short distances to drive from Sarina to the residential facility, she had not had the tyres replaced by the time the car was taken by Bailey and his companion on 9 June 2021.

## Post mortem examination

15. On 15 June 2021 a post mortem examination was undertaken by a specialist forensic pathologist. Bailey exhibited a number of limb fractures, none likely to have been the cause of his death.

16. I can reasonably infer that Bailey survived the initial collision, although he was entrapped in the vehicle, and ultimately succumbed to the effects of the fire resulting from the collision.

17. The formal cause of death was concluded to be:

> 1(a) Effects of fire, due to or as a consequence of.
> 1(b) Motor vehicle collision with fire.

18. I accept and adopt the cause of death for the purpose of these findings.

## Finding as to the driver of the vehicle

19. Based upon the evidence available to the Inquest, I find that Bailey was the driver of the Toyota when it collided with the tree. Counsel Assisting asserts the evidence supporting such a finding (with which I agree) is:

(i) the evidence of Bailey's companion, who advised, following the accident, that he was a passenger in the car, and that Bailey had been driving;

(ii) the evidence of the positions, in the front seat area of the vehicle, in which the two children were found by rescuers following the collision, i.e. that Bailey was on the driver's side, while his companion was on the passenger side; and

(iii) that Paramedic (Hannan), who provided a statement and also gave evidence to the Court, attested to the fact that Bailey's companion had a "seat belt indent" on his body, extending from the left shoulder, across his body, to the area of the right hip. This is a reasonably clear, and reliable guide, to the position in the vehicle (i.e. the left-hand side) of the person at the time when the restraining force was applied by the lap/sash seat belt.

20. I add to the above that no other possibility (that the companion was driving) was advanced at Inquest or prior.

## The circumstances in which Bailey came to be placed in Departmental care

21. Until almost exactly one year prior to his death Bailey lived in Bowen with his mother Mrs Sonia Pini. Tragically Mrs Pini died from terminal cancer on 29 June 2020. Bailey and his mother were described by Bailey's oldest sister Troydon, as 'peas in a pod'. As the inquest came to learn, Bailey's life unravelled from the time his mother died, leaving him bereft and rudderless. At the time of his death Bailey was suffering deep trauma from the death of his primary care giver, the rejection of his surviving biological parent and displacement.

22. Bailey was 13 ½ years of age at the time of his death. Bailey had no court history and was the subject only of a missing persons report (self-placed with friends), and low level youth justice intervention for unnecessary Triple0 calls.

23. Bailey is one of four siblings. Despite their love and affection for him, none of his older siblings (and / or half siblings) were in a position to, or had the capacity to, raise him. Bailey for a period of time prior to his death, lived with his biological father. In the month or so prior to his death Bailey's father disowned him, evicted him, and placed him during Easter 2021 with a friend of the father's, Ms Cheryl Williams in Bowen (Ms Williams not previously well known to Bailey's siblings). Bailey's father played no part in the inquest proceedings.

24. Ms Williams gave evidence in person at inquest, and she says that for the most part Bailey settled in at home with her and her de-facto partner and all was going well enough. Ms Williams had difficulty enrolling Bailey in the local Bowen school because his father refused permission for Bailey to attend and insisted on Bailey attending Proserpine State School, which would require a 140 kilometre round trip every day on a bus. Ms Williams ability to make practical every day decisions for Bailey was impacted by difficult dealings with his father.

25. Ultimately Ms Williams was unable to continue as Bailey's carer because her de-facto partner required brain surgery and she says she was concerned that his treatment would re-traumatise Bailey (noting he witnessed his mother die from a terminal illness).

26. Ms Williams gave evidence at inquest (and in a statement provided just prior) that she had always intended for Bailey to return to her care after her partner had recovered and rehabilitated. I have difficulty accepting that proposition. For all intents and purposes from the time Bailey was placed in care there was no suggestion that Bailey's placement was intended to be temporary. I cannot see that it was made clear to the department or IFYS, certainly they continued to proceed and expend resources on the basis that Bailey would require longer term care.

27. Bailey's father relinquished Bailey into the departments' care on 12 May 2021. Again, Bailey's father proved difficult to deal with and despite him voluntarily relinquishing care, having him attend and sign relevant forms at a police station proved problematic. The department assessed Bailey as being 'unsafe' after a safety assessment on 13 May. He was the subject of an Assessment Care Agreement at the time of his death.

28. Bailey was placed at a youth residential facility located near Sarina. Counsel for the department submits that:

> *Ideally the Department would have preferred to place Bailey in a residential service closer to if not in Bowen itself. However Dimitra Fotinos, the Department's Regional Director of the six (6) Child Safety Service Centres ("CSSC") in the North Queensland Region, deposed to factors which made that impossible.*
>
> *There were no licensed residential care services in Bowen due to:*
>
> a. *"The small sporadic need for adolescents requiring this type of model of care in the area;"*
>
> b. *"Staffing and housing challenges associated for both government and nongovernment personnel posing limitations to staffing an intensive 24/7 model of care."*
>
> *c. "Any young person requiring a residential care placement in Bowen is provided with this model of care in and around Mackay (eg Sarina) and subsequent support can be provided by the Mackay CSSC."*

*d. Further conversations were held with additional family members on 14 May 2021 "who identified no further family options to care for him".*

29. I accept that within the limitations of location, staffing, and needs, Bailey's placement at the Sarina residential facility was appropriate.

