QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Indianna Rose Hicks**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2012/2569
DELIVERED ON:	12 December 2014
DELIVERED AT:	Brisbane
HEARING DATE(s):	2 September 2014, 1-2 December 2014
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, SIDS, child day care, policy and procedures for safe sleeping

REPRESENTATION:

Counsel Assisting:	Miss E Cooper, Office of State Coroner
Counsel for Department of Education, Training & Employment:	Mr B McMillan I/B Crown Law
Counsel for Centacare:	Mr M Burns I/B Minter Ellison
Counsel for Mrs Emma Hicks and Mr Derek Hicks:	Mr C Gnech, Robert Faith Lawyers
Counsel for Mrs T Cross:	Mr S Zillman I/B Gilshenan & Luton

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Introduction

1. Indianna Hicks was 5 months old when she died suddenly and unexpectedly on 20 July 2012. At the time of her death, she was in the care of a family day care facility at the Sunshine Coast. Tracey Cross was her day carer. Mrs Cross resided and cared for children at her home at Little Mountain, Caloundra.

2. Sometime between 2:30 and 2:45 pm, Mrs Cross went to get Indianna up from her afternoon sleep. Mrs Cross noticed that Indianna was lying face down and her skin was pale. Resuscitation efforts were futile. An autopsy examination concluded the death came within the category of Sudden Infant Death Syndrome (SIDS).

Sudden Infant Death Syndrome (SIDS)

3. SIDS is defined as the sudden and unexpected death of an infant under one year 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.

4. 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.

5. In relation to Environmental factors the studies strongly suggest that inappropriate sleeping arrangements increase the risks of SIDS. The constant message disseminated by public health sources in relation to safe sleeping practices, includes putting the baby on the back to sleep from birth and to sleep with the face uncovered. A number of other environmental factors, which are not found in this case, can also be relevant.

6. SIDS has been a formal diagnostic entity for over 25 years. The term 'sudden unexpected death in infancy' is a general term that covers not only SIDS but also other types of unexpected infant deaths. Various categories of SIDS and SUDI have been adopted in an attempt to improve the specificity of diagnosis and to facilitate more comprehensive investigations and categorisation of cases of an unexpected infant death. It is the view of many that terms such as 'undetermined' or 'unascertained' are plagued with non-specificity, which the new definitions have attempted to avoid.[1]

7. The evidence from the investigations did not immediately suggest there were any unsafe practices or environment. The cot in this case complied with Australian Standards, and there was nothing else in the cot aside from Indianna, who was wrapped in a bunny rug in accordance with Mrs Hicks' instructions. The most likely situation is that Indianna has managed to roll herself over onto her stomach, thus placing her in a dangerous position for sleeping, however it cannot be determined conclusively that

[1] Krous HF, Byard RW. Controversies in Pediatric Forensic Pathology. Forensic Science, Medicine, and Pathology 2005, 1:1:9 at page 12

this was the main causal factor. Further investigations were then completed and the evidence reviewed. Professor Jeanine Young also provided a report regarding SIDS and SIDS prevention relevant to the provision of day care services and Best Practice.

Issues for the Inquest

8. Indianna's parents have expressed a number of concerns about how Indianna died. They lodged a complaint with both Centacare and the Department of Education, Training and Employment (DETE). Subsequently they requested an inquest be held.

9. Centacare was the Approved Provider of the day care scheme under which Mrs Cross operated. The Sunshine Coast Family Day Care Scheme (SCFDCS) was the service provider. Tracey Cross was the day carer and operated directly with SCFDCS and was subject to its policies and procedures. The Department of Education, Training and Employment (DETE) is the Queensland State Government department responsible for regulating the day care industry. It became evident during the investigation that at the time of Indianna's death in July 2012 there was a transition between the previous state based regulatory regime for day care providers to one uniformly adopted from 1 January 2012 under a National Law framework.

10. Given there were a number of issues raised about the circumstances of Indianna's death, a decision was made to hold an inquest. The issues for the inquest were determined at a Pre-Inquest Conference as follows:

    a. The findings required by section 45(2) of the *Coroners Act 2003*
    b. Investigate the circumstances leading up to the death;
    c. Examine 'best sleep practices' with respect to infants in the age group of 3 – 6 months; and
    d. Consider if there are ways to prevent a similar death from occurring in the future.

