QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Lucas Tran**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2015/4568
DELIVERED ON:	17 April 2019
DELIVERED AT:	Brisbane
HEARING DATE(s):	9 November 2018, 4 - 6 February 2019
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, Sudden Infant Death Syndrome (SIDS), risk factors for SIDS, Family Day Care home, sleep and supervision policies, amendments to National Quality Framework and National Law

REPRESENTATION:

Counsel Assisting:	Ms M Jarvis
Counsel for Family:	Mr M Holmes i/b Murphy Schmidt
Counsel for Department of Education:	Miss E Cooper i/b Crown Law

Counsel for Ms X and Mr Y	Ms S Robb i/b Vardanega Roberts Solicitors, Sydney
Counsel for Moorooka Family Day Care:	Mr T Lethbridge, Croftbridge Lawyers

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Introduction

1. Lucas Tran was five months old when he died suddenly and unexpectedly on 18 November 2015. He was the first baby of Tuan Anh Tran and Tuyet Binh Huynh.

2. At the time of his death, Lucas was being cared for by Family Day Care Educator, Ms X and her husband and Family Day Care Educator Assistant, Mr Y at their home in Moorooka. He had been dropped off at the home that morning around 8.00am.

3. At 10.38am that morning, the Queensland Ambulance Service (QAS) received an emergency call requesting ambulance attendance at the home. The QAS operator was advised by the male caller that the home was a family day care and that '*one of the babies sleeping here, when we saw him, he was facing down*'. The operator then asked the caller about the condition of the baby. The male caller advised he was not moving, not awake and not breathing. The operator began giving instructions for how to perform CPR on the baby and several ambulance crews were dispatched to the address via a 'Code 1A lights and sirens' response, with the first crew arriving seven minutes after the call was made.

4. Upon entering the lounge area of the residence, paramedics found Lucas lying on the floor unconscious, not breathing and pulseless. An adult female was kneeling beside him. Paramedics immediately began treating Lucas however despite advanced resuscitation attempts including artificial ventilation and adrenaline injections, Lucas was unable to be resuscitated and was declared life extinct at 11.24am.

5. At autopsy, there were no specific findings to explain Lucas' cause of death. The forensic pathologist, who also attended the scene and was able to make observations of Lucas' care and sleeping environment inside the home, concluded his death was consistent with a diagnosis of Sudden Infant Death Syndrome (SIDS).

6. The forensic pathologist noted variations in the descriptions of the circumstances in which Lucas was found. She advised that, if Lucas was asleep, his death would fall within 'Category II SIDS' which involves the possibility of a degree of mechanical asphyxia due to an unsafe sleep environment. However, if Lucas was awake at the time of his death than his death may fall into the category of an 'Unclassified Sudden Infant Death' (USID). The forensic pathologist stated she would be willing to review her opinion as to cause of death if more information came to light.

7. Queensland Police Service (QPS) officers also attended the home that morning and began taking versions from the two adults present, Ms X and Mr Y. During these initial investigations, police and ambulance officers discovered several children in different rooms of the house including one child sitting underneath a desk in a room that appeared to be an office, and another child crouched down in the corner of a wardrobe behind a box. The seven-year-old son of Ms X and Mr Y,

Master Z, was found in their bedroom. Altogether there were seven children present in the home that day, six of whom were under school age. Ms X was only permitted to care for four children under school age and initially she and Mr Y denied to police there was anyone else present in the home other than Lucas and the three other children whose names were recorded as being signed in for care that day.

8. Also during their time at the residence that morning, police officers observed the inside of the home to be extremely hot with no windows open or fans on. One of the constables described the house as very disorganised and cluttered, and recalled thinking it was not a safe environment for children. Scenes of Crime officers attended and took detailed photos of the scene.

9. Lucas' death was subsequently investigated by detectives from the Morningside Child Protection Investigation Unit, who recorded conversations with Ms X, Mr Y and their son Master Z.

10. Ms X described placing Lucas down for a sleep between 8.50am and 9.10am that morning, in a portable cot in a rear bedroom. She checked on him 20 minutes later and found him to be sleeping. She checked on him again in another 20 minutes and found him face down and lying in milk or vomit. Ms X says she immediately commenced CPR, then called for her husband to come help her.

11. Mr Y described that around 10.00am or 10.15am or 10.30am he heard his wife call out for help. He was downstairs at the time with his son, and Ms X was upstairs with the other children. He went upstairs and Lucas was on the floor and his wife was trying to save him. He took over CPR so that his wife could call Triple Zero. She then handed him the phone to speak to the operator. Mr Y stated when he was doing CPR 'a lot of milk came out'. Mr Y said neither he nor Ms X fed Lucas anything that morning.

12. Master Z (the son of Mr Y and Ms X) was spoken to on two different occasions by police, once at the home and again later that evening at the Morningside Police Station. The second conversation was conducted pursuant to section 93A of the *Evidence Act 1977*. During his first conversation with police, Master Z described that he was downstairs cleaning with his dad, and his mum was also downstairs feeding Lucas milk. He said '*my mum was feeding Lucas and then the baby vomited, Lucas vomited and he choked and then he died and we just called the police…my mum shouted and called my dad and my dad dropped whatever he was carrying and then he ran to my mum…and then my mum and dad took (the baby) upstairs…*'.

13. During the 93A interview later that evening, Master Z told police he had been confused earlier that day when he told police his mum had been downstairs. He said he was downstairs with his dad, and his mum was upstairs. He heard his mum call out to his dad and his dad rushed upstairs. Master Z was asked if he had seen Lucas eating anything that day. He stated he did see his mum feeding Lucas at

some time during that day, but later during the interview Master Z stated he did not see his mum feeding Lucas because he was downstairs with his dad.

14. When asked where Lucas normally slept, Master Z stated Lucas would sleep in his room in a thing that can be folded and looks like a chair. He said it was a baby chair, a rocking chair. The scenes of crime photos include a photo of a baby chair fitting the description given by Master Z, placed on its side in the recess of a shower.

15. As a result of Lucas' death, the Department of Education (the Department), which regulates family day care services in Queensland, commenced an investigation into the Moorooka Family Day Care (MFDC) Scheme with whom Ms X was registered, and also visited Ms X's home and interviewed Ms X and Mr Y. That visit was conducted on 19 November 2015, the day after Lucas' death. During that visit, departmental officers formed a view regarding numerous alleged breaches of the *Education and Care Services National Law (Queensland) Act 2011* (the National Law) as it applies to family day care, including in relation to the physical environment inside the home.

16. Records obtained suggested Ms X's home had been visited on several occasions in 2015 by a Family Day Care Coordinator employed by MFDC. The reports of those visits did not identify any concerns with the physical environment inside the home.

17. After visiting Ms X's home, the Department also carried out inspections of ten other educators approved by MFDC and identified multiple alleged breaches. In accordance with section 73 of the National Law, the Department determined to immediately suspend MFDC's approval effective 20 November 2015 as it was satisfied the health, safety and wellbeing of children in care at the service were at immediate risk.

18. On 17 May 2016, the Department sent MFDC a show cause notice to amend their service approval.

19. On 15 June 2016, the Department sent MFDC the decision in relation to the proposed amendments to the service approval. The decision was made to place conditions on MFDC's service approval. The amendments took effect on 20 June 2016 and MFDC have been permitted to continue operating since that time in accordance with those conditions.

20. Apart from the Department's actions to suspend and then impose conditions on MFDC, no other action has been taken against Ms X or Mr Y by any law enforcement or regulatory authorities.

Issues for Inquest

21. Upon review of the evidence gathered by QPS and the Department, and having regard to the findings at autopsy, including the comments of the forensic pathologist noting variations in the descriptions of the circumstances in which Lucas was found, a determination was made to hold an inquest into Lucas' death. The issues identified for the inquest were:

    i. The findings required by s. 45(2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death.

    ii. The circumstances surrounding the death of five-month-old Lucas Tran on 18 November 2015 at the home of a Family Day Care Educator.

    iii. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the *Coroners Act 2003*.

22. The following witnesses were heard at the inquest:

- Detective Senior Constable Michael Irving, QPS: QPS lead investigating officer.
- Critical Care Paramedic Sandra Cowley, QAS: First responder and lead paramedic, provided care to Lucas, received information from Ms X about Lucas.
- Constable Melissa Rodgers, QPS: Attended scene, spoke to Ms X and Mr Y.
- Forensic Pathologist Dr Nadine Forde, QH: Attended scene, conducted autopsy and determined cause of death.
- Family Day Care Educator Ms X: Caring for Lucas at the time of his death.
- Family Day Care Educator Assistant Mr Y: Caring for Lucas at the time of his death.
- Family Day Care Coordinator Florence Roberts: Visited/audited Ms X and Mr Y's residence on several occasions in 2015 prior to Lucas' death.
- Director and Educational Leader Amina Elmi, MFDC: Responsible for operations of MFDC and for monitoring Educators enrolled with MFDC, including Ms X and Mr Y.
- Abdulkadir Warsame, Chief Financial Officer, MFDC: Participated in interview with the Department in relation to MFDC's role for monitoring Ms X and Mr Y.
- Susan Todhunter, Department of Education: Attended Ms X and Mr Y's home as part of the Department's response to Lucas' death.
- Catherine O'Malley, Department of Education: To speak to the Department's response to Lucas' death from a systems perspective.

Non-publication order

23. At the commencement of the inquest I made a non-publication order to ensure the identity of the Family Day Care Educators' son, Master Z was not identified as well as all other children present on the day in question. I expanded that to include the identity of the parents of Master Z as his identity would become readily apparent if they were specifically named. I did this for his protection mainly but I also took the view that some sensational information about the Family Day Care Educators and their home environment may have been ventilated at the inquest, and this information ultimately required testing through the inquest.

24. I have considered whether I should extend this order indefinitely in balancing the children's interests with the transparency of the court process and have ultimately decided the non-publication order should be extended until further order. I have therefore de-identified these published findings such that Master Z and his parents Ms X and Mr Y are not identified by name anywhere within these findings.

Autopsy results

25. On 20 November 2015, Dr Forde performed a full autopsy. Dr Forde also attended the scene. Dr Forde recalls the lounge was a very busy room and the house was cluttered. She saw the porta-cot was not fully erected. She recalls the room was very warm. She did not make a note specifically of the presence of mould in the room.

26. External post-mortem examination showed a morphologically normal male infant of Asian appearance with some vague rashes on the forearms and around the mouth but no other significant abnormalities. There was evidence of recent intravenous access on the arms and legs consistent with emergency medical treatment. There was no evidence of dehydration.

27. Internal post-mortem examination showed:

    - Bilateral anterior rib fractures with no significant associated haemorrhage;
    - Patchy petechial haemorrhages on the anterior and posterior surfaces of the thymus;
    - Relatively large spleen;
    - No significant natural disease or congenital anomaly to explain death; and
    - No other injuries.

28. CT scans showed some possible aspiration changes in the lungs but no evidence of injury. Histology showed extensive aspiration changes throughout the lungs with some possible early reaction but no established pneumonia. Dr Forde stated those features were consistent with a peri mortem event and were not uncommon in someone dying. Dr Forde explained that at the time someone is dying they may vomit and may not have the ability to protect their airways, such that oral or gastric contents can enter the airways. In this instance there was vomit found at the scene, there was some milky content in Lucas' airways and, on microscopic examination,

there were some changes in the lungs that were very typical of aspiration changes. There was not any acute inflammatory changes to suggest underlying pneumonia.