30. I did consider that given the geographical distance from Bailey's home (base) in Bowen and the potential trigger of the first anniversary of his mother's death, some provision could and should have been made to proactively have him engage with family (by transporting him to Bowen for a day trip/s to visit his sister / grandmother / family) or making arrangements for his sister / grandmother to meet with him somewhere in between.

31. Bailey spent just 4 weeks (to the day) in the facility and ongoing considerations for his care arrangements and needs and support (now identified in retrospect) were all scheduled for discussion at the time of his death (in fact on the day of his death his case workers were scheduled to convene).

32. The Sarina youth residential facility housed three other adolescent boys. It seems that within the days leading up to the removal of Ms Jones vehicle from the facility there had been an increasing sense of trouble or discontent brewing amongst the cohort.

33. When I asked Mr Eyre from the IFYS during his evidence if either 'gender or age' would have enhanced the supervisory capacity on the night in question his response indicated that the boys had misbehaved in recent times for both male and female carers, and irrespective of the age of the carer. The dynamic between this particular cohort was known, and recent meetings had occurred between staff and management to discuss strategies to deal with the behaviour.

## How the carers car keys were removed

34. On the night of the 8 June, Bailey and a new friend / companion he met within the residential facility were engaged in misbehaviour, including refusing to go

to bed, taunting another resident, and being disrespectful to their resident carer, 63 year old Ms Heather Jones.

35. Ms Jones retired for the night (she says she went to her room to encourage de-escalation of their behaviour, an approved staff procedure when required). Ms Jones left her car keys in a correspondence tray in the locked office of the residential facility office. She later heard a disturbance near the office and got up to see Bailey and his friend running from the direction of the office and hiding. She found that the lock to the office had been tampered with. She checked to ensure it was still secure and returned to bed.

36. At about 4:30am, she woke, and on checking the office, found a hole in the wall, through which entry to the office appeared to have been gained. A check revealed her car keys were missing, and she found her Toyota Echo 517-MBX to be absent from its parking place.

37. Both Bailey and his friend were missing.

38. Ms Jones did not give evidence at inquest. I was satisfied that medical evidence provided by her, and on her behalf indicated that she was not medically fit to give evidence. Counsel Assisting, and Counsel for the Department and IFYS did not press for Ms Jones to appear in person. She has suffered an aneurism and stress is to be avoided with her condition. Her previous sworn statements and a record of a conversation with the forensic crash unit investigator were tendered within the coronial brief of evidence.

39. The latter conversation was later written up by the FCU investigator and provided in a report to the Coroner. The report contains information provided by Ms Jones to the police officer. IFYS objected to that precis being relied upon. In circumstances where it was not put to the investigator that the contents were incorrect, merely that his words were used to fill in obvious gaps (those words were clearly indicated as being in brackets) I am content to have regard to the document, although ultimately the contents of the conversation were uncontentious at Inquest. (For example Ms Jones refers to limitations within her training. I ultimately find that Ms Jones was appropriately skilled for the role, she received appropriate training, and that all IFYS training and security

protocols were in place, and that such protocols and procedures were known and approved by the department).

40. As the inquest progressed the issue became not one of whether relevant protocols or procedures were in place, for I accept they were, the issue was whether those protocols and procedures were robust enough to prevent Ms Jones keys being taken, in circumstances such as these. The circumstances included forced entry by juveniles into a locked office space to remove her car keys located in a correspondence tray and then drive to Bowen.

## Issue 3: Should security at the youth residential facility be reviewed.

41. I have had regard to the submissions of Counsel Assisting; co-Counsel Assisting the inquest; and Counsel for the department and IFYS. I refer to those submissions when addressing these (and all) inquest issues.

42. Simply put, access to Ms Jones car keys was the mechanism by which her vehicle could be taken by Bailey and his friend. Had the keys not been available to them, Bailey's death would not have occurred as it did.

43. Ms Jones' keys had been placed by her in her correspondence tray within the locked office at the residential facility.

44. The security of the office area, and of car keys, had previously been tested by the young residents of the facility. Information pertaining to these past events was provided to the inquest by Detective Senior Constable Searle, of Sarina CIB.