The events of 20 July 2012

11. Indianna's mother, Emma Hicks, dropped Indianna and her older toddler brother Lachlan, aged 3 off to Mrs Cross' house at about 9:30am on 20 July 2012. Mrs Cross was also caring for another toddler that day. Mrs Cross had previously looked after Lachlan in a formal day care arrangement and had looked after Indianna informally on a few occasions but this was the first day of formal day care for Indianna. There had never been any issues before.

12. On the day of Indianna's death, Mrs Cross had been informed by Mrs Hicks that Indianna had been suffering from a cold/virus but was otherwise well. Indianna was also teething.

13. Mrs Hicks provided a statement to the police confirming that Indianna did have a virus, or a cold of some sort in the lead up to her death. She had taken Indianna to the GP for a check up on 17 July 2012. Dr Amir Akram's assessment at that time was that Indianna was suffering from a common cold or viral upper respiratory tract infection. Test results confirmed the presence of Rhinovirus, the predominant cause of the common cold. In all other respects Indianna was well and was meeting

her developmental stages and had received the recommended immunisations.

14. Mrs Hicks provided Mrs Cross with a pre-prepared bottle of formula, which was to be given to Indianna at about lunch time. As she was teething, Mrs Hick had Indianna wearing an amber teething necklace. The evidence is that Indianna had developed to the stage where since 3 months, she was able to turn from her back to her tummy but was not able to return to her back. Mrs Cross was aware of this.

15. Mrs Hicks adopted a form of wrapping/swaddling of Indianna such that the whole of her body including her arms were tightly held in. Wrapping is considered a useful method to help babies settle and sleep on their back.[2] Mrs Cross was aware of this preference and Mrs Hicks had shown her how Indianna should be wrapped as she would not settle.

16. It is evident Mrs Hicks and Mrs Cross were aware of the importance of babies being placed on their back to sleep. Mrs Cross had been supplied with the SIDS and Kids Safe Sleeping booklet and was aware of the importance such as no toys and other items being placed in the bed, adequate ventilation and infants being placed on their back.

17. Mrs Hicks was unaware of the recommendation of SIDS and Kids and other paediatric authorities that you need to consider the baby's stage of development and the arms should be left free once the startle reflex disappears around 3 months, or when the baby is able to roll from their back to their tummy, given that the wrap may prevent an older baby from returning to the back sleeping position. Mrs Cross said she was aware of this matter but took the view that the parent knows the child best and she would follow what the parents said. Mrs Cross stated she would take the same attitude in relation to teething necklaces, although she is aware some carers do not allow them.

18. Mrs Cross says Indianna consumed the entire bottle when she was fed at lunchtime and did not display any concerning behaviours or conditions prior to or after the lunch time feed. She had her nappy changed and was wrapped and burped before being put down for her routine sleep at about 1pm. She was placed in a travel cot, which was located in a room directly adjacent to the family/kitchen area.

19. There was no other sheeting in the cot other than the clothes Indianna was in, and the bunny rug she was wrapped in. Indianna was wearing a nappy, leggings, singlet, a pair of socks and a top. She was also wearing a teething necklace and had a dummy in her mouth. There was adequate ventilation in the room as the main bedroom door was open and the side double doors were open a little bit.

20. After about 10 minutes Mrs Cross heard Indianna crying so she went and checked on her. Indianna had spat out her dummy. Mrs Cross put the dummy back in and then left the room. This happened another two times. On the fourth occasion that Mrs Cross checked on Indianna, she noticed that Indianna had wriggled out of her bunny rug. Mrs Cross wrapped her back up and made sure she was placed on her back to continue sleeping.

[2] Sids and kids website

21. Indianna was placed on her back to sleep. Mrs Cross says she checked on her a number of times over the next 90 or so minutes. On each occasion Indianna was still lying on her back. Mrs Cross stated that she could see the cot from the playroom and in addition to the four occasions that she specifically recalls attending to Indianna, she would have also walked out a few times and past her and she seemed to be having a good sleep and was on her back.