29. The rib fractures were all of similar appearance, that is, they were incomplete involving the cortical surface on one side of the rib and showed no associated haemorrhage, inflammation or reactive changes and were considered to be consistent with resuscitation efforts. There were some changes in the upper airways consistent with a recent respiratory tract infection. The spleen was congested. No other significant abnormalities were noted.

30. Neuropathological examination of sections of the brain and skeletal muscle was performed. These were normal. Chemical analysis of vitreous humour (eye fluid) showed glucose and electrolyte levels typical of post-mortem change. There was no evidence of dehydration.

31. Microbiological testing was performed on blood and a number of tissue samples. Specific tests for N. Meningitidis, S. Pneumoniae, Hepatitis B, Hepatitis C, HIV, Adenovirus, HSV 1 and 2, EBV, Enterovirus, Parvovirus, B. Pertussis (whooping cough), C difficile, enteric pathogens, respiratory viruses and Toxoplasma were all negative. Enteric organisms grew in blood, heart, lung as well as Streptococcus oralis in the lung and Staphylococcus species in the blood. Given the mixed growth and absence of other signs of infection, these are considered to be contaminants and not evidence of active infection.

32. CMV (cytomegalovirus) DNA was detected in liver and lung, however Dr Forde advised that this is not an uncommon finding and can indicate past exposure rather than active infection. There were also cytomegalovirus inclusions within the salivary gland but this is a common finding in young children and considered likely to be incidental to death. Molecular karyotyping was performed. Results were consistent with a male karyotype, however a 1.8Mb duplication at 7qll.21-7qll.22 was also detected. The clinical significance of this is uncertain and Dr Forde recommended genetic counselling.

33. Metabolic screening showed post-mortem change. There were no features to suggest a metabolic disorder. Toxicological analysis of post-mortem blood and vitreous humour did not detect any drugs or alcohol.

34. Dr Forde advised that SIDS is a term used to describe the sudden unexpected death during sleep of an infant aged under 12 months that is not explained by the circumstances surrounding death, death scene examination and a thorough post-mortem examination. Dr Forde stated as a forensic pathologist she follows a standardised international protocol for classifying a death as SIDS. The cause of SIDS is not known, but is likely multifactorial, involving environmental, developmental and familial aspects. Where autopsy or other findings fall outside the classical definition of SIDS, other subcategories may apply.

35. There were no specific findings at autopsy to explain Lucas' death. Aspiration was found, which is a condition in which there is inhalation of oral or gastric contents

into the airways. Dr Forde advised this is a common post-mortem finding and was likely to be due to an agonal event although she noted that in Lucas, the changes in the lungs were quite extensive. Dr Forde stated this may raise the possibility a vomit blocked Lucas' airways but this was a difficult call to make.

36. Dr Forde described the contents of the stomach as being a thick cream fluid but she was unable to say how long it had been since Lucas had been fed.

37. The presence of cytomegalovirus (CMV) inclusions within the salivary gland and CMV DNA within the liver and lung is common in young children. There was no evidence of pneumonia or neurological involvement, and this finding was considered to be incidental to death.

38. There was an abnormal cytogenetic finding of a large area of duplication on chromosome 7. There were however no obvious congenital abnormalities and Dr Forde advised that similar duplications have not been previously reported and the abnormal finding was therefore of uncertain significance. It was recommended that the parents seek genetic counselling.

39. There were no features of dehydration, an observation supported by the post-mortem electrolyte levels, however overheating is a known risk factor for sudden infant death and while the temperature in the house was not recorded and had been ventilated prior to Dr Forde's arrival, the home was described as being "hot" by attending police. Dr Forde stated the information provided to her was the maximum temperature that day was recorded to have been 25 degrees Celsius.

40. Dr Forde advised that in this case, the autopsy findings are consistent with a diagnosis of SIDS and the circumstances provided in the Police Form 1 support this. At the time of attending the scene, Dr Forde noted that the porta-cot was incompletely erected, which may affect the sleep surface, raising the possibility of it being an unsafe sleep environment. This would place the death in Category II SIDS, in which a degree of mechanical asphyxia cannot be determined with certainty. Dr Forde was asked about the use of a towel tucked into the mattress and said whether it was a towel or sheet may not make a difference.

41. Dr Forde advised that she considered the broader circumstances carefully in forming an opinion as to the cause of death. This death has occurred in a family day care in which concerns have been raised including the carers exceeding the permitted number of children in their care, and allegedly hiding children prior to police arrival. Dr Forde advised that this does not necessarily impact on the cause of death. Dr Forde said that the description of the circumstances provided to her at the scene did vary slightly from those in the Police Form 1, in that the infant was initially understood to have been found on the floor in the play area. Dr Forde said that if the child was asleep, it would still fall within Category II SIDS. If however the child was awake in the play area, then it would more suitably be considered an unclassified sudden infant death (USID).

42. Dr Forde advised that she attributed the death to SIDS and considers it to fall within the definition of Category II, based on the information in the Police Form 1 and the potentially unsafe sleeping environment.

Sudden Infant Death Syndrome

43. SIDS is defined as the sudden and unexpected death of an infant under 12 months of age, with the onset of the lethal episode apparently occurring during sleep, and which remains unexplained after a thorough investigation including performance of a complete autopsy and review of the circumstances of death (including death scene) and the clinical history.

44. Common factors have been identified in large scale epidemiological studies worldwide and are broadly divided into four groups of factors namely Infant factors, Parental factors, Socio-economic factors and Environmental factors.

45. As I stated in my decision in the Inquest relating to Indianna Rose Hicks[1] the very nature of making a finding of SIDS, being a finding of exclusion, means that no one specific contributing factor can be identified. However, the extensive epidemiological studies conducted over many years has identified varying risk factors, and in this case one of the factors raised included that of safe sleeping practices and supervision.

46. The Red Nose organisation (formerly SIDS and KIDS) have published extensive material online as to the current 'Sleep your baby safely' recommendations for infants 0-12 months, including as follows:

    - Sleep baby on back from birth, not on the tummy or side;
    - Sleep baby with head and face uncovered;
    - Keep baby smoke free before birth and after;
    - Provide a safe sleeping environment night and day;
    - Sleep baby in their own safe sleeping place in the same room as an adult carer for the first 6 to 12 months; and
    - Breast feed baby.

47. The Australian Children's Education and Care Quality Authority's Guide to the Education and Care Services National Law and the Education and Care Services National Regulations 2011[2] does not state a specific time to check an infant, however in relation to *Adequate Supervision* (National Law Sections 165, 167, 174; National Regulations: Regulations 101, 176, 166, 168) the Authority states that an example of adequate supervision 'with children birth to three educators need to be able to see and hear the children at all times especially if sleeping.'

48. The Guide states that;

    - When considering the supervision requirements of sleeping children, an assessment of each child's circumstance and needs

[1] *Findings of the Inquest into the death of Indianna Rose Hicks,* delivered 12 December 2014

[2] *Guide to the National Quality Framework*

should be undertaken to determine any risk factors. For example, because a higher risk may be associated with small babies or children with colds or chronic lung disorders, they might require a higher level of supervision while sleeping; and

- Sleeping children should always be within sight and hearing distance so that educators can assess the child's breathing and colour of their skin to ensure their safety and wellbeing. Rooms that are very dark and have music playing may not provide adequate supervision of sleeping children.
- A family day care service should have an agreed and documented practice for the supervision of sleeping children, tailored to the unique way and safety considerations of each family day care residence or venues as well as the ages and development stages of the children in care.

49. In this instance the policy of MDFC was that supervising staff will allow babies to find their own sleeping position, but will maintain close supervision at recorded 10 minute intervals.

Moorooka Family Day Care Policies and Procedures Manual

50. By way of context for a consideration of the facts in this matter it is apposite to set out the relevant MFDC policy on sleep and SIDS prevention. At the time of Lucas' death, the MFDC had 42 policies in place as outlined in their Moorooka Family Day Care Policies and Procedures Manual. This includes the 'Sleep, Rest, Relaxation and Clothing Policy' (the Policy). The Policy was implemented in December 2014 and states:

> "Educators will:
>
> - Provide a quiet and restful environment for sleep and rest that enables them to see, hear and closely monitor children.
>
> …
>
> - Ensure educator to child ratios are maintained at all times children are sleeping and resting.
>
> …
>
> - Follow the procedures in this policy which are based on recommendations from SIDS and Kids. If a child has a medical condition which prevents educators from following these procedures, for example a condition which prevents a child from being placed on their back an alternative resting practice must be authorised by a registered medical practitioner in writing. This should be part of a child's Medical Management Plan.
> - Communicate daily with parents about their child's sleep and rest routines at the service and at home.
> - Regularly monitor all children who are sleeping with specific attention to breathing patterns, and monitor all babies every 10 minutes;
> - Monitor the temperature of the rest environment to ensure it is comfortable without becoming too hot or cold.
>
> …
>
> - Support children who need rest and relaxation outside a designated "rest time".
> - Group children in a way that minimises overcrowding.

- Comfort children when required. We discourage rocking children to sleep so that children do not come to expect this from their families at home; and
- Respect the privacy needs of each child when dressing and undressing.

…

Safe resting practices for babies (birth to 24 months)

Educators will:

- Place babies on their back to rest (unless a medical practitioner has authorised an alternative resting practice due to a medical condition);
- Allow older babies to find their own sleeping position if they move after being placed on their back to rest;
- Ensure a baby's face is never covered with bed linen while they are sleeping;
- Place babies so their feet are close to the bottom end of the cot and they cannot wriggle under the bed linen;
- Ensure quilts and doonas are not used as bed linen, and that pillows, soft toys, lamb's wool and cot bumpers are not use;
- Use light bedding as the preferred option, and tuck all bedding in to prevent a baby from pulling it over their head. Sleeping bags with a fitted neck and arm holes (and no hood) may also be used instead of bed linen;
- Play calm, relaxing music;
- Provide dummies if required but they will not be attached to chains.

…

Cots

All cots must meet Australian Standards and be labelled AS/NZS 2172:2010 or AS/NZS 2195:2010 (folding cots).

- Cot mattresses should be in good condition, clean, firm, flat and must fit the cot base with no more than a 20mm gap between the mattress and the sides of the cot.
- The distance between slats must be at least 50 mm

…

The Moorooka Family Day Care Co-ordinator will review the sleep and rest practices implemented at residences or venues during regular home visits".

Background

51. Lucas was Ms Huynh's first pregnancy. Routine antenatal blood tests were unremarkable. Antenatal ultrasounds were normal. He was delivered at 38 weeks gestation via vacuum extraction following a prolonged second stage of labour. Vaccinations were up to date with the most recent vaccination on 6 October 2015. He had been growing well with no health concerns.

52. Ms Huynh says that Lucas was a normal healthy baby and needed no special treatment. He wasn't on medication apart from some cream for a rash on his face. She says that Lucas was quite mobile and if put down, he could roll himself over

onto his belly. She says that when she put him to sleep, she would always lie him on his side and put pillows around him to stop him rolling around.