45. It would appear that the security of the office had been previously breached, or an attempt had been made to do so on occasions as follows:

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|---|---|
| 12/04/17 | Forced entry to the office through both internal and external doors. |
| 07/04/20 | Entry gained to the office by a window, internal room broken into, vehicle keys taken for carer's car, residents drove to Mackay, committing property offences (mention |

| | |
|---|---|
| | is made of a locked box, but it is not clear, from the brief report that it was forced open). |
| 09/04/20 | Apparent entry to the office by smashing a window. |
| 30/04/20 | Office found by carer to have been into, with screen and wooden door forced open, and paper on the pin board in the office set on fire. |
| 28/06/20 | Juvenile male broke into carer's office to retrieve his confiscated laptop. |
| 25/10/20 | Residents found with "drills and tools" for the purpose of breaking into the office. |
| 27/10/20 | Residents youths broke into the office, and stole keys to a vehicle, but they were stopped by a carer and prevented from driving it away. |
| 02/11/20 | Entry forced to the locked office, and property damaged inside. |
| 28/02/21 | Locked office door opened by causing the locks to come out of the door. |
| 09/06/21 | Bailey and his companion broke into the office by kicking holes in the walls adjacent to the doors, took a carer's car keys, and drove her car to Bowen. |

46. I accept that further attempts to forcibly enter the office are a foreseeable possibility. Car keys have been targeted on some occasions, while in other cases damage was caused, or a fire was started in the office.

47. The log entries (information requested by me of relevant incidents and compiled by Det Snr Constable Searle) indicated that from 8 to 9 June 2021 at some time prior to breaking into the office, Bailey and his companion entered the ceiling-space. Their purpose appears to have been to harass another resident child.

48. I accept that further attempts would or could be made by the youth residents to access the office through a breach in the office ceiling.

49. The office itself is protected by two "Crim-Safe" doors, with sturdy locks. The walls, however, appear, in the photographs, to have been normal two-skinned walls, with sheeting perhaps gyprock or fibro, or perhaps Masonite.

50. It is likely that the residential provider IFYS has already, over the period of its operation, necessarily outlaid a very substantial amount of money to replace doors, locks, windows, and wall panelling, certainly to make necessary modifications

51. IFYS is a registered charity. It has limited funding and ever-increasing responsibilities. It is not a realistic option to convert the offices in residential facilities into impregnable fortresses. The point was made in Mr Pignata's statement (Managing Director IFYS Limited) and echoed in Mr Eyre's (the Executive Manager IFYS Limited) oral evidence, that many of the facilities are rented, and modification or re-conversion of alterations which may be made must similarly be funded at the time of expiration of the relevant lease.

52. There is a limitation to modifying or converting the physical environment of a facility and there is an imperative to provide the youths a home like environment and ensuring the safety of all requires a balance. The youth residential facility is not a detention centre. The IFYS residential facility is set up (according to the IFYS website) specifically to be 'accepting, sharing and non judgemental'.

53. Counsel Assisting submits the precise harm intended to be remedied, is access to the keys of vehicles parked at the residential facility, whether they be departmental or IFYS vehicles, or the private vehicles of carers performing their shifts. I agree.

54. The use of motor vehicles by youthful and inexperienced drivers gives rise to a real apprehension that serious injury or death might ensue in the event of a road accident, which could affect both the young people using the vehicle, and the general public who use the road transport system.

55. The extent of the public interest in the prevention of events of this nature has been the subject of judicial comment at a high level.

56. IFYS presently has a Motor Vehicle policy which is in the following terms:

***Storage of IFYS Vehicles***

*Vehicles should be stored in the garage onsite in all programs where a garage is available. Otherwise ROs, wherever possible, are to store the IFYS vehicles after hours within the confines of their residential property and the vehicle must be securely locked at all times.*

*For vehicles kept at Child Protection funded residential houses, the motor vehicle keys are to be kept in a locked box, which is to be stored inside a locked filing cabinet or storage unit, at all times (when not in immediate use).*

*The locked filing cabinet or storage unit must be kept in the employee office or bedroom.*

57. The construction of this policy, applies to IFYS vehicles, and not to vehicles belonging to carers. This interpretation was supported by Mr Timothy Eyre of IFYS, who gave oral evidence to the Inquest.

58. Ms Shaw, Senior Executive Director of Investment and Commissioning, of Children's Services, with the Department of Children's, Youth Justice, and Multicultural Affairs ('the Department'), in her evidence at the Inquest, expressed her perception that the above policy applied to both IFYS and carers' vehicles. That position was maintained in written submissions prepared by Counsel for the Department.

59. This is an issue which should be clarified. Having regard to the purpose of any proposed comment, and to the situation where both IFYS and carers' vehicles would seem to be at equal degrees of risk from the actions of residents, the same rule should extend to both categories (which the Department says that it does).

60. I err toward a narrow interpretation that the current policy infers such application to official IFYS vehicles only. (I also take from Ms Shaw's evidence that she believes the policy should apply to all vehicles, and if that is so, I agree with that view).

61. Ms Shaw's evidence at the inquest was that, to that time, some 516 residentials had been audited by reference to car key security, and it was hoped that the audit could be completed by 30 June 2022. If, however, the policy against which

the audit was being conducted was that which is reproduced above, that policy was not intended to apply to carers' vehicles.