22. Mrs Cross said that whilst the children were asleep she also attended to cleaning up the playroom, washing up the children's lunch containers, refilling water bottles, taking nappies to the rubbish bins and having her own lunch. Whilst Mrs Cross was doing all of these things she was constantly walking past Indianna's room and would check on her.

23. At some time around 2:30pm Mrs Cross began preparations for starting the school run to pick up the other children. She placed the two toddlers in the motor vehicle. She states that she would have walked past Indianna in this process. She stated that she would have had a fleeting glance at Indianna. In her evidence she stated that she was guessing that Indianna was by this time on her tummy, but she does not recall that now and does not recall noticing this was the case. It has to be said that my impression of Mrs Cross's evidence at this point appeared to be have been made with hindsight and a possible reconstruction of the events in her mind.

24. Sometime between 2:30 and 2:45pm, Mrs Cross went to get Indianna up from her sleep as she was starting the school run to pick up the other children. Mrs Cross noticed that Indianna was lying face down and her skin was pale. Mrs Cross picked her up and noticed she was limp. Her eyes were a dark colour and there was a small reddish mark on the right side of her face, which looked like where she had been lying.

25. Mrs Cross noticed froth and mucus in Indianna's nose and mouth area. Mrs Cross cleared this and began CPR. She called Queensland Ambulance Services (QAS) at 2:52pm and they arrived at 3:01pm.

26. QAS took Indianna to the Caloundra Hospital. At no point did Indianna respond to the attempts to resuscitate her and she was pronounced deceased at the hospital. It is apparent that the other two children remained in the motor vehicle during these events and did not see anything.

27. Mrs Hicks was not contacted during this emergency period. She arrived at the residence at about 3:40pm to pick up her children to find Mrs Cross on the floor of the living room visibly upset. It was at this stage that Mrs Cross informed Mrs Hicks that there had been an incident involving Indianna and she had been taken to hospital. I will refer to this later as it is an issue that understandably compounded the grief experienced by the parents.

28. Mrs Cross did contact the SCFDCS and someone from the scheme as well as her husband attended to provide support. At this point Mrs Cross was very upset and felt that she must have done something wrong.

29. Among other issues, which included the supervision of Indianna, Mrs Hicks raised the fact that she received a notification on her Facebook account which showed that Mrs Cross was on Facebook at about 1:19pm on the afternoon of Indianna's death. This concerned Mrs Hicks, as her

view was that it meant that Mrs Cross was not supervising her daughter properly.

30. Mrs Cross addressed the Facebook issue in an addendum statement. She said that on the relevant day her computer and Facebook were both on as usual. In fact they are left on 24 hours a day. She recalled that after she put Indianna down for her afternoon sleep she did go into her office. She usually spends the time when the children are asleep to make phone calls and attend to the daily paperwork. Mrs Cross does not think she played any computer games on this particular afternoon.

Autopsy results

31. A full internal autopsy was conducted by an experienced forensic pathologist Dr Peter Ellis on 24 July 2012.

32. No skeletal abnormalities were detected nor was there any evidence of previous injury. Indianna was well developed for her age and well nourished. There were no obvious external abnormalities.

33. Internal examination revealed a number of small haemorrhages on the surface of both of the lungs but no other abnormalities were detected. No significant pathological abnormalities were found. Toxicological examination revealed no alcohol or drugs other than a very small quantity of paracetamol.

34. Given the lack of pathological features at autopsy, Dr Ellis concluded that Indianna's death fell into the category of Sudden Infant Death Syndrome (SIDS), classic type 1(a).

Report of Professor Ansford

35. Professor Ansford is also an experienced senior forensic pathologist and was engaged by the lawyers representing Centacare to provide a report. He was of the opinion Professor Ellis performed all appropriate tests and the pathological evidence was consistent with his conclusion that Indianna's death was a classic SIDS type 1 (a) death. There was no evidence to support any positive finding regarding the cause of death.

36. The only pathological abnormality noted was a number of small haemorrhages on the surface of both lungs which is typically associated with SIDS deaths.