53. Lucas' parents first made contact with Ms X and Mr Y on 2 September 2015. They attended the home that night and were shown around the house and discussed Lucas' placement. Ms Huynh says that she was told that they only look after four children as there was a limit of how many children they could have. Over the following days, Ms Huynh exchanged multiple text messages with Mr Y in relation to her eligibility for Centrelink benefits and the price for Lucas' placement.

54. Lucas commenced care with Ms X and Mr Y at their house from 14 September 2015. Ms Huynh says that when she arrived, Ms X told her about the previous scheme they were associated with. Ms Huynh says that Ms X told her that it was much stricter than the current scheme they were associated with, in that she had to change the babies' nappies every hour and check on them every 5 to 10 minutes.

55. It appears that an enrolment form was completed on this date and was signed by Ms Huynh. One of the questions on the form was "what is your Children routine in regard to sleeping/resting". Next to this question is written: "dummy to helping".

56. Ms Huynh says that Ms X told her that she had not liked the previous scheme and changed to the current one. When Ms Huynh picked Lucas up one afternoon, Ms X told her to get a swaddle for Lucas so that he would sleep better if he was wrapped up.

57. On the morning of 18 November 2015, Ms Huynh says that Lucas had woken up about 5:30am and was given his normal bottle of 150mls of formula milk. She then dropped Lucas off at Ms X's home at 8.00am. Ms Huynh says Lucas was wearing a blue t-shirt and jean shorts.

Events of 18 November 2015

Telephone call to MFDC

58. Hanan Hussein Abdalla worked as an administration officer at MFDC. She stated she would speak to the educators such as Ms X almost daily and was also familiar with Mr Y. She provided a statement in which she stated she recalls at between 9.50am and 10.15am on 18 November 2015 she received a telephone call from Mr Y. She said she knows this was the time because soon after his call she made an entry on the computer diary system. She was able to produce what she described as a printout of the diary entry.

59. She stated Mr Y asked her for information about Lucas including how to spell his last name, his date of birth and his Centrelink reference number. She asked why this information was needed as he should have any information already. He replied "because as we have told you earlier we will be taking a break and another educator might need this information and I just wanted to check". She recalls that a few weeks previously Mr Y had mentioned about Ms X and him having a break.

60. Ms Abdalla states that this was the only time that Mr Y phoned her that day. Her diary entry states he sounded very normal when he spoke, greeted her as usual and there was no difference in his voice. In her evidence she stated she added this to her note after police had asked her if Mr Y sounded normal.

61. Subsequently at my request, Ms Abdalla provided a second statement. She states she received a telephone call from Mr Y on 18 November 2015. This call came in on the main telephone of the business, at the time being 33928350.

62. She states she made an entry onto a spreadsheet which was generated for the purpose of recording telephone calls from the educators. This spreadsheet was saved on the work computer. The business moved at one stage and now has new computers. There was a new system made to record all contact with the educators. She checked the computers and has been unable to find that old spreadsheet she used. She does not recall what entry she made on the system in 2015 apart from the one provided in her previous statement.

63. Subsequently telephone records were obtained from telephone company providers and the records indicate two calls were received at the MFDC business number from Mr Y's mobile for approximately two minutes each at 11.08am and 11.11am. In evidence, Ms Abdalla thought the time was earlier and she recalls only one call and that another call might have been taken by someone else in the office.

64. I am satisfied on the evidence that the calls were made to the office at these times and not at earlier times, which would have placed them before an emergency call was made to QAS. The fact Mr Y made these calls at that time is consistent with the evidence that he was unable to find enrolment details for Lucas at the home day care as requested by police and hence the actual reason for the call.

Queensland Ambulance Service attendance

65. At 10.39am, QAS received an emergency call in relation to the address. Mr Y can be heard speaking with the operator on the phone. The operator was advised that Lucas was not moving, not awake and not breathing. When asked, Mr Y can be heard advising there was no defibrillator available. The operator directed Mr Y to place Lucas on the ground on his back, and clear Lucas' mouth and nose of vomit. The operator then directs Mr Y how to perform CPR which can be heard occurring during the call.

66. Critical Care Paramedic, Sandra Cowley was detailed to attend the scene with QAS officers Kiri Anderson and John Hagen and the case was assigned priority code 1A Lights and Sirens response. They arrived at 10.45am and were initially unable to gain access because the gate was closed and they were unable to open it. Approximately two minutes later, the gate was opened by Mr Y and the QAS officers immediately went into the house. Ms Cowley described the property as dishevelled generally but the lounge was clean and tidy. Her focus was on the child and she does not recall the temperature at the time.

67. Ms Cowley observed Lucas lying on the floor of the lounge room beside a TV cabinet and that he was topless. She says that his skin was mottled white and he was completely still. She observed that his head was towards the front of the house where they had entered. An adult female was kneeling beside Lucas but no CPR was being performed. Ms Cowley immediately started compressions and defibrillator pads were applied. There was no electrical activity and no breathing. During the initial treatment, Ms Cowley determined that there were no advanced death signs (no lividity or rigor mortis). She also observed no obvious signs of trauma to Lucas' body.

68. A QAS supervisor (Domonique Payne) and two further paramedics (Peter Drew and Simon Edwards) arrived. The QAS continued to work on Lucas and Ms Cowley performed an intra osseous in Lucas' left upper tibia for drug administration. She also inserted an endotracheal tube. Adrenaline, sodium bicarbonate and saline were administered. There was a white substance in the throat which was not copious and she described it as curdled milk. At some point, Lucas was moved to a low cabinet that was in the lounge so that there was better access. After 36 minutes of resuscitation, it was decided that Lucas could not be revived and he was declared deceased at 11.24am.

69. Ms Cowley says that soon after time of death it was decided to move Lucas to a quiet location for the parents. Ms Cowley says that paramedic Peter Drew then moved the child.

70. Ms Cowley says that Mr Drew picked up the child and she moved to open a door of a room off the lounge room. Just as she opened the door the adult male (Mr Y) started to say in a firm voice:

    "Don't go in there, Don't go in there".

71. Ms Cowley had already opened the door and saw, sitting on the floor with their backs against the far wall were three small children who looked to be under school age. She says that the children didn't move when she opened the door. Mr Y said something like:

    "*That's not his room".*

    Ms Cowley says that Mr Drew then said something like:

    "Well show us the room".

72. They then followed Mr Y down a small hallway past another two children sitting on a chair. Ms Cowley says they were led to a bedroom off to the left of the hallway. In that room, she observed a collapsible cot. Ms Cowley observed a mattress in the cot that had a synthetic zippered bag on top. She says there was no other linen in the cot. She says that Mr Drew placed Lucas into the cot and that she placed a towel on top. Ms Cowley was adamant the towel was placed by her on Lucas. Ms Cowley cannot now recall where the towel came from but she repeated there was no linen in the cot. Ms Cowley says that about 15 minutes later police arrived.

Queensland Police Service attendance at the scene

73. The QPS investigation was conducted by Detective Senior Constable (DSC) Michael Irving of the Morningside Child Protection and Investigation Unit. He provided a report to me regarding the investigation and detailing the circumstances of the death and investigations conducted. Police had been detailed to respond to assist QAS officers who had attended the emergency call. First response police attended and declared a crime scene due to conflicting versions provided to QAS and QPS officers. Police located three living children under the age of two as well as Lucas. They arranged for the other children to be collected by their parents. Whilst conducting their investigations police located two further children secreted in the dwelling.

74. DSC Irving stated he arrived at 12.00pm with other police and QAS officers already on the scene. He recalls the house was quite hot and uncomfortable with no fans or air conditioner running. He stated the place was untidy and toys were scattered around but he was more concerned he could see medications scattered about in the main play area, which would have been able to be accessed by children. DSC Irving was shown photographs of the ceiling where Lucas was said to be sleeping and agrees it looks like mould but he had not paid attention to that on the day. He did examine the porta-a-cot, which would not stay up and he stated he tried to do so.

75. According to the police incident log, the QPS were first called to attend at 11.19am and the first responders arrived at 11.22am. Constable Melissa Rodgers was one of the first to attend along with Constable Benjamin Gray. She observed that the yard of the house was unkempt and there were old toys scattered around. She spoke with QAS officers and was told they had been working on a five month old baby for about 35 minutes, however he had not responded and passed away. She was asked to contact the mother urgently.

76. As Constable Rodgers entered the house, she noted that it was extremely hot with no windows open or fans on. Constable Rodgers checked other rooms and it was obvious to her there was little ventilation and no air conditioner on. This observation was also made by Constable Gray. Constable Rodgers saw that the house was very disorganised and cluttered with small tables and paperwork spread over the tables. She says there were medications and scissors lying around. She recalled thinking it was not a safe environment for children. She observed there were three small children about two to four years old, sitting on plastic chairs lined up against the wall and sitting very still and not moving (also confirmed by Constable Gray).

501690489 FR1467784 2864680-IMG_0554.JPG 2015-11-18 12:35:22 40251 [illegible] Exhibit F1 Page 27

77. Constable Rodgers asked Mr Y and Ms X whether there were any other persons in the house to which they both responded "No". Constable Rodgers asked Constable Gray to clear the house. Mr Y and Ms X's seven year old son, Master Z was then located in the main bedroom. Constable Rodgers asked Mr Y why he had not told her of Master Z's presence and Constable Rodgers was advised that Master Z was home sick from school. Mr Y and Ms X were again asked whether there was anyone else in the house to which they again responded "No". At this point Mr Y was moving around and wanting to leave and Mr Y and Ms X were told they were both detained and could not leave and were warned about obstructing an investigation. They were unable to produce enrolment forms for Lucas.

78. Constable Rodgers had a look in the rooms, which she described as a terrible mess. Things were upturned and scattered everywhere. All the windows were shut as were the doors. She noted that there was nowhere for the children to sleep except the rear room with the cot in it. She observed the kitchen had food scraps everywhere and was dirty. There was a large container of water and chemicals in the lounge room where the children were. Mr Y reportedly told her in an angry voice this was for cleaning.

79. Constable Rodgers saw that Ms X had given a young infant less than 10 months old a cardboard clothing tag to chew on. She says that she told Ms X:

> "*Don't give the baby that. It is a choking hazard and apart from that, the ink on the print could be poisonous.*
>
> Constable Rodgers says Ms X replied:
>
> *"No No teething. Cheap than teething things".*

80. The tag was removed from the baby. The next of kin for the three children were contacted to collect them.

81. At 12.02pm, DSC Michael Irving and DSC Christopher Voysey from the Morningside Child Protection and Investigation Unit ('CPIU') arrived at the scene. The officers were directed to a bedroom at the rear of the house where Lucas was observed to be lying in a porta cot, which was in a state of half erection.

82. At 12.40pm, Senior Constable Alan Lonsdale from Mount Gravatt Scenes of Crime attended the scene. SC Lonsdale observed Lucas lying under a white coloured blanket and lying on top of what appeared to be a grey coloured nylon bag (presumably the carry bag for the porta cot). He also observed that the porta cot frame did not appear to be in the fully locked position as all four side rails were sagging in the middle (and this is consistent with Scenes of Crime photos taken of the cot shortly afterwards).