62. As at the date of Mr Pignata's statement (on 6 May 2022), IFYS was in the process of implementing a recommendation from its own IFYS Death Review Committee, that

> *"…employees ensure that all personal belongings are locked in a filing cabinet or safe inside the Residential Care Service's offices, staff quarters, and/or storage areas and that internal documentation and training are amended as necessary, and communicated, to reflect this."*

63. Mr Eyre was unable to advise if safes (wall / floor or otherwise) were in use in other residentials.

64. I accept Counsel Assisting's submission that with respect to filing cabinets, they are generally of light metal, and would be unable to resist determined efforts to open them, with the use of such implements of knives, sturdy screwdrivers, or lever bars.

65. Ms Heather Jones, in her statement, indicates that she has previously had her car keys stolen from her personal bag. She thereafter opted (and certainly on this occasion) to place her keys separately from her other belongings, in a correspondence tray within the locked office.

66. Precisely what constitutes a "locked box" within the above policy was not articulated in evidence. If it refers to a box in the nature of a petty cash, or postage tin, or box, it would seem likely that it could be readily accessed by determined residents with some basic tools.

67. Ms Shaw has indicated in her statement that "one of the common mandatory requirements of Indicator 4.2 is documented and implemented processes for vehicle safety, including secure storage of car keys.

68. I accept that notwithstanding the existence of various policies (which I also accept were in effect), none operated to prevent the events of 9 June 2021.

69. It is submitted by Counsel Assisting that relevant policies should be reviewed to require:

- The installation at vulnerable residential facilities of a small safe, in the nature of a "key safe", or similar, which is –
  - Affixed to the floor or wall in a secure area;
  - Operable by way of key and combination;
  - Possessing a strength and durability capable of resisting attempts to take car keys by reasonably foreseeable methods used by residents.

70. In response Counsel on behalf of the IFYS submits that:

> *There was no specific evidence placed before the Coroner as to the cost of installing something like a safe within the secure office.*
>
> *IFYS' position is that if DCYJMA is prepared to provide funding not only for the installation of such devices but also for their removal at the end of tenancy then IFYS would comply with such a recommendation.*

71. Counsel Assisting does not advance large commercial-type safes for key safety and instead recommends a safe readily available from hardware and or office suppliers such that they can be fitted by the drilling of holes either in a timber or concrete floor, or in a wall so as to affix to the internal studs.

72. Practical and experienced advice as to the appropriate safe may be provided by the local Queensland Police Service's Crime Prevention Units. Professional locksmiths will also possess the knowledge to assist the department / IFYS with an appropriate solution.

73. The department in their written submissions helpfully suggest each office being fitted with an alarm in addition to a locked safe. I accept that as a sensible additional layer of key protection.

74. I am referred by Mr Collins of Counsel to communication from IFYS Executive Manager (Child Protection) to staff by email on 1/10/19 and 7/4/20 impressing

upon all residential staff to remain vigilant by minimising access to keys and to enforce the policy that no residents were to be in the office at any time.

75. The evidence before the court is that on 3 June 2021, Authorised Officers from the department conducted an unannounced inspection of residential facility located at Sarina (approximately one week prior to the incident). The IFYS Case Manager confirmed the IFYS work vehicle keys are kept in a lockable tin inside a lockable filing cabinet, located in the Coordinator's Office that is kept locked. The IFYS Case Manager advised that staff store their belongings in the top drawer of the filing cabinet.

76. That audit revealed that all security measures which had been prescribed by DCYJMA had been complied with.

77. I accept Counsel for IFYS submissions that the facts and circumstances of this case indicates that IFYS has been compliant with all of the protocols, standards and system requirements imposed by DCYJMA. I further accept that there was no failure on the part of IFYS in relation to the security of keys on the evening of 08 June 2021. The accepted policy at the time was adhered to by Ms Jones in her capacity as a residential carer.

78. In his oral evidence, IFYS Manager Mr Eyre conceded that with the benefit of hindsight a more secure system of key security may be appropriate. Such concession is appropriate and I ultimately determine that the use of the key-safes should be mandatory a the Sarina facility.

> *(As an aside, and not raised at Inquest is the issue of insurance. As I understand it insurers allocate a 'cash rating' to safes, commensurate with the quality of the safe. A professionally installed safe may have a higher cash rating than less secure apparatus. That information is useful not only from an insured / insurance perspective, but for residential care facilities to gain an understanding of what type of safe attracts what type of rating as a guide to how adequate the safe is considered to be).*

## Issue 4: Staffing levels at residential facilities, during the sleep-over shifts.

79. In this case, Ms Heather Jones was the sole carer on duty, from late on the night of 8 June through until the morning of 9 June 2021, when "day" staff would return.

80. Ms Jones' account of the events which transpired is contained in her statement, and her information underpins the IFYS record of the incident.

81. When the time arrived to switch off the wi-fi internet at 10:30pm, Ms Jones thought it appropriate to leave the "TV hotspot" switched on, so the residents would continue to watch Netflix. She believed this was an appropriate (de-escalation) measure, in order to avoid any unnecessary confrontation with the residents – in particular, with Bailey and his companion.