37. Professor Ansford noted that SIDS is thought to be an asphyxial mode of death, at least in part. SIDS research suggests that abnormal or delayed brain development in an infant, can result in the brain not correctly getting and interpreting the messages that it needs to tell the lungs to breathe, resulting in asphyxiation and death. It was not possible to say whether this was the cause in this case. The evidence in the case did not indicate another cause of asphyxiation, such as smothering, positional asphyxia or aspiration of vomit, was more likely.

38. He was of the opinion the pathological evidence indicates that Indianna most likely died between 2pm and 2:45pm, between 15 minutes and 1 hour before QAS arrived at the scene at approximately 3pm.

39. In relation to preventive measures he was of the opinion, based on the evidence available, that Mrs Cross took measures generally accepted as

reducing the risk of SIDS. This included putting her to bed swaddled and on her back, on a firm mattress, without any loose soft toys or other items in the cot. He agrees with the comment made by Dr Young that it may not have been appropriate for the arms to have been included in the wrapping at the age of 5 months.

40. Professor Ansford disagreed that the use of a pacifier was an adverse feature and noticed that SIDS and Kids has a special section in its material in relation to the use of a pacifier and there is some evidence that its use is associated with a reduction in the incidents of SIDS. He agreed that the use of baby monitors is not a generally recommended preventative measure and there is no conclusive evidence as to their effect or reliability for this purpose.

41. He noted reference by Dr Young to the wearing of a teething necklace. He was of the opinion that if it had been a significant factor, then it would have left a mark in the form of an abrasion around the neck and none was seen at the autopsy. He does not believe the necklace played any significant part in the death.

42. With respect to CPR he stated that as a general rule, it is only effective if commenced within minutes of cardiac arrest. By 10 minutes post arrest, a person's prospects of being successfully resuscitated and surviving, without severe brain damage or indeed at all, are very limited.

The investigations

43. As a result of the death a number of investigations were commenced by the following agencies:
    - Queensland Police Service;
    - Department of Education, Training and Employment; and
    - Centacare (establisher of the Sunshine Coast Family Day Care Scheme).

Queensland Police Service (QPS) and evidence led at the inquest

44. The QPS investigation was led by Detective Senior Constable Robert Coffey of the Sunshine Coast District CPIU. He concluded his investigation and provided a report that has since been reviewed and approved by multiple senior police officers.

45. The investigation obtained statements from both of Indianna's parents, Mrs Cross, other relevant persons from the Sunshine Coast Family Day Care Scheme (SCFDCS), relevant police officers, ambulance staff and doctors at the Caloundra Hospital.

46. The police investigation came to the following conclusions:
    - Indianna was placed on her back to sleep, and was then located on her stomach and not breathing – this leads to possible positional asphyxiation as being the cause of death;
    - Indianna's face was against the mattress and may have obstructed breathing whilst she was lying on her stomach (the mattress covers were made of nylon);
    - It is possible that Indianna freed her arms from the bunny rug and rolled over onto her stomach thus putting herself in a dangerous position for sleeping;
    - Autopsy has established the cause of death as SIDS;

- Although tragic, the circumstances surrounding the death do not highlight any issues of negligence to a criminal standard;
- The death does not give rise to any suspicious circumstances; and
- There is no recommendation for any person to be charged in connection with the death.

Centacare (establisher of the Sunshine Coast Family Day Care Scheme)

47. Centacare provided information through its lawyers and a number of statements have been provided.

48. Centacare holds a Provider Approval under the *Education and Care Services National Law (Queensland) Act 2010*. Pursuant to that Provider Approval, Our Lady of the Rosary Catholic Parish in Caloundra (OLR) established the Sunshine Coast Family Day Care Scheme (SCFDCS), an approved education and care service operating under OLR's management.

49. As a result of Indianna's death, Centacare commenced its own internal investigation. The investigation being conducted by Centacare was to review the policies and procedures relevant to family day care arrangements and more importantly critical incidents.

50. Centacare provided a preliminary response to the concerns raised by the family.

51. In that response, Centacare informed the family that SCFDCS and Centacare were continuing to undertake close and regular reviews of Mrs Cross's day care service and were supporting Mrs Cross in her work.

52. It was also confirmed that, at the time, through regular reviews and support processes, SCFDCS and Centacare were satisfied that SCFDCS's conduct was appropriate throughout the events leading up to and since the death on 20 July 2012.