Conversation with Master Z the seven year old son of Mr Y and Ms X

83. At a time not recorded but presumably not long after arrival, DSC Irving had a conversation with Master Z which was recorded. Master Z was asked what children were there when he had woken up to which he replied:

> *"The same ones that are here now".*
>
> He named M, O, C, M, A and Lucas.
>
> After he had played with O and M that morning, Master Z said he and his Dad had gone to clean downstairs and that:
>
> *"My Mum was feeding Lucas and then the baby vomited, Lucas vomited and he choked and then he died and we just called the police…my Mum called my Dad. My Mum shouted and called my Dad and my dad dropped whatever he was carrying and then he ran to my Mum…and then my Mum and Dad took her [sic] upstairs and I saw what happened".*
>
> When asked where Lucas was when this was happening, Master Z replied:
>
> *"Well there was like a downstairs room on that side…Mum was down there…Lucas was in there too because my Mum was feeding him the milk and then he choked".*
>
> Master Z was then asked when Lucas came out of the room with Mum, was that upstairs or down stairs, Lucas replied:
>
> *"He was down stairs…he was definitely down stairs at the time".*
>
> When asked what his Mum had told his Dad, Master Z replied:
>
> *"Well I don't know but they just said in Chinese very quickly and then they just rushed upstairs".*

When asked when they rushed upstairs, where did Lucas go? Master Z said:

"Lucas just went with them and because they were calling the police…my Mum and Dad carried him".

Conversation with Mr Y

84. At 1.16pm, DSC Voysey and DSC Irving had a conversation with Mr Y which was recorded. Mr Y said that he was cleaning with his son who had not gone to school as he had a sore throat. He initially said that it was about 10.00am or 10.15am when he heard Ms X call out:

"…'Mr Y help Mr Y Help'…that's when I discover the baby was unconscious…we were in shock…what we gonna do?"

When asked who was down stairs, Mr Y replied:

"Master Z and me".

When asked who was upstairs. Mr Y replied:

"Ms X and all the kids".

Mr Y was then asked how many kids were there to which he replied:

"All up, I think there were four today…O, M, C and Lucas".

When asked to clarify the time that Ms X had yelled out was 10.00am, Mr Y replied:

"No…I reckon about 10:30 something like that, our clock is a little bit faster ok, so we look at that clock but we know its 15 minutes faster….actual 10:30 on iPhone, I think it would be around that yeah".

When asked how long he had been down cleaning, he said:

"15-20 minutes but before that I was up there".

85. When asked to tell them everything he saw when he went upstairs when Ms X has called out, Mr Y said:

"The baby was on the floor and Ms X was trying to save him and then I said to her you quickly dial 000 and then I took over… And then when someone picked up the phone, it was on speaker, I can hear and then Ms X gave it to me".

Mr Y says that Lucas was not wearing anything but had a nappy on. He indicated that Lucas was lying on the floor on his back in the middle of the living room near the TV. He says that Ms X was *"really nervous…really worried".*

He said that he thought he gave Lucas CPR for about 10 minutes and then Ms X took over for about 5 minutes. He said that the ambulance arrived quickly.

When Mr Y was asked what had happened with Lucas from the moment he arrived, Mr Y said:

"When he turned up at about eight o'clock, I held him and then Ms X was there because she was settling C and then Ms X took care of Lucas and that was it for me. I saw Lucas in the playground and then probably in the bedroom…the only interaction I had with him was holding him".

Mr Y said that Ms X would normally feed Lucas and that he had only fed him three or four times under Ms X's supervision. Mr Y said that he would not normally interact with the kids and that Ms X would look after the babies. He was not aware that Lucas took medication.

When asked whether Lucas was sick or anything when he had arrived, Mr Y states:

"Look a little bit off or tired, like subtle, quiet, not jumpy, tired, I suspect he was tired".

When asked whether Lucas was fed anything after he had arrived that morning, Mr Y states:

"I didn't feed anything and as far as I know when I feed any baby anything, when I feed any children I don't really feed babies and when I feed children anything, Ms X always know…so I did not feed anything and I did ask Ms X what did he eat or whatever when that happened, after the ambulance arrive, she said he did not have anything because he just slept a little bit, woke up and then play and went back to sleep, that's all I know…something like that he didn't eat anything".

Mr Y was asked about what police had been told by Master Z. Specifically that when Master Z had woken up children by the names of A and M had also been there. Mr Y was asked who they were:

"They were other kids but they come here on and off".

Mr Y was asked when A and M were last there to which he replied:

"They left yesterday in the afternoon".

Mr Y was also asked about what Master Z had said in relation to Ms X being down stairs feeding Lucas to which he replied:

"She came down stairs…she yelled out and I went up stairs".

When asked to clarify that at no time Lucas came down stairs, Mr Y replied: "No"

When asked what he thought happened to Lucas, Mr Y stated:

"I think from what I think because I looked at the bedroom I believe, coz he can flip and maybe he was I think because when I resuscitate him a lot of milk came out and we did not feed him anything at that time as far as I know I think he might have coughed or something and it blocked his airway".

When asked where Lucas would sleep while he was there, Mr Y states:

"He sleep only in the cot…we have one cot there and that's for babies…its very new"

Ms X's clothing

86. At 1:32pm, Ms X approached Constable Rodgers and asked if she could change her clothes as she had vomit on them. Her clothes were photographed by Scenes of Crime. In that photo, white markings can be seen on the right sleeve, left side of the shirt, abdominal region and at the base of the skirt.

Conversation with Ms X

87. At 1.41pm, DSC Irving and DSC Voysey had a conversation with Ms X which was recorded. Ms X confirmed that she had previously undertaken family day care with the Wesley Mission but had changed as it had been too far for her to drive to lodge the timesheets.

88. Ms X explained that she has been doing family day care for about three years. She advised she holds a Blue Card (which was sighted by police). She advised that she held a certificate in first aid but was vague about when/where this qualification was last renewed or updated. She said that she was taught about allergy and CPR and "all the first aid things".

89. Ms X explained that she also needed to study for a certificate in child care.

90. Ms X said that she would get a routine inspection from MFDC and thought the last one had occurred about a month prior.

91. Ms X confirmed that Lucas arrived at 8.00am. She says that his mum did not say anything about him being sick. She says that she was told that he had been fed. Ms X says that she took Lucas and sang some gospel songs and then Lucas had some tummy exercise for about 6-7 minutes. Then she held him up and walked around with him. She states that she thinks that Lucas fell asleep at about 9.10am. When asked where he fell asleep, Ms X advised that he was on his back in the cot room.

Other children found in the home

92. At around 2 pm and 26 minutes into the interview with Ms X, a loud disturbance can be heard emanating from upstairs and a police officer can be heard yelling words to the effect of: "where are the children?!" By this time the children who were then found would have been there for over two hours whilst QAS and QPS were present.

93. At around the same time, Sergeant Daniel Sheppard says that he entered a room which appeared to be an office. It was very untidy and in an unkempt state. He says that he looked to the foot well area beneath an office desk and observed a small child sitting perfectly still facing the wall. He picked up the child who he describes as three to four years of age. He turned to Mr Y and asked who the child was. Mr Y replied:

> *"There are other children in the house but I am not the proprietor, go and see Ms X".*

94. Mr Y was asked by Acting Sergeant Hallie Andrews with Constable Rodgers present where the other children were and was warned about obstructing police. Mr Y said they should speak to Ms X, that it was not his business. He then proceeded to be aggressive towards police and was arrested for resisting arrest. He was later charged with obstructing police.

95. Constable Benjamin Gray then searched the remaining rooms and in the course of searching the main bedroom opened the centre compartment of a built in wardrobe and pulled out a box which was in the cupboard. He observed a small female child crouched down in the corner of the cupboard. The child was visibly shaking. After a further search (including by the Queensland Fire and Rescue Service who were requested to search the roof cavity), no other children were located.

Resumption of interview with Ms X

96. The interview with Ms X was resumed and Ms X was then formally cautioned by police.

97. She was asked why she had not told police about the two other children. Ms X replied that they were not under her care and they were children of a friend. She says that they were under the care of her husband and that this child was playing hide and seek with her son. She says they were not charging money for the children.

98. DSC Irving then continued to ask Ms X about Lucas. After she had put Lucas in the cot, Ms X said she did some craft with the other kids. She says Lucas cried a little bit but self-settled. In relation to the checks conducted on Lucas Ms X said:

> *"I did check Lucas and then I went inside to check again and the Lucas, I found Lucas lying in the milk, the vomit"*
>
> *DSC Irving: "Tell me everything about that part"*
>
> *Ms X: "And then I quickly get him out"*
>
> *DSC Irving: "What position was he in?"*

Ms X: "He was facing down"

…

DSC Irving: "When you put him down for his sleep and he self-settled, what was he wearing exactly?"

Ms X: "Just a blue top and a nappy"

DSC Irving: "What about his pants?

Ms X: "Is off because its very hot and yes"

99. When asked whether his colour was different when he was found, Ms X said that he was darker colour but he was not blue.

DSC Irving: "What time did you go and check on him?"

Ms X: "I don't know exactly time but I do check every 20 minutes"

DSC Irving: "How many times did you check on him then?"

Ms X: "One time and then I about to go check for another time"

DSC Irving: "So it was the second time you checked him, so were talking so you said he went down for a sleep and about 09:10 and you checked on him 20 minutes later, that would be what 09:30"

Ms X: "Sorry"

DSC Irving: "So you said he went down for a sleep at 09:10"

Ms X: "Yeah, around like 08:50 go in there"

DSC Irving: "So then you checked on him 20 minutes later which is 09:10 to 09:30 and he was, what was he like then, the first time?

Ms X: "No the first time is the time I put him in, put him in, yes"

DSC Irving: "Ok so you've put him in"

Ms X: "Yes, he's fine he looks good"

DSC Irving: "And then you checked on him 20 minutes later"

Ms X: "Yes"

DSC Irving: "And what happened then?"

Ms X: "He's like that"

DSC Irving: "So the first time you checked on him after putting him down is when you found him?"

Ms X: "Yes in the milk, vomit"

…

DSC Irving: "And what was he lying on in the cot? What was he sleeping on?"

…

Ms X: "We have a towel to cover him"

DSC Irving: "A towel, so what was underneath him?"

Ms X: "The mattress"

DSC Irving: "Was there a sheet on the mattress?"

Ms X: "Just that towel"

DSC Irving: "So there was a towel underneath him?"

Ms X: "Yes"

DSC Irving: "What was on top of him?"

Ms X "…Just that same towel"

DCS Irving: "And that vomit where was the vomit?"

Ms X: "All on the towel and also on the bed, yes"

…

"I try to do him first in the cot and yeah he have more milk come out"

DSC Irving: "Tell me about that part? How did you do the CPR exactly?"

Ms X: "On his chest here with two fingers, first I tilt him to see if there anything inside the mouth and then more milk come out so I have to let him lie sideway"

DSC Irving: "And this all happened in the cot?"

Ms X: "Yes, yes"

DSC Irving: "And what happened next?"

Ms X: "And then I quickly call Mr Y come help me"

DSC Irving: "And when you called Mr Y, where was Lucas?"