82. During the evening, Bailey and two other residents had been "baiting" a fourth resident. Ms Jones advised this fourth resident to remain in his room, and not to respond to the others.

83. Ms Jones retired to her own room. She could hear Bailey and a companion "trashing" the house, setting off the fire alarms, and shouting at her for turning off the wi-fi. She remained in her room, and continued to audibly monitor the boys, not wishing to aggravate the situation.

84. At one point she could hear Bailey and his companion moving about in the ceiling-space, trying to communicate with the fourth boy who remained in his room.

85. On a number of occasions, she did come out of her room to deal with the two boys, as the others were trying to sleep. She received verbal abuse from the boys in return.

86. She was still awake at 1:30am, when she heard the sound of metal on metal from somewhere inside the house. She noted in her statement that she had heard this sound before, and knew what it was – it was the sound of someone trying to break in to the locked office.

87. She immediately left her room, and saw Bailey and his companion run from the office door into the toilet area. She went to the office door, and saw that the door had been tampered with, by someone trying to prise off the metal plate adjacent to the door knob.

88. She checked the office, and confirmed it was still secure, and then locked the metal screen door as well.

89. She called out to the boys, telling them to “cut it out”, and to go to bed. She received more abuse in response.

90. She returned to her room, and estimates that she fell asleep at perhaps 3:00am.

91. She rose at 4:30am, and made herself a coffee. She then undertook a perimeter inspection of the property, and observed that a large hole had been made in the wall of the office, adjacent to the entry doors.

92. She saw that her car, a Toyota Echo, previously parked there was missing. She then notified the authorities.

93. Later inspection of the property found that the covering door to the electrical switchbox on the outside wall of the house, had been jemmied open, and bent out of shape.

94. I accept the submissions of Counsel Assisting that it is difficult when reading her account, not to have a great deal of empathy for Ms Jones. Alone, she was required to exercise what control she could over two young teenagers who were, on all accounts, quite out of control.

95. I agree that her own conduct, in trying to deal with the incident, and not contribute to its aggravation was admirable.

96. The overwhelming sense is that a mature lady of 63 years (albeit with appropriate training, and experience) was expected to contain the situation which presented itself to her. (Having said that, as I referred to earlier it was

Mr Eyre's evidence that the boys living in this residential facility had misbehaved for workers regardless of age and gender.)

**Resourcing and Funding arrangements**

97. Operation of residential facilities are conducted through standing agreements with the department. There are relevant award provisions in respect of carer's sleepover shifts which also have to be followed.

98. Mr Anthony Pignata, Managing Director IFYS, advised the court in his written statement that, with respect to the sleepover shift, the agreement between IFYS and the department allowed for only "a single 8-hour sleepover shift (1 worker only), 7 days per week".

99. Mr Eyre explained in oral evidence that the night shift at the Sarina facility consisted of one worker, sleeping for 8 hours. The expectation was that the carer will sleep during that shift, as is required by the Social Community Disability Services Award. Carers are not paid a full salary for such a shift, but rather an allowance (this allowance was suggested to be in the order of $50). The facility is currently not funded to roster two staff on a night shift and, in any case, there were sometimes difficulties retaining sufficient qualified staff to fill the existing rosters.

100. Ms Shaw confirmed that funding was allocated to facilities based upon the needs of individual children, and that additional funding could be allocated if additional supports were needed. Her evidence was to the effect that the 8-hour sleepover shift was the required standard for children to be housed in that particular service based upon their needs, and the funding had been capped accordingly.

101. If a worker was to remain awake during a night shift, then the funding would need to change. It would be the responsibility of the organisation to manage their budget and renegotiate funding as part of contract management discussions if it became clear that needs of the children placed with them had changed or become more "extreme".

102. The QPS calls for service history provided for this particular residential facility, as collated by Detective Searle, raises questions as to whether the sleepover staffing arrangement, as it presently exists, is effective to protect both the residents and the carers.

103. I accept the submissions of Counsel Assisting that an appropriate level of care should contain provision for the immediate attendance, at the facility, if needed, of a second care worker (cognisant, of course, of the particular idiosyncrasies of this residential facility with respect to remote location and acknowledged difficulties recruiting qualified staff in the area).

104. The agreements should contain an emergency clause which would permit staffing of this second carer in special circumstances. What those circumstances should be – what type of situation should trigger this further funding – is a matter for careful consideration by the department in conjunction with the providers. There are protocols in existence which govern the calling of the QPS to incidents in residentials. These are put in place for a specific purpose, and we do not suggest that any change is appropriate.

105. In this particular case, Ms Jones, after remaining awake and monitoring the situation for a number of hours, fell asleep. The residential was apparently quiet, and it followed that she was fully entitled to believe the boys had settled down.

106. The available evidence does not inform the court whether the boys had in fact settled down for a few hours, or whether they were simply playing a waiting game, until they thought Ms Jones would probably have gone to sleep.