53. It is apparent that for a period of four weeks Mrs Cross self-imposed a decision to not care for any children, a decision back by SCFDCS. She then came back slowly with school-age children first and then younger children but no infants until the following April/May 2013.

54. It is also apparent that Mrs Cross went through the annual safety audit on 10 May 2012 where there were no concerns noted. Regular unannounced home visits were conducted every 3-4 weeks.

Department of Education, Training and Employment

55. The Department of Education, Training and Employment (DETE) is the relevant government department which oversees early childhood education. Within the 'early childhood education' banner, DETE monitors compliance with the *Education and Care Services National Law (Queensland) Act 2010* and *the Education and Care Services National (Queensland) Regulation 2011.*

56. DETE has an obligation to ensure that early childhood services uphold the requirements and standards of the legislation. DETE has authority to take compliance action against an Approved Provider or educator, in the event that it is determined the provider or educator has contravened the

legislation. DETE also has an obligation to respond to complaints and investigate according to the legislative requirements. Indianna's parents made a complaint to DETE following the death of Indianna.

57. The responsible officer at DETE to conduct the investigation was Lynne Asnicar. She has provided a statement outlining the extent of the DETE investigation and the outcomes of that investigation. Ms Asnicar has also provided 2 volumes of internal DETE material comprising of case notes and emails relating to the investigation.

58. DETE were notified of the incident at 4:37pm on the afternoon of Indianna's death. DETE did not attend Mrs Cross's home due to the ongoing police investigation. DETE liaised with Centacare to ensure relevant supports were in place for the Hicks' family as well as ensuring that legislative requirements were met in terms of the reporting process to be followed.

59. On 15 October 2012, DETE received a letter from the family outlining concerns. On 30 October 2012, DETE met with Centacare to discuss the letter of complaint. On 2 November 2012, DETE visited the home of Mrs Cross. Contact by DETE on both occasions was to ensure that legislative requirements had been met. The contact was not made to facilitate an investigation surrounding the actual death, given that police were still conducting an investigation on that basis.

60. DETE ultimately came to the view that there was no evidence to indicate that the legislation had been contravened and, consequently, no compliance action was taken against the Approved Provider or the educator. On 4 December 2012, DETE wrote to Indianna's parents outlining its findings that no further action would be taken by the Department with respect to SCFDCS as an organisation or any individual (i.e. Mrs Cross).

61. Catherine O'Malley provided a statement. She is the Executive Director of the Early Childhood Education and Care Division.

62. She noted that notification of the death was given to DETE on the day of the incident. The complaints management policy at the time was that in cases where external investigations, such as those conducted by the police were underway, the Department should not conduct any further investigations or visit service until police have been advised in the matter discussed with them. A compliance visit to the residence was conducted on 30 October 2012 and 2 November 2012 after advice was received from police that such a visit would not compromise any ongoing investigation. No compliance issues were identified. No other investigation has been conducted by the department as it is awaiting the outcomes of the police and coronial investigations.

63. Ms Malley also provided information concerning the introduction of the *National Quality Framework for early Childhood Education and Care* (NQF). This applies to education and care services, including most long day care services, pre-prep, outside school hours care services, family day care services and kindergartens. The NQF commenced on 1 January 2012 in Queensland.

64. Under the National Laws DETE proactively and reactively monitors education and care services and pursues compliance action in the event

that non-compliance is detected. A range of compliance activities may be pursued depending on the seriousness of the matter.

65. SCFDC did undergo an assessment and rating and was rated as meeting the National Quality Standard overall on 12 June 2013.

66. Under the National Law, becoming an Approved Provider is a pre-requisite to operating an education and care service. An assessment as to whether the applicant is a fit and proper person to be involved in the provision of that service is conducted. On the basis of transitional provisions Centacare and SCFDC were declared an Approved Provider and an Approved Service respectively as at 1 January 2012. An Approved Provider is responsible for engaging educators and determining their suitability and that of the residence and in accordance with the National Law. The process by which this occurs is not dictated by the National Law. The Approved Provider is ultimately responsible for the standard of care provided by any Approved Services.

67. The National Law and regulations prescribed the policy and procedures that all education and care services must have. None of these prescribed policies and procedures relates specifically to sleep and rest requirements, however all services must generally have health and safety policy and procedures.