Ms X: "On my hand"

DSC Irving: "What happened next?"

Ms X: "And then we call the ambulance…"

Ms X was then asked whether she had fed Lucas anything that day to which she replied*: "I didn't"*

DSC: "When would he have been due to feed?"

Ms X: "At the time he wake up"

DSC Irving: "What time does he usually wake up?"

Ms X: "10:40-10:50"

100. Ms X denied giving Lucas any medication. She also denied that he had any falls, hit his head on anything or choked on anything.

Section 93A interview with Master Z

101. At 6:50pm, police again spoke with Master Z at the Morningside police station.

102. Master Z was asked to clarify the events of the day. He said that he had been confused (earlier when he spoke to police that day) when he said that his Mum had been downstairs. He said that she was upstairs.

103. He says that he had been downstairs to help his Dad clean. They then took a break. He says that his Mum called to his Dad and his Dad rushed upstairs to his Mum. When asked if he had seen Lucas eating anything that day, he said:

"Yes... I saw my mum feeding him today…after I came out from that room coz I finished playing hide and seek with E"

Master Z was then asked "what was your mum feeding him out of?".

Master Z replied*: "Well I don't know but I saw my mum preparing the bowl that Lucas always eats from".*

Master Z could not recall what time of the day it was.

104. When asked again later during the interview about Lucas being fed, Master Z changed his story and said that no he didn't because at that time he was downstairs with his dad. He was asked where Lucas normally slept. Master Z said that he would sleep in his room in a thing that can be folded and looks like a chair. He said: "it's a baby chair, it's a rocking chair".

105. On review of the scenes of crime photos, there is a baby chair fitting the description provided by Master Z.

Evidence of Mr Y and Ms X at inquest

Mr Y

106. Mr Y stated that Ms X was always the primary educator and he provided secondary support as an Educator Assistant. He stated he had taken up working toward a Certificate III in Child Care back when they started but it is evident this had not been completed. He was unable to given any particulars as to what parts he had completed or if he got any credits for these when he re-enrolled with another Registered Training Organisation (RTO).

107. I am not at all convinced the course work was being progressed seriously. It is also evident the course Mr Y subsequently enrolled in was with a training organisation run by the husband of the owner of MFDC. Ms X's evidence on this matter was similar and I will make further comment on this issue in the course of recommendations.

108. Mr Y's explanation for changing from Wesley Mission to MFDC was on the basis Wesley Mission moved their office to Morningside and it was a long way to drop off time sheets or to post them. It was put to him that parents had complained to Wesley Mission about them and he agreed with that proposition. He was unable to say if Wesley Mission then placed conditions on them. It was suggested and he denied they changed schemes because MFDC was more relaxed.

109. He was unable to say if any induction with MFDC included safe sleeping practices. He stated they received a policy and procedures manual but was unable to explain why he could not produce it to police or the Department the next day other than to say they were in shock. He believes the induction was done by Abdulkadir Warsame, the proprietor's husband.

110. As to the events of 18 November 2015, Mr Y stated he had gone downstairs to throw away some rubbish. His son was with him and he was there for 5 to 10 minutes (he told police 15 to 20 minutes). He then heard his wife scream out his name and saying Lucas was not breathing. He says he did CPR for a short period of one to three minutes and called QAS. He had to open the gate for them.

111. In respect to the issue of the other children being present and not disclosing his son and the other two under school age children found later, Mr Y stated they were asked how many children were in his wife's care so he answered there were no others. He argued the other two children were not under his wife's care and they were there informally and were there so his son had friends for company and he was looking after them not his wife. It was put to him he had deliberately hidden the children, which he denied and said this did "not sound very nice". He also denied misleading the police.

112. In respect to the porta cot, Mr Y stated he may have set up the cot that day but could not recall. He was asked about the presence of the nylon bag in the cot but did not remember that. He denied he had placed Lucas in the baby rocker to sleep but was unable to say if his wife had.

113. On the issue of the cot being found not fully erect, Mr Y stated his wife is not tall and so he lowers the sides of the cot in order for her to be able to reach in to place and lift out the children. He denied the suggestion Lucas had not been placed in the cot but in a rocker. He denied the cot had been only put up just before QAS and police arrived, hence it being partly erected and the carry bag being on the mattress.

114. Mr Y denied he had coached his son to change his story. He agreed he had been told his son's initial version by police at the house and before his son's second interview.

115. As to the two calls he made to MFDC, Mr Y was hesitant to concede he made any call but agreed after the records were put to him he must have made a call. He could not explain why he had not disclosed anything about the incident involving Lucas in the telephone call.

116. On the issue of mould, Mr Y denied there was any mould. There had been mould, which they had washed away and what was left was a stain.

117. As to the messy condition of the house, Mr Y stated this was due to the police raiding the house.

118. Similarly to Ms X, in relation to the house being hot, Mr Y stated they have solar panels and do not have to pay electricity and therefore they would not need to be careful about using electricity. He seemed to say the air conditioner may be on for one hour and then switched off. He was unaware if it was on at all that day. He stated often it would be one hour on and one hour off.

Ms X

119. Ms X denied feeding Lucas at any time that morning. She stated she put him to sleep in the cot at around 9.20am to 9.30am. The cot was fitted with a towel wrapped into the corners of the mattress for safety. This was because she says she had not been provided with a sheet that day by Lucas' mother.

120. Ms X stated she sets an alarm on her mobile telephone to remind her to check on sleeping babies every 20 minutes. She states that the first time she checked Lucas was sleeping face up.

121. At some point Ms X had to change another child's nappy, which was very soiled and she had to clean the bathroom. Accordingly,3 she turned the alarm off and it took an extra 10 minutes (hence at least a 30 minute gap) before she checked on Lucas who was unresponsive and lying face down.

122. Ms X said she saw milk on Lucas' face and she dug out some from his mouth with her fingers and turned him over. She pressed his stomach and milk came out. She then had to push down on the cot sides to get to him to bring him out of the cot. She says that milk went on to the towel.

123. Ms X was shown photographs of the cot with the grey fabric bag in it and said that should not be there and was on the floor. As to the cot she said she had to unclick the sides and said she could do this even with the mattress in the cot. She denied the suggestion obtained through Mr Y's evidence that the cot always had the sides down.

124. Ms X said she had called out to Mr Y who was downstairs dumping nappy rubbish for only a few minutes. She disagreed with what Mr Y told police that he had been downstairs for 15 to 20 minutes as wrong.

125. Ms X also disagrees with the evidence of Mr Y when he said he commenced CPR first before calling for QAS to attend. She said she told Mr Y to call QAS and he only took over CPR once he had done this.

126. Ms X said she told the three children in her care to stay in the area and her son and the two others to go to the main bedroom. She denies moving them into other rooms or into a cupboard to hide.

127. As to the explanation as to why she did not disclose the presence of the other children to police Ms X said she took it they were asking about the children in her care.

128. Ms X stated the other two children were friends of the family and Mr Y was looking after them.

129. Ms X also denied speaking to her son in between the interviews other than to give him a hug and she says she was not aware he had already spoken to police.

130. As to the suggestion Lucas had been put to sleep in the rocker found in the bathroom, Ms X denied that and said he was always placed in the cot to sleep.

131. Ms X said in relation to the police observations that the premises were hot, very similarly to her husband, she explained they had solar panels and did not have to pay electricity and could have the air conditioning on all day. She agreed she had probably not turned the air conditioning on that day by the time police arrived.

132. In evidence, Ms X stated she could not recall if it was hot that day. It is noted she told the Department's investigators the next day it was hot.

133. As to safe sleeping practices and sleeping environment, Ms X was taken to a file note of the conversation the Department's investigators had with her and Mr Y on 19 November 2015 where Ms X advised she placed a towel in the cot that day; that it was a very hot day; normally the baby was wrapped in a swaddle but it was too hot for that; and they closed the door as the children in the other room can be very loud and they play music. In the same conversation she advised they check on babies around every 20-30 minutes, and do not document sleeping checks or sleeping times.

134. Ms X told the court she was not aware the MFDC policy on safe sleeping required her to monitor all babies every 10 minutes.

135. In respect to Ms X's evidence about policies and induction it is evident neither she nor Mr Y was able to produce the MFDC policy manual to police or later to the

Department's investigators on 19 November 2015. Her evidence about her understanding of the policies and induction was that at Wesley Mission she was taken through the policies page by page but at MFDC this was not the case and they may have been given the policy manual after they started. Ms X was not sure if she recalled the sleep policy and certainly was not aware of the particulars of the policy. Ms X recalls the induction included a fire drill but she could not recall not any detail on a sleeping policy and she received nothing on SIDS prevention.

136. Ms X said that Florence Roberts, a MFDC Coordinator, came to the home regularly and she expected Ms Roberts would say something if it was not right.

Moorooka Family Day Care

Previous inspections of premises by MFDC

137. Florence Pinky Roberts was employed at MFDC as a Coordinator from 2013 until 18 October 2015, when she says her position was terminated due to a downturn in business. She stated her role was to conduct assessments of new educators who had applied to join the scheme. She would review the applications and ensure that they met the criteria to conduct child care. She also attended the premises where the child care was being conducted to assess its suitability. Her observations and recommendations were recorded in documents, which were added to the educator's file. If she identified any areas of concern or safety issues she would notify the educator and give them time to remedy the concern. She would follow up later to confirm everything had been addressed before they were allowed to commence child care.

138. Part of her duties also included ongoing supervision of 11-15 educators. She would ensure they were meeting the standards of safety and hygiene, quality education, government policy compliance, paperwork and she would audit the care for each child being cared for. She would attend each premises monthly. Sometimes the visit would be planned and other times she would call in randomly. While at the premises she would check the children had the correct paperwork and would also observe their care. She would be at each educator's home for approximately one hour.

139. Ms Roberts states she recalls that Ms X and Mr Y were transferring from the Wesley Mission and remembers they were almost ready to commence working. She recalls having them to install some barricades and also to sign a statutory preparation that the children were not allowed outside in the yard to play as it was not a suitable play environment. The children were to be taken on excursions to a park for play rather than use the yard of the house. She was also aware they could only care for four children under the age of five. She was aware Ms X's son who was over five was often also being cared for. She remembers requiring Ms X to enrol in a child care course as she had no formal qualifications. She thinks Mr Y also enrolled. They both had Blue Cards.

140. Ms Roberts appears to have completed a home inspection document on around 3 July 2014 and an induction was said to have been held at the home by Ms Roberts. She stated despite Ms X having worked with another provider she still had to complete an induction as they had different policies. She stated the induction included information about SIDS and a number of posters reflecting the policy on such matters were provided. She says she would have spent three hours with Ms X going through the policies and posters, SIDS included.

141. She recalls visiting the home twice in the first month and each month thereafter. She does not recall any compliance issues. To her recollection they started about six months prior to her leaving in October 2015. She stated she would have therefore visited about six or seven times. All the reports that she completed would be on the day care file. She recalls she completed some electronic records on the MFDC computer as they were moving to an electronic system.

142. The records indicate that on 9 February 2015 a planned home visit was carried out by Ms Roberts. The monitoring form indicates that the home was checked against a number of quality areas including programming and learning outcomes, kitchen, play area, sleeping/rest area, nappy items, bathroom, car, outside and communication. Ms X's home was observed to be safe and clean and tidy. Ms X reportedly advised that she cleans daily before the children arrive. There were no issues identified at the time of the visit.