107. In this case, therefore, it was considered that because Ms Jones managed the situation on her own to that point; a second carer was not required to restore order.

108. However, the serious matters of the theft and use of motor vehicles, and fire-setting within the facility, do raise very important questions relating to the ability to call in additional staff at short notice when needed to prevent injury to a child or carer. If the proposed “key-safe” initiative were to be introduced, there would

be no necessity for a second carer to attend a facility in order to maintain "eyes-on" supervision, and thus additional deterrence.

109. It also seems to me that a further additional possibility presented itself at inquest in relation to having an additional staff member on site for the whole of the shift. It would seem self explanatory that having two persons present on site for night shift would provide an additional safety measure for both the residents and the staff who care for them. In this case the IFYS management had become aware of the increasing behavioural issues amongst the cohort of 4 residents, such that neither gender nor age had influence over their (escalating) antisocial behaviours.

110. It may be obvious in hindsight to have rostered on an additional staff member on duty to accompany Ms Jones OR funding of 'awake staff' (noting that Ms Jones was entitled to sleep on her shift) as a preventative measure.

111. Counsel for IFYS submit on this point:

> *The evidence was that during the sleep over shift the workers are not paid, but rather paid a small allowance.*
>
> *It follows that should there be a recommendation that there should be an awake shift the present funding arrangements do not provide funding for an awake shift at night.*
>
> *Similarly, it follows that if any such recommendation would be to be made it would be necessary to make a recommendation for increased funding.*

112. Rather than extract or cherry pick each point about key locks; alarm; awake or asleep shifts, it may be that the time has come to revisit the funding arrangements between this particular facility and the department. This particular cohort of boys escalated their behaviours and they had become difficult to manage. It should not be the case that the system is stretched to the point that one 63 year old woman becomes the last bastion between the

residents and car keys and in this case which provided the means for the collision. Saying that I am cognisant that the survivor of the collision was seen as somewhat of a ringleader and had influence over Bailey. His earlier removal from the facility may have been another solution.

113. My observations are of course made with the benefit of hindsight and the sense of trouble brewing was perhaps only obvious when all of the evidence coalesced.

114. My recommendations in relation to key safes; revisiting the work mix and reviewing funding arrangements are made in respect of this Sarina residential facility only, HOWEVER given the relevance of these issues to all residential facilities there would be wisdom in establishing whether any of the recommendations would have application state wide. I am satisfied that audits and reviews to date undertaken by IFYS and the department are a direct result of the circumstances of Bailey's death and that the inquest comes at the tail end of what is already known to both relevant entities.

## Issue 5: How Bailey came to be placed at this particular residential facility (matching the child to the facility).

115. This issue was explored against a background where Bailey's companion on the day of his death had experienced a greater level of exposure to the youth criminal justice system than him, and had been involved in previous behavioural incidents at the residential facility. Their carer, Ms Jones, had characterised this other boy as the "instigator" of many such incidents, whilst Bailey and others joined in.

116. The document titled 'Youth Justice History for co-tenants', tendered by the department and marked as Exhibit 'MFI-1', demonstrated that Bailey had been placed with children who, I accept, on the whole, had very limited exposure to the criminal justice system. The risks and needs of the household, relative to other children under the care of the Department, were considered comparatively low.

117. Nevertheless, Counsel Assisting submits, and I accept, the following as worthy observations about Bailey's placement, and the placement of children by the department generally.

a. Departmental policy dictates that placement decisions are fundamentally based upon the best interests and individual needs of the child. Whilst the preference is generally to place a child with kin, this can also include a decision to place a child within a residential facility. Care is then taken by the department and the placement provider to appropriately match a child with a facility based upon risk factors such as behavioural issues, substance abuse, and the existing dynamics of young people within the facility.

b. It is accepted that, in Bailey's case, there were extensive enquiries made by the department in the hopes of securing stable accommodation for him with family and/or their connections. The "tenacious efforts" of the department to identify such supports for Bailey were commended in the internal review process. Unfortunately, no such person was willing or able to house Bailey in the long-term, hence the arrangement for an "assessment care agreement" or "voluntary care agreement" with the department.

c. It was noted by the department that Bailey's father and other family members seemed to hold an "overly simplistic" view of Bailey entering care, believing it would "fix" him somehow. His sister Troydon explained to the inquest that the family genuinely saw departmental care as Bailey's "safest option".

d. Beyond the family unit, there were no foster carers or licensed residential care services in Bowen, nor was there sufficient staffing or housing in the area for the Department to make alternative arrangements locally. Bailey was subsequently placed at Sarina on 13 May 2021, taking into account his family's wish that he be placed in a smaller town over a larger city. Although his placement was over 230 kilometres away from his hometown of Bowen, this appears to have been the closest available placement in a country town.

e. Bailey reportedly settled in well at the Sarina facility and enjoyed a good rapport with the other children, although some concerns were recorded that he had been "mimicking" the poor behaviours of others there. His behaviour was, importantly, considered in the context of his grief following his mother's passing.