68. Regulation 81 requires an Approved Provider to "take reasonable steps to ensure that the needs for sleep and rest of children being educated and cared for, having regard to the age, development stage and individual needs of the child". It is also noted that under the National Quality Standard, against which services are assessed and rated, it is required that each child's comfort is provided for and there are appropriate opportunities to meet each child's need for sleep, rest and relaxation. The National Laws and Regulations do not require that these matters should be written into a specific policy. Ms O'Malley stated that in her personal opinion this would be a good idea.

69. The National Law also provides that an Approved Provider must ensure all children being educated and cared for are adequately supervised at all times.

Report of Dr Jeanine Young

70. Professor Jeanine Young is the Chairperson, National Scientific Advisory Group for **SIDS and Kids Australia**. She was provided with the brief of evidence and asked to give her opinion as to the following:
    - An explanation of best sleep practices for infants in the age bracket of 3 – 6 months;
    - Following on from point (1) above, an explanation of whether all of those best sleep practices were followed in Indianna's case;
    - An opinion on the usefulness of electronic baby monitors in preventing SIDS, and further whether the use of electronic baby monitors should be considered as a mandatory requirement for family day care facilities; and
    - An opinion on the issue of the regularity of supervision of infants whilst sleeping, in particular, whether there should be designated timeframes in place for the supervision, checking and inspection of infants whilst in family day care facilities.

71. Professor Young concluded there were factors present in Indianna's sleeping environment that may have contributed to her vulnerability on that day. She stated she has made several recommendations following this review, consistent with the parents' wish for a thorough investigation and to learn from Indianna's death in order to help future families reduce the risk of sudden infant death.

72. She stated the chance of babies dying suddenly and unexpectedly is greater if they sleep on their tummies or sides. As babies grow older beyond 5–6 months, they may move around the cot and roll over. Babies should be settled on the back but then let them find the sleep position they feel most comfortable in. A safe cot and safe sleep environment is still necessary for older babies.

73. Professor Young set out in some detail the current *Sleep Your Baby Safely Recommendations (SIDS and Kids 2014)*, based on her review of the International evidence, which applies to infants aged 0-12 months.

74. In relation to infant wrapping, she noted this is a useful strategy that parents can use to help their babies to settle and sleep on their back, especially during the first 6 months of life. However, the recommendation was that when the baby is able to turn onto the tummy during sleep, that wrapping the baby should be discontinued. Tummy sleeping increases the risk of sudden unexpected infant death and must be avoided. However, wrapping a baby and placing them in the tummy position is even more dangerous as it prevents babies from moving to a position of safety.

75. Professor Young stated the recommendations relating to the strategies for safe infant wrapping are available through the *SIDS and Kids* website and have been incorporated into education programs for parents and health professionals in Queensland and are provided to new parents in the *Child Health Record Book.*

76. Professor Young noted that studies in the United States found a large proportion of deaths attributed to SIDS occurs in child care settings. Previous studies reported that unaccustomed prone sleeping puts infants at high risk for SIDS and this characteristic was found to be associated with SIDS in child care and may partly explain the high proportion.

77. Professor Young noted the following infant care practices that were not optimal at the time of death:
    - Infant wrapping used for an infant at 5 months of age
    - Bunny rug used which may have contributed to overheating an infant who was not completely well. Light cotton or muslin wraps are recommended, or use an infant sleeping bag.(In evidence Professor Young stated she had recently seen a photograph of the Bunny rug and was satisfied it was of light weight material).
    - Infants hands were enclosed in wrap (not recommended after 3 months of age)
    - Infant was wearing a teething necklace at time of sleep. Necklaces are a choking hazard and may cause pressure or constriction on the infant's airway as they turned over inside/outside of the bunny rug wrap.

78. Professor Young also opined that Indianna was a vulnerable infant who had several factors, which contributed to her vulnerability and external

stressors in her sleeping environment, and which increased the risk of a sudden unexpected death.