143. Similarly, during a planned visit on 17 March 2015, there were no issues were noted. The plan was to follow up by phone the following month which appears to have occurred via telephone on 21 April 2015. There were no issues or concerns documented during this phone call.

144. A home visit took place on 25 May 2015.

145. A telephone support call was made on 29 June 2015 and 21 July 2015.

146. It appears the last home monitoring carried out by MFDC Coordinator Florence Roberts was on 1 September 2015. The home monitoring and quality care observation sheet states:

> *"Generally educator home service was clean and tidy as required. Great set up…"*

147. She does not recall that Lucas was being cared for by Ms X while she was employed by MFDC. It is noted however that Lucas started day care on 14 September 2015.

148. Ms Roberts was shown a number of photographs taken of the premises by police on the day and particularly of the play area and was asked if it was similar to what she had observed on her visits. Ms Roberts pointed to what appeared to be sunscreen and hand sanitiser bottles on a table within potential reach of children,

and said these were normally stored near the front door where parents signed the children in for the day.

149. In respect to policies it was noted the Policy Manual that had been produced to the court was headed Version 1.0 December 2014. As Ms X and Mr Y commenced with MFDC in July 2014 it is unclear what Policy Manual was provided to them at that time. Ms Roberts stated at the time of induction there was a blue folder with a smaller policy booklet included and this included information about SIDS. Amina Elmi gave evidence to effect there was a manual before 2015 but it cannot be found and the only one available is the updated one.

150. Ms Roberts stated her role in relation to inspecting cots used by educators would be to look for a mark indicating they were manufactured according to the Australian Standards. She cannot recall seeing or inspecting a portable cot at Ms X's home.

Evidence of Moorooka Family Day Care officers

151. Abdulkadir Warsame provided a statement to the Morningside CPIU. He was married to Amina Elmi who started the MFDC scheme in 2010. He was the Chief Financial Officer. Amina's brother Mohamed Elmi helped out in the business as an assistant financial officer.

152. He stated he knows a person by the name of Florence Roberts who was employed as a coordinator for the scheme. Mr Warsame stated Ms Roberts started with the business around 2013 and left employment when the business was suspended. She did not come back when the business started up again. Mr Warsame corrected this evidence at inquest, saying he looked back at MFDC records and these confirmed Ms Roberts left employment with MFDC around October 2014.

153. Mr Warsame stated he did not recall that Ms Roberts was later employed by his RTO company to train in child care, as Ms Roberts suggested in her evidence.

154. He states the scheme was suspended around 20 November 2015. Amina continued to work to get the license back. He focused on another business he was running.

155. He stated he had no involvement with the assessment of any educators and does not recall having any contact with the carers.

156. He states he heard of the death of Lucas, probably through Mohamed and later through uniformed police.

157. The next day officers from the Department attended and he was present when they had a conversation with Amina.

158. Amina Elmi said she had been a Director of MFDC since its registration on 13 January 2010 and a sole Director since 10 July 2016. She has at all times had the

day to day running of the business. Both her husband Abdulkadir Warsame and brother Mohamed Elmi retired as directors on 10 July 2016.

159. She states she had no personal involvement in Ms X becoming engaged as an educator. The company's usual process is that a coordinator is responsible for engaging new educators.

160. According to the records Florence Roberts conducted an initial home safety assessment of Ms X's home on 3 July 2014. Ms Elmi says she was not present. Florence also conducted an induction process for which she was also not present. Ms Elmi had not personally visited Ms X's premises until after Lucas's death.

161. Safety checks are to be conducted annually. A safety check conducted in 2015 document was unable to be produced by MFDC to the Department, although one was located in records and was produced with Ms Elmi's statement. Ms X was also asked if the annual safety check could be produced but was unable to do so. The home safety check appears to have been conducted by Ms Roberts on 3 July 2015.

162. Ms Elmi believes an *Educators Handbook w*ould have been provided. The Handbook refers to the Sleep, Rest, Relaxation and Clothing Policy but also appears in the MFDC Policies and Procedures Manual. She has been unable to locate the version that existed in July 2014. Changes were made in February and October 2017 to comply with changes to the national regulations regarding safe sleeping practice.

163. Ms Elmi stated the changes include specific reference in the induction process to include SIDS.

164. An educator's agreement was signed on 3 July 2014 and Ms X would have begun providing care soon afterwards.

165. A further educators' agreement was signed on 4 July 2015 after Florence Roberts conducted a second home safety audit on 3 July 2015.

166. Ms Elmi said the company policy was for coordinators to conduct home visits on each educator's premises at least once every three months, but preferably, every month. She receives all home monitoring reports and her usual process is to review each and sign them. She is unable to explain why some of the reports have not been signed by her. In her evidence it was put to her there were a number of such discrepancies and it is evident her monitoring of such reviews was not as consistent as she may have made out.

167. Ms Elmi does not recall any significant problems being identified with respect to Ms X's premises or with respect to Ms X generally. She also has meetings approximately monthly with coordinators to discuss any issues. She has been unable to locate minutes from all meetings conducted during 2014/2015. She does not recall any specific issues being raised with respect to Ms X's premises during these meetings.

Investigation by the Department of Education

168. Catherine O'Malley is the Executive Director, Regulation Assessment and Service Quality, Early Childhood and Community Engagement for the Department. The day care facility in Ms X's home in Moorooka was operated through MFDC. In her statement she advised MFDC was first licensed to operate under the *Child Care Act 2002* on 6 September 2010. Service approval to operate under the National Quality Framework (NQF) was given on 28 November 2011 in preparation for the commencement of the NQF on 1 January 2012. MFDC had 24 educators and approximately 141 children enrolled as at 12 November 2018.

169. The Department regulates approved early childhood education and care including family day care under the *National Quality Framework National Law.* Family day care services apply to the state they are located in for approval. The Department assesses the capacity of an Approved Provider to deliver a service. Each Approved Family Day Care Service coordinates and supports a number of individual Family Day Care educators operating from their own homes. Each service is responsible for assessing the capacity of individual educators to provide family day care in their homes. There are a range of physical requirements for family day care homes to ensure the health safety and wellbeing of children.

170. Family Day Care Services are assessed against regulatory requirements and all seven quality areas of the *National Quality Framework* including educational programming, health and safety, hygiene practices, physical standards, staffing qualifications and ratio requirements. Each educator can provide for up to 7 children, with no more than 4 children below school age. The Department visits individual Family Day Care educators on a risk-based regulatory model including in response to complaints and other risk factors. Individual Family Day Care Homes are also randomly selected for assessment against the quality standards. Family Day Care services are subsidised by the Australian Government under the Child Care Benefit and Child Care Rebate.

171. As a result of Lucas' death, the Department commenced an investigation into MFDC and Ms X as the educator and conducted an inspection of the home on 19 November 2015. The Director, Early Childhood Education and Care for the Metropolitan Region, Susan Diane Todhunter was one of the attendees along with two Authorised Officers under the National Law namely Louise Ewin and Steven Rogers. Ms Todhunter attended as support given the serious nature of the incident. The visit was digitally recorded by one of those officers. They attended at the home of Ms X first but there was no one there and they later returned to the home after having gone to MFDC.

172. At MFDC, Ms Todhunter's statement refers to speaking to Director Ms Amina Elmi and Assistant Director Mr Bill Armitage. The transcription of the interview refers to a person Bill Armitage. It has now become apparent there was no one known by the name of Bill Armitage and any reference to him relates to Abdulkadir Warsame.

Ms Todhunter has explained in a supplementary statement she relied on the transcription provided by a transcription service in preparing her statement. On listening to the recording she agrees that a person introduced himself as Abdul, assistant director, and there were only two representatives of MFDC present that day and involved in the interview.

173. After this visit the three Departmental officers attended the home of Ms X and Mr Y.

174. During this visit, Departmental officers observed the following alleged breaches of the National Law:

- Information required to be displayed such as fire evacuation plans not being displayed correctly or at all;
- Prescribed records not kept;
- Enrolment forms for their previous scheme of the Wesley Mission were produced and attendance records not comprehensive;
- Breaches in relation to the service's education program including no documentation or signs of educational programs or assessments;
- No medication records produced;
- Laws and regulations not kept available; and
- Services policies and procedures not kept available.

175. The investigators also listed a number of alleged breaches in relation to the physical environment:

<u>Physical environment</u>

- Floors were littered with rubbish and had not been vacuumed or mopped
- Mould evident throughout particularly on the kitchen door and ceiling of the room where the younger children slept
- Main living area cluttered with personal documents, books videos, toys equipment, containers and boxes
- The front door did not have safety glass and a Perspex sheet had been placed in front to prevent breakage
- Equipment was stored inappropriately, was not secured and was at a height that posed a hazard to the safety of children
- Unencumbered space for babies and toddlers to crawl and explore was inadequate
- Perimeter fence in disrepair
- Furniture, materials and equipment including limited equipment for children under the age of two
- Laundry and hygiene facilities were not identified during the visit

<u>Inadequate toilet and hygiene</u>

- No step for children to access sink to wash their hands;
- Nappies changed on a mat on the floor
- Latex gloves accessible to children

<u>Ventilation and natural light</u>

- All windows shut with little to no ventilation. Resources and items packed up against windows prevented them being opened

- Temperature in house uncomfortably hot even with an air-conditioner being apparently on

176. It should be noted that ultimately the decision by the Department in respect to the re-issuing of the home day care licence to MFDC was based on a conclusion that only the issue of mould found at the house could be relied upon in so far as the physical environment. This in part appears to have been due to a difficulty for the Department where Police are involved in the investigation the Department had an internal protocol that they may go in and look at the particular service and see if there has been any non-compliance with the National Law and regulations but understandably they would not investigate the actual death. The problem for the Department is they considered the protocol prevented their presence at the scene on the day of death and therefore they could not independently consider the physical environment on that day. The experience of the Department was they would need to obtain that information from the police but were not able to do so because the police stated it was a coronial matter and was a matter for the coroner. Departmental officers were not aware that they could have obtained the consent of the coroner to receive that information.

177. It must be said that even the issue concerning the existence of mould may not have been open for the Department to rely on, as although photographs show stains on the ceiling that look like mould, no investigation was carried out to identify what was in fact on the ceiling and therefore one could not exclude the evidence of Ms X and Mr Y that there had been mould in the past but it had been cleaned and what was left was a stain that could only be removed by painting over it.

178. It is evident from the interview with Departmental officers that Ms X was unsure of what was being asked of her in relation to the production of service policies and procedures and legislation. Ms X stated she had attended some training including that of child protection, food safety and on documentation. She was unable to produce MFDC manuals and procedures and referred to her previous provider in Wesley Mission on the basis she already knew what to do from that service.

179. Ms X and Mr Y told the investigators they change nappies on the floor rather than a changing table. It is evident the children were only cared for inside the dwelling as the outside of the house was considered unsuitable for children to play. Any outside outings were technically available but it is clear they did not arrange for any such outings.