f. Therapeutic interventions and supports were being considered by the department at this early stage of his placement, there had been delays in obtaining medical information due to difficulty engaging his father. On the day of Bailey's passing, there had been a meeting scheduled about a permanent order to grant long-term guardianship to the department. Ms Fotinos, Regional Director for North Queensland, explained to the inquest that it had been anticipated this would give the department the necessary authority to meet Bailey's ongoing therapeutic needs such as grief counselling.

g. During Bailey's placement away from Bowen, the department encouraged and facilitated his contact with family by providing unrestricted access to a telephone and obtaining contact details for family members. This was good practice by the department.

h. Nevertheless, as the month of June 2021 progressed (noting that the first anniversary of his mother's passing was on 29 June), Bailey was increasingly homesick. Over consecutive days from 5 to 8 June 2021, he is noted as speaking longingly of Bowen and his friends and family there and expressing a desire to visit during the school holidays. With the benefit of hindsight, perhaps this should have raised a red flag.

i. Ms Fotinos, in her evidence, explained that the department were cognisant of the impending anniversary of Bailey's mother's death, and it had been their intention to arrange an opportunity for Bailey to visit family around this time. Ms Fotinos accepted that, regrettably, she simply did not know whether Bailey himself was kept abreast of these plans or not. Whether this would have changed the boys' ill-fated plan to travel to Bowen that day, we will simply never know. That said, it was a largely opportunistic pursuit by them.

j. I accept that the residential facility was the best possible placement for Bailey as at May 2021, with the limited resources and options available to the fepartment at the time. There were clearly strategies being employed to mitigate the tyranny of distance between this young person and his family, through ongoing telephone contact and a contemplated visit to Bowen, though it remains unclear whether Bailey was kept informed of these matters.

## Possible comments pursuant to section 46:

118. Section 46 of the *Coroners Act 2003* empowers a Coroner to make "comments", which might include observations, or recommendations, with a view inter alia to the prevention of deaths in similar circumstances in the future. This power is a discretionary one; its exercise depends upon the facts of a particular case, and whether, taking into account the circumstances which gave rise to the death under investigation, a Coroner can discern that a possible change in practice, procedure, or policy - in the context of a particular undertaking - may prevent or reduce the probability of future deaths in circumstances similar to the case before the court.

119. The use of the term "similar" is a clear indication that the circumstances of foreseeable future events in respect of which prevention is recommended need not be identical. Where the potential to preserve life is involved, a benign interpretation should be afforded to the terms of section 46.

120. It is possible that cases may arise in which the making of preventive recommendations is so strongly indicated that a failure to do so could appear to be unreasonable. This case, is such a case.

121. Issues 3, 4 and 5 were directed to possible comments concerning procedures and policies in place at the time of Bailey's death and were designed to highlight possible areas of inquiry for the benefit of interested persons whose interests might be affected by any changes to existing systems.

122. Such issues, of course, can only ever be provisional. They are drafted before any evidence has been taken; and it is always possible that, as the inquest

progresses, emphases may shift as evidence is led. That is the nature of an inquest.

123. Issues 3, 4 and 5 raised consideration of three areas of procedure or policy, which can be briefly described as:

(3) the security of car keys at residential facilities;
(4) the adequacy of existing staff numbers on the sleep-over shift;
(5) the placement of young people in residential facilities, which may already house other young people who may have greater experience within the youth criminal justice system.

## Referral under section 48

124. The evidence in this inquest does not disclose the possible commission of an offence, or a breach of professional duty.

## Recommendations, Conclusions and findings of Coroner

125. I find that Bailey Ezekial Pini aged 13 years, a resident of a youth residential facility at Sarina, died when the motor vehicle he was then driving lost control, collided with a tree on Queens Road at Bowen causing the vehicle to overturn. He was entrapped in the vehicle and died when the vehicle became engulfed in flames. Bailey died at the scene from the effects of the fire.

126. The vehicle belonged to Heather Jones a carer employed at a Sarina youth residential facility. Bailey acquired the car keys for the vehicle when with a companion (one of 4 youths who lived at the facility) he forcibly entered the locked office space and removed the keys from a correspondence tray.

127. He and his companion from the facility drove from Sarina to Bowen (approximately 235 kilometres). They were not licensed to drive a vehicle. Bailey's companion survived the collision as first on scene civilian witnesses managed to pull him from the vehicle. The accident occurred in the vicinity of a family friend who had been caring for him until his residential placement. The events occurred in the same month coinciding with the death of his dearly loved mother one year prior.

128. The inquest examined the circumstances in which Bailey and his companion gained entry to the office and acquired the car keys and Ms Jones vehicle. That inquiry necessarily explored relevant policy and procedures relating to standing agreements between the Department of Children and Youth and the relevant residential care provider IFYS and to IFYS policies specifically and whether they had been breached. I do not so find.

129. The policies in place at the time at all levels were adhered to by IFYS and their employees. The policy did not contemplate youth residents climbing in the roof cavity; forcing entry into the locked office space; and removing keys with the intention of acquiring Ms Jones vehicle without her knowledge or consent.