79. The risk factors included:
- Exposure to some cigarette smoking in the first 6 months of life (mother 5 cigarettes/day, reference to child care being a smoker – in evidence Mrs Cross said neither she nor her husband smoked but some of her children had, which may explain the smell of cigarette type odour as stated by Mrs Hicks).
- Evidence of atopy and allergy: congestion with introduction of formula feeding and treatment for eczema
- Recent upper respiratory tract illness during last 2 weeks
- Not breastfed
- Previous sibling death (stillbirth at approximately 20 weeks gestation in 2006)
- Use of a dummy

80. The strengths included:
- Indianna was breastfed for 3 weeks
- Indianna was immunised according to the National schedule
- The mother reports she did not smoke during pregnancy
- Supportive relationship with the father
- Motivated mother aware of importance of back sleeping and attempting to keep child on her back for sleep through use of wrapping strategy

81. Professor Young noted that Indianna at 5 months of age was at the developmental stage where it was likely that she was able to turn from her tummy to her back and would have begun to turn from her back to her tummy. For these reasons the safe wrapping guidelines provide strategies that are based on the developmental stage of the infant and include that the wrap be modified and/or be discontinued, typically when the baby is able to roll from their back to the tummy and then onto the back again.

82. She stated the evidence indicated Indianna ended up on her tummy in the prone position and may have been unable to move out of this position as her arms and hands had been enclosed in the wrap. This constitutes an unsafe sleeping environment for an infant due to the infant being at an increased risk of suffocation through 2 modes, including direct cover of the nose and/or mouth; or chin to chest positioning, which internally occludes the baby's airway if the baby has rolled onto the prone position or ends up facedown.

83. She stated that Indiana was reported to have a respiratory illness that may have increased the amount of secretions in her respiratory tract and may have inhibited effective swallowing and arousal mechanisms, and combined with the vomit found present on the bedding, and/or increased respiratory secretions in her oropharynx, might have contributed to triggering the laryngeal chemoreflex.

84. Professor Young was asked for her opinion on the usefulness of electronic baby monitors in preventing sudden infant death and if monitors should be considered a mandatory requirement for family day care facilities. She stated a number of reviews have concluded there is no scientific evidence that using any type of monitor will prevent a sudden infant death. Monitors can be useful for some particular babies but should only be used under the supervision by a doctor or nurse. She stated there

is insufficient evidence to support the electronic baby monitors as mandatory requirement for family day care facilities. No form of monitoring replaces actively sighting and checking the baby at regular intervals, particularly if the baby cannot be settled to sleep in the same room as the carer.

85. Frequent use of baby monitors may lead to parents becoming desensitised to the sound of an alarm and they may fail to respond if the baby has a true, clinically significant event.

86. Professor Young stated that in family day care and child care centre settings, active monitoring and supervision with the ability to be able to see and hear the infant, is regarded as best practice.

87. If a caregiver is unable to share the same room as the infant to ensure active monitoring, the *SIDS and Kids Child Care Kit* information specifically for education and care services, states that a monitor may be suggested to ensure you can hear the baby's breathing, and to actively sight the baby as frequently as possible, and in accordance with state Regulatory Authority and the nominated supervisor coordinator for the service.

88. Professor Young was also asked for her opinion on the issue of the regularity of supervision of infants whilst sleeping, in particular, whether there should be designated timeframes in place for supervision, checking and inspection of infants whilst in family day care facilities. She stated that all children should be adequately supervised at all times. Constant supervision in the same room with ability to see and hear babies is regarded as best practice.

89. In some child care services and day care settings it may not be possible for babies to share the same room as the adult caregiver while asleep. Best practice is still actively monitoring and supervision with the ability to see and hear the baby.

90. There no specific times set out in the various regulations under the *Education and Care Services National Law* but the Authority states that *"with babies and toddlers who are sleeping, educators need to be able to see and hear the children."* She stated that some child care centres have incorporated the *SIDS and Kids* recommendations into their Rest and Sleep policies and also specify regular checks of children in their care (several specified 10 minute checks) and in addition require the removal of infant jewellery prior to sleep.