180. The carers allegedly had a baby monitor for the sleeping area for babies but agreed it was not operating on the day in question. The carers stated the babies' sleeping area where Lucas was said to have been sleeping would usually be closed because the other children would be playing and music would be playing. Ms X was asked how often she checked on any sleeping babies and she replied every 20 to 30 minutes. These observations were not documented anywhere. The carers stated their previous contract with Wesley Mission provided for a log of observations but it was not a document they used with MFDC.

181. Ms X was asked about Lucas' sleeping arrangements and she reportedly advised that normally they swaddle Lucas because of the way he would sleep at home. She said that it was too hot that day for him to be swaddled. The Departmental officers inspected the porta-cot but could not determine if it met the Australian Standards. Ms X and Mr Y could not recall where the porta-cot had been bought from but it would appear from Departmental photos it had been imported by Target. Ms X stated on the day in question a towel instead of a sheet was placed in the porta-cot.

182. Ms X and Mr Y stated that Lucas sleeps in the porta-cot in their son's bedroom. The inspection of this bedroom noted it was a small room that was extremely hot on the day the investigators were present. There was a ceiling fan and air conditioner installed but was not turned on that day. The investigators recorded mould was evident in numerous places on the ceiling. There was one single bed as well as a single child-sized blue mattress on the floor with a doona and pillow without covers. Ms X stated she had been sleeping on this mattress at night as her son had been very sick with the lots of coughing and a very bad chest.

183. Ms X advised the other children sleep on mattresses placed around the living room.

184. Ms X advised that during the day she had up to four children in care during the day and there could be three to four children at night. The morning care started at around 6.30am and the last child leaves at 10.00pm to 11.00pm. She said she had a little break between children in the afternoon.

185. The Department also carried out inspections of 10 other educators approved by MFDC and identified multiple alleged breaches. In accordance with s 73 of the National Law, the Department determined to immediately suspend MFDC's approval effective 20 November 2015 as they were satisfied that the health, safety and wellbeing of children in care at the service were at immediate risk.

186. In January 2016 and May 2016, the Department contacted Ms X to ask whether she was providing education and care to children. On both occasions, Ms X confirmed that she was not providing care and did not intend to provide care as part of an education and care service again.

187. On 17 May 2016, the Department sent MFDC a show cause notice to amend their service approval. The proposed amendments were that the service operates with a maximum of 30 educators, employs one coordinator for every 10 educators and provides a copy of the assessment of potential educators' homes to the Department.

188. On 15 June 2016, the Department sent MFDC the decision in relation to the proposed amendments to the service approval. The decision was made to place the proposed conditions on their service approval. The amendments to the service approval require MFDC to operate the service with a maximum of 30 educators, employ one co-ordinator for every 10 educators and provide a copy of the

assessments of potential educators' homes to the Department prior to engaging the educator. The amendments took effect on 20 June 2016.

189. As at 17 June 2016 the service was operating with two educators. The Department conducted monitoring visits at both of the educators' homes and a visit also took place at the scheme office on 15 and 16 June 2016, respectively.

190. According to Ms O'Malley, MDFC underwent an assessment and rating and on 12 October 2017 it was rated as *"Working Towards"* National Quality Standard overall. Under these seven quality area standards MDFC was assessed as working towards the standard on four categories and meeting the National standard on three. Of interest the quality areas which related specifically to educational program and practice, children's health and safety, physical environment and relationships with children were all at the rating of "working towards the standard". It was only in the quality areas of staffing arrangements, collaborative partnerships with families and community and leadership and service management that it was considered as meeting the National Quality Standard.

191. Ms O'Malley explained in her evidence the seven quality area standards were aspirational and she had no concerns about the fact they were still working towards the standard in a number of areas.

Conclusions on the issues

192. In reaching my conclusions it should be kept in mind the *Coroners Act 2003* provides that a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something. 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 with a view to reducing the likelihood of similar deaths.

193. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw*[3] sliding scale is applicable. This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.

194. With respect to the *Briginshaw* sliding scale it has been held that it 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.

[3] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361;

195. When determining the significance and interpretation of the evidence the impact of hindsight bias and affected bias must also be considered. That is, after an event has occurred there is an inclination to see the event as predictable, particularly where the outcome is serious, despite there being few objective facts to support its prediction.

Cause of Death and circumstances of how the death occurred

196. The above issues are explored together as unsurprisingly they are in many respects interrelated.

197. There were three submissions as to what I should find as the cause of death.

198. Counsel for the family submitted I should find the cause of death was due to mechanical asphyxia either due to aspiration and/or suffocation from loose bedding or a poorly erected cot.

199. Counsel for Ms X and Mr Y submitted the cause of death should be Sudden Infant Death Syndrome simpliciter.

200. Counsel Assisting submitted I should rely on the evidence of Dr Forde and find the cause of death was SIDS Category II indicating a degree of mechanical asphyxia cannot be determined with certainty. As Dr Forde stated, where a SIDS death involves an unsafe sleep surface this may give rise to the possibility of mechanical asphyxia, bringing the death within the Category II definition.

201. This then leads into a consideration of the other possible inferences as to other causes of death and generally as it relates to the sleeping surface on which Lucas was placed and found.

202. I agree with the submissions of Counsel Assisting that one cannot rely on the statement made by Master Z to police that Lucas was being fed by his mother and he choked and vomited. Master Z's age at the time and other statements subsequently made by him to police that he was not a witness to his mother feeding Lucas are factors supporting such a conclusion. The evidence points to the fact that Master Z was most likely with his father downstairs at the time. There is otherwise no evidence to suggest Ms X was feeding Lucas at the time and is consistent with her denial.

203. As to the suggestion that Lucas had been placed in a baby rocking chair to sleep at the time of his death, I agree with the submissions of Counsel Assisting that although that was an inference available due to the evidence of Master Z's statements to police; the fact a baby rocking chair was present in circumstances suggesting it was being cleaned perhaps after vomit was found on it; and the partially erected porta cot perhaps indicative of it not being in use. However, there is other evidence that negates this inference even without taking into consideration the denials of Ms X and Mr Y.

204. Ms Crowley observed a synthetic bag on the mattress in the cot. SOC officer Lonsdale says that he also saw a bag in the cot, which he assumed to be a carry bag for the porta cot and that the sides were collapsed. After his death

and before the arrival of his parents at the home, Lucas' body was placed on top of this bag in the cot.

205. It is not clear at what point in time the bag was placed inside the cot, if Ms X's evidence that it was not inside the cot when Lucas was placed there to sleep is accepted. It is possible police or QAS officers placed the bag in the cot for some reason, although there is no evidence to suggest this. However, another inference available on the evidence is that Lucas was not found unresponsive in the cot and it was erected hurriedly in an attempt to contrive a scene to conceal the true nature of where he had been sleeping.

206. I find it is more probable Lucas was placed in the porta cot to sleep by Ms X. I also find at the time the cot was only partially erected and in a condition as reflected in the photographs taken by SOC officers. The evidence in favour of such an inference is:

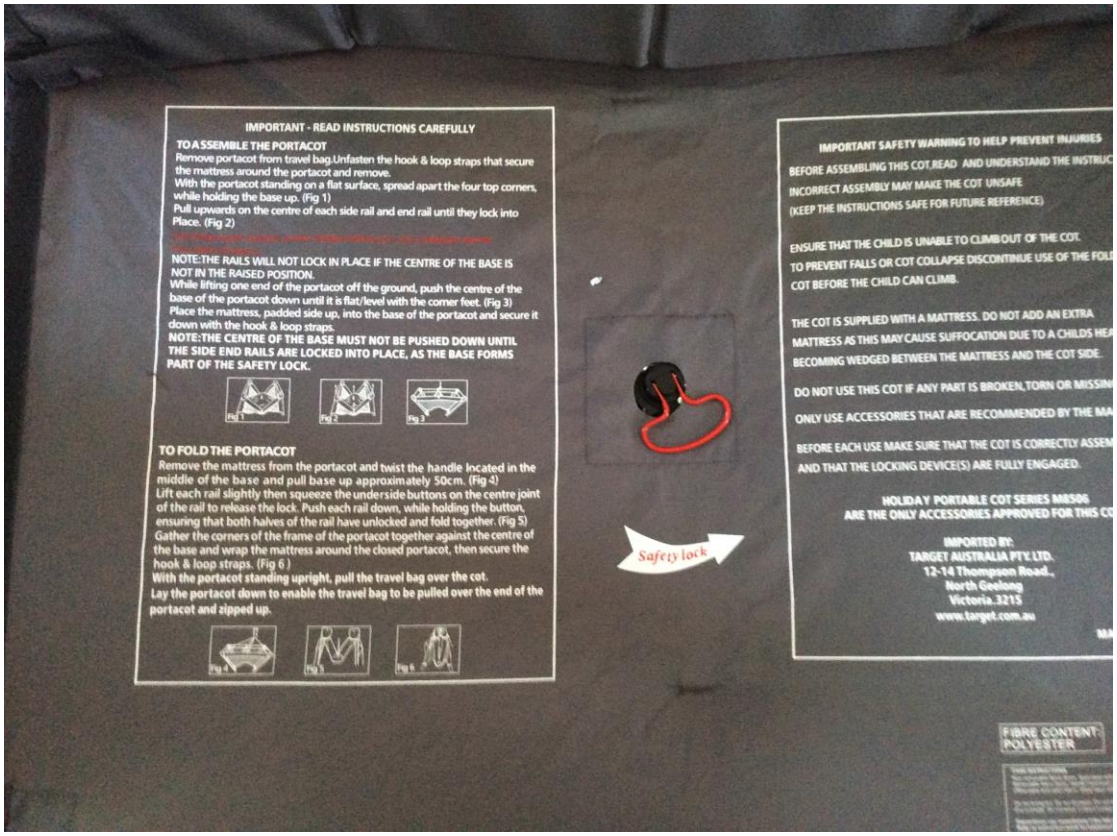
- Mr Y's evidence at inquest that it was his wife's usual practice to keep the rails unlocked and lowered so she could reach into the cot more easily due to her short stature;

- The fact that this was the state of the cot when found by QAS and police later;

- Accepting the evidence is not absolutely conclusive about the precise locking and unlocking mechanism (it having not been specifically examined by police during the investigation), there is evidence available from various sources including the photographs of the cot assembly and disassembly instructions set out in large print on the base of the cot. This suggests a need to remove the mattress, twist a handle on the base and pull the base up, to then enable the rails to be unlocked;

- The instructions further state the base forms part of the safety lock, and must not be pushed down until the rails are locked into place;

- Therefore, I do not accept the evidence of Ms X to the effect the side rails can be unlocked even with the centre of the base fully pushed down and locked.



207. The only evidence to support an assertion the porta cot was fully erected is from the evidence of Ms X and one has to say there are many aspects of her evidence and that of Mr Y generally that are highly problematic. For instance, they both gave similar explanations for not informing the police or other emergency workers (after a number of hours and after being given a number of opportunities) of the presence of two other below-school-age children in other rooms. That this was explained as being on the basis they thought police were simply asking about children allegedly under the care of Ms X only simply defies belief.

208. Mr Y in particular was asked about the two other children specifically as Master Z had named them as being present that morning and his answer was: *"They were other kids but they come here on and off".*

Mr Y was then asked when A and M were last present, to which he replied:

"They left yesterday in the afternoon".