130. With the benefit of hindsight and with a thorough examination of relevant policies and procedures I am satisfied that as at the time of these events adequate practices procedures and policies were in place at both the departmental level and by the care provider IFYS and they were adhered to. What is borne out by this inquest is that more robust measures / another layer of protection are required to prevent similar incidents from occurring in the future.

131. I recommend that the Sarina Youth residential facility be fitted with an appropriate dedicated key safe. Appropriate is a measure to be determined by the department but would include a safe capable of being affixed to floor or wall and with a combination lock.

132. The Sarina facility is located in a remote location and not easily or quickly accessed out of business hours, nor is there currently provision for an 'awake' funding model or a second overnight rostered on staff member, or emergency backup. A compliant key safe is the most proactive way to prevent key theft and could not be penetrated if a break in occurred. The opportunity and temptation is then completely removed.

133. Whilst I accept that some modification will be needed it will be no greater in my view than modifications already required to residential facilities (there was evidence of reinforced office doors and 'crim safe' type products installed – I

am not sure if they were already in place when IFYS took on the premises or if the modifications were later approved by the landlord).

134. I endorse but do not formally recommend that the Department fund IFYS (or any care provider) for an 'awake rostered staff member' on an as needs basis. The standing agreements are finely tuned, and I have insufficient evidence before me to consider what is viable or feasible. Saying that there are circumstances, including this, where the dynamic between the youth cohort was known due to the antisocial behaviours leading up to these events, where it would be appropriate to provide funding sufficient to cater for appropriate measures on the night shift. I accept IFYS would welcome and support this measure so long as they received ex-gratia funding.

135. Counsel Assisting the inquest submits that it may be desirable that providers receive financial assistance to implement the "key-safe" initiative. Even though the costs of the proposed installation of secure storage of keys may be modest, it is clear that some providers operate multiple facilities, and are constrained by financial circumstances necessarily upon these multiple operations.

136. I accept those submissions although exercise restraint when considering a formal recommendation that binds the department and all youth residential facilities across the State, noting as I have that I am not fully appraised of the state wide funding agreements and consider such any broader recommendation (to adjust or re-allocate funding) is beyond the remit of this inquest.

137. I have some confidence that both the department and IFYS are fully cognisant of the so called 'blind spots' and areas for improvement and have already and will continue to work towards improvements and solutions.

138. I agree with Counsel Assisting that any measure which reduces car theft by young offenders should be accorded a high priority.

## Acknowledgements

139. I firstly acknowledge the first on scene civilians, and the emergency responders who tried so bravely to extricate both boys from the vehicle before it caught fire. It is absolutely clear that the events of the day were traumatic, and beyond

anyone's expected human experience. They continue to be deeply affected in both head and heart because they could not save Bailey.

140. I take this opportunity to thank Counsel Assisting the inquest Mr J Aberdeen and co-Counsel Ms M Mahlouzarides for all assistance they have provided to me and to this inquest. I also extend my gratitude to Ms Carmody and her instructor, and Mr Collins and his instructor, for their assistance to this inquest, and to all for their professionalism and courtesy displayed at all times, particularly to Bailey's family.

## Condolences

141. In matters such as these words are simply not enough. The family and the community are all the poorer for Bailey's loss. Bailey's siblings, grandmother and Aunts watched on with quiet dignity through the two days of inquest. Bailey's sister Troydon honoured his memory by leading a family tribute in words and pictures at the conclusion of inquest. Bailey was loved, deeply loved and his death in these devastating circumstances is shocking and tragic. His overwhelming gravitational pull home to Bowen led him to a series of choices that his family have firmly expressed in word and action hope will act as a deterrence to other youth.

May he rest in peace.

## Findings required by s. 45

**Identity of the deceased** – Bailey Ezekiel Pini

**How he died** – I find that Bailey Ezekial Pini aged 13 years, a resident of a youth residential facility at Sarina, died when the motor vehicle he was then driving lost control, collided with a tree on Queens Road at Bowen causing the vehicle to overturn. He was entrapped in the vehicle and died when the vehicle became engulfed in flames. Bailey died at the scene from the effects of the fire.

The vehicle belonged to Heather Jones, a carer employed at a Sarina youth residential facility. Bailey acquired the car keys for the vehicle when

with a companion (one of 4 youths who lived at the facility) he forcibly entered the locked office space and removed the keys from a correspondence tray.

He and his companion from the facility drove from Sarina to Bowen (approximately 235 kilometres). They were not licensed to drive a vehicle. Bailey's companion survived the collision as first on scene civilian witnesses managed to pull him from the vehicle.

**Place of death** – Queens Road BOWEN QLD 4805 AUSTRALIA

**Date of death**– 09/06/2021

**Cause of death** – 1(a) Effects of fire, *due to, or as a consequence of*,
1(b) Motor vehicle collision with fire.

I close the inquest.

Nerida Wilson
Coroner
CAIRNS