That statement is demonstrably false.

209. On the issue of the towel that was allegedly placed on the mattress instead of a sheet, I do not accept it was placed by Ms X over the mattress and tucked into each end to secure it. The issue is not so much the content of the material (towel or cotton sheet) as such but whether it was secured. QAS officer Ms Cowley was adamant there was no linen in the cot when she brought Lucas into room. She could not recall where she got the towel from but it was not in the cot.

210. One also has to take into consideration Ms X's own statement to police that day that the towel was partially under and partially over Lucas in the cot. It was submitted that I should be careful with accepting this statement at face value because for Ms X English was a second language, but I have no such difficulty. I heard her give evidence and I did not find a language barrier as an issue. Her response to police was fairly specific and was developed over answers to a number of questions and not an isolated statement addressing one question.

211. A third issue of relevance to the physical environment relates to the temperature of the house and bedroom in question. The relevance is due to the fact that the research on SIDS and as noted by Dr Forde is that overheating may increase the risk of SIDS. In this case there is considerable evidence to support a finding the inside temperature of the home was at least warm and there did not appear to be any air conditioning, fans or ventilation in operation. Constable Rodgers noted that it was extremely hot with no windows open or fans on. Dr Forde stated the room Lucas was placed in was quite warm and understood from police that they had turned some fans on or opens windows in the house and according to them was a bit cooler by the time she got there. Ms X herself told Departmental officials it was hot that day, hence Lucas not wearing a top.

212. There is also the issue of the level of supervision and in particular the monitoring of Lucas when he was asleep. Ms X's evidence was that she would check Lucas every 20 minutes. In her interview she states that she put him down between 8.50am and 9.10am and that when she checked on him twenty minutes later, he was face down and non-responsive. Presumably, this would have been between 9.10am and 9.30am. Her evidence throughout the interview about how many times she checked on him was however confusing. In the police report it states she had checked on him twenty minutes later and found him to be sleeping and then there was a further check another twenty minutes later. The more probable explanation is Ms X did conduct a second check as indicated by the police report (presumably between 9.30am and 9.50am) but this leaves a period as conceded by Ms X of 30 minutes when he was not directly monitored.

213. The MFDC policy (of which Ms X appears to not be aware of) is that sleeping children should be checked every 10 minutes and that the sleeping child should be in a cot in clear sight.

214. During her interview with Departmental officers the following day, Ms X confirmed that the door would normally be closed because the kids play outside and that there would always be music. She also again stated that she would check on babies every 20-30 minutes. Ms X was clearly in breach of the MFDC policy.

215. As well there is the issue of the number of children Ms X was caring for on the day in question and if it included the other two below-school-age children that

were subsequently found in other rooms hidden away. I do not accept either of Ms X and Mr Y's denials that the children had been placed there by one or the other of them. Even if one accepts that Mr Y was notionally the person allocated to care for these two children, it is evident that at the time Lucas passed away Mr Y was downstairs with his son for at least a 20 minute period leaving Ms X with the responsibility of looking after six children under school age. It cannot be without coincidence that on Ms X's version she was waylaid for an extra 10 minutes at this time. The issue exceeding the permitted number of children in their care, and allegedly hiding children prior to police arrival was considered by Dr Forde who advised that this does not necessarily impact on the cause of death. I accept this is the case but the limitation of the number of children a family day carer has to educate and supervise has been put in place for a reason, and the number of children being supervised by Ms X at the point in time when Lucas was not monitored for a 30 minute period is just another factor to be considered.

216. Where this gets to in having an understanding of the circumstances of the death and how it related to the cause of death is of course not something that can be stated with any certainty due to the very nature of SIDS. As stated earlier the nature of making a finding of SIDS, being a finding of exclusion, means that no one specific contributing factor can be identified. However, the extensive epidemiological studies conducted over many years has identified varying risk factors, and in this case some of the factors raised included that of safe sleeping practices, sleep environment and supervision.

217. As a result, Red Nose recommendations, the Guidelines adopted in the Australian Children's Education and Care Quality Authority's Guide to the Education and Care Services, and MFDC policies addressed certain issues concerning safe sleeping practices, environment and supervision. They were adopted for obvious reasons to reduce the risks. It does have to be recognised that even with all those risk factors removed Lucas' death could still have occurred.

218. In respect to safe sleeping practices it is arguable a partially erected porta cot is by no means an optimal sleeping environment. The cot appears to comply with Australian standards but it is self-evident that if it is not completely erected then it does not comply with the standard. The instructions seem quite clear about this.

219. The fact I have found Lucas was partially covered in a towel and it seems likely there was no covering sheet on the mattress is but another factor raised about the adequacy of the sleeping environment.

220. It is also evident the conditions that day were at least warm and there was no observable cooling and ventilation was limited. The MDFC policy manual stated carers should monitor the temperature of the rest environment to ensure it is comfortable without becoming too hot or cold.

221. In relation to supervision the Australian Children's Education and Care Quality Authority's Guide to the Education and Care Services states that sleeping children should always be within sight and hearing distance so that educators can assess the child's breathing and colour of their skin to ensure their safety and wellbeing. Although a specific time for monitoring is not stipulated in the National Laws the MDFC policy provides that carers should regularly monitor all children who are sleeping with specific attention to breathing patterns, and monitor all babies every 10 minutes.

222. There is some question about how optimal the induction Ms X was provided when she commenced with MFDC was, or if she had ever read or absorbed the detail of the policy, but clearly she had the view that sleeping a child in a closed room with limited ventilation on a warm day and checking every 20 minutes was appropriate. On this occasion she left Lucas unobserved for at least 30 minutes.

223. It is not possible to say that any of the risk factors raised here and which were present were directly causal to Lucas' death, as that is the nature of a SIDS diagnosis. What can be said is recommendations as to sleeping environment and supervision to reduce risk factors thought to have some connection to SIDS have been developed over many years for a reason and these polices were not applied in the tragic circumstances of Lucas' death.

Findings required by s. 45

Identity of the deceased – Lucas Tran

How he died – On 18 November 2015 Lucas was being cared for by a Family Day Care Educator in her home. At some point in the morning he was put down to sleep. The sleeping environment included a partially erected porta cot, a loose towel covering him with no bed sheet, the door to the room was closed and there was limited ventilation on what was described as a warm day. There was at least a 30 minute period in which Lucas was not directly observed by his carer. When next observed he was unresponsive and despite CPR by his carer and QAS was unable to be revived. An autopsy examination found no pathology to explain death and the forensic pathologist came to an opinion the cause of death was Sudden Infant Death Syndrome Category II meaning that a degree of mechanical asphyxia cannot be determined with certainty. SIDS being a finding of

	exclusion, means that no one specific contributing factor can be identified. However, the extensive epidemiological studies conducted over many years has identified varying risk factors, and in this case some of the factors raised included that of safe sleeping practices, physical environment and supervision.
Place of death –	7 Wallace Street MOOROOKA QLD 4105 AUSTRALIA
Date of death–	18 November 2015
Cause of death –	1(a) Sudden infant death syndrome (SIDS) Category II

Comments and recommendations

224. The evidence of Ms O'Malley brought up a number of issues that could be the subject of comment and recommendations.

225. Firstly, Ms O'Malley brought up an issue concerning the exchange of information from police during its investigation to the Department which could be relevant to decision-making of the Department. This issue was only first raised in her evidence so QPS have not been heard about the issue. On that basis I will be recommending that QPS and the Department consider implementing a Memorandum of Understanding or some other protocol regarding the sharing of information that may be relevant to each of their separate investigatory responsibilities. This is not limited to SIDS death but could encompass all investigations jointly involving Education and Police including consideration as to the extent of not only information sharing but also joint involvement in investigative strategies. For instance it may have been helpful for Departmental investigators to have been able to attend the scene on the day Lucas died to gather evidence relevant to their regulatory obligations.

226. Secondly, the issue concerning Family Day Care Educators still being able to provide day care services even though they do not have a Certificate III in Children's Services and only having to show that they are actively working towards that qualification. The evidence supports a conclusion that in this instance the Family Day Care Educator was not actively working towards her Certificate III and may not have for some time or at least the evidence of progress was most unclear.

227. This issue is important because from the evidence of Ms X it is uncertain the extent to which she was aware of the up-to-date recommendations concerning SIDS risk factors and in particular monitoring of supervision times. Given it seems any induction by MFDC does not seem to have improved her awareness, having received training in the form of a Certificate III course may well have provided that awareness. If we are going to be serious about caring for children and infants, the least that should be expected is Family Day Care Educators have the basic training from a course such as a Certificate III.

228. I can understand why that regulation allowing Family Day Care Educators further time to obtain a Certificate III was necessary when the National Law commenced in 2012 but now that has been in place for some years, Ms O'Malley agrees that it should be prescribed in legislation that at this point in time Family Day Care Educators should hold a Certificate III before they commence caring for children in such a setting. Ms O'Malley pointed out that in South Australia there is a specific regulation to that effect. Whilst Queensland could also adopt a Queensland specific regulation to that effect Ms O'Malley stated there should also be consideration as to whether nationally that should also apply.

229. With respect to whom such recommendations should be made she referred to the Australian Children's Education Quality Authority.

230. Submissions made by the Department noted that any changes to the National Law and the National Regulations require consultation and Ministerial Council approval. It was also noted a review of the National Quality Framework has recently begun and a discussion paper is currently being formulated. It was submitted that the appropriate approach was to refer the matters directly into the Ministerial Council for its consideration. I propose such a course.

231. Thirdly, I consider there is some value in making a specific recommendation about ensuring information about safe sleeping practices/SIDS and complaints mechanisms is given to parents, rather than just being described in a policy that is tucked away in an approved provider's/educator's induction materials and may never be seen by a parent.

232. If Lucas' parents were given really detailed information about safe sleeping and how important safe sleep surfaces are, they may have been more alert to how Ms X was using the porta cot (that is, in a partially erect fashion) and taken some action to ensure Ms X was using it more

safely. There is still a question of course as to whether that would have made any difference but it was a risk factor that was present for Lucas when he died.

233. Regarding complaints mechanisms, on Ms O'Malley's evidence it is clear this is one way the regulator becomes aware of which Family Day Care Educators they need to more actively monitor, that is, when parents raise safety concerns. Parents naturally have a much greater vested interest in the safety of their children and are more likely to alert the regulator to those issues, if and when they observe any safety concerns relating to their child's time spent at a Family Day Care Educator's home.

234. I make the following recommendations:

1. That QPS and the Department consider implementing a Memorandum of Understanding or some other protocol regarding the sharing of information that may be relevant to each of their separate investigatory responsibilities, for incidents that arise within a child care environment.

2. That the Ministerial Council and the Australian Children's Education Quality Authority consider changes to the National Law and the National Regulations to require all Family Day Care Educators to hold a Certificate III in Children's Services before they commence caring for children.

3. That the Ministerial Council and the Australian Children's Education Quality Authority consider changes to the National Law and the National Regulations to require information about safe sleeping practices/SIDS and complaints mechanisms be given to parents of children who attend Family Day Care.

I close the inquest.

John Lock
Deputy State Coroner
BRISBANE
17 April 2019