91. Professor Young stated that in her opinion there is sufficient evidence to indicate that:
    1. Active monitoring and supervision with the ability to see and hear the baby is best practice in both family day care and child care centre settings
    2. Designated timeframes should be in place for supervision, checking and inspection of babies less than 24 months of age
    3. A timeframe of 10–15 minute checks would be reasonable for infants aged 0-2 years and is commonly the designated time frame demonstrated in a small audit of Rest and Sleep policies available online from facilities in Australia

4. Babies may be wrapped if so requested by families but such wrapping will reflect safe sleeping practices as recommended by *SIDS and Kids* and the principles of safe infant wrapping
5. Necklace/bracelets including Amber teething necklaces, must be removed while the infant sleeps at night or day

92. Professor Young has made a number of recommendations as follows :

Recommendation 1

All child care centres and family day care service providers need to demonstrate documented evidence of the service's engagement with the SIDS and Kids Safe Infant Sleeping recommendations through their Rest and Sleep policy.

Recommendation 2

Specific inclusion of the principles of safe infant wrapping into the child-care facility or family day care service's Rest and Sleep policy to highlight and encourage discussion of the infant's changing development needs and infant sleeping environments.

Recommendation 3

Public awareness needs to be a raised relating to the risk of using teething necklaces for infants. It is noted the ACCC has issued a Warning notice concerning Amber teething necklaces on the basis they pose a strangulation and choking hazard and if used, should be removed while sleeping during the day or night.

Recommendation 4

Improve information gathering relating to clinical history of the infant. (*This issue specifically related to gaps in the information contained in the Form 1 initial report to the coroner.)*

Centacare Policies

93. Further requests were made and the Office of State Coroner was provided with the following:

- A copy of the Centacare/Sunshine Coast Family Day Care Scheme (SCFDCS) policy handbook as it was at the time of Indianna's death, AND as it is now;
- A copy of any additional Centacare/SCFDCS policies (if any) relating to the standard of care to be provided to infants whilst in care;
- The current position of Centacare/SCFDCS regarding any implementation of mandatory timeframes for the supervision, checking and inspection of children, particularly infants, whilst in care; and
- The current position of Centacare/SCFDCS regarding any implementation of a mandatory requirement for electronic baby monitors.

94. Centacare requires family day care providers to supervise children in accordance with the applicable obligations under the *Education and Care Services National Law.* As at July 2012 *the National Law and National Regulations* did not impose specific timeframes for the supervision,

checking and inspection of children (including infants) in the care of family day care providers. That is still the position. Since December 2013 Centacare has required SCFDCS to comply with its Sleep and Rest; Bedding and Sleeping and Supervision policies. The Sleep and Rest Policy provides for 15 minute checks of infants.

95. The use of electronic baby monitors is not specifically mandated under the National Law and Centacare does not currently specifically mandate their use.

96. The Director of Centacare Child Care Services, Ms Alana Crouch provided a statement. Centacare provides child care services in the Brisbane Archdiocese of a non-profit basis. It is a member of the peak body for early childhood advocacy and outside school hours care services. Centacare holds a provider approval under the National Law. SCFDCS was 1 of 2 family day care schemes issued with a service approval by Centacare. Mrs Cross was an independent contractor to SCFDCS. SCFDCS had been established under other child-care regulatory frameworks since around 1980.

97. Ms Crouch stated that from at least 1994 until July 2013, SCFDCS was managed and administered without substantial hands-on involvement by Centacare or its predecessors. SCFDCS was essentially managed by The Caloundra Catholic Parish and operated in accordance with its own policies and procedures, and was not required to comply with Centacare's usual policies and procedures. This arrangement was said to be unique compared with other child care services approved pursuant to Centacare's provider approval. There was some degree of oversight and involvement when it was requested.

98. Ms Crouch was told about the tragedy on 21 July 2012 and made arrangements to travel to Caloundra on 23 July 2012.

99. In July 2013 a decision was made to transition the 2 family day care schemes to the direct management of Centacare by incorporating them into the same reporting and management structure which applies to other services operated under the provider approval. In December 2013 the 2 family day care schemes operated under Centacare's care own policies which applied generally across child care services.

100. It was noted that under Centacare's Sleep and Rest policy, 15 minute checks are now mandated. Ms Crouch agreed that this could also be included in their separate Supervision policy. She stated that Centacare's policies are updated with a schedule of review time table set out.

101. It was noted there were no safe wrapping policies within the Centacare policies and Ms Crouch also agreed that there was no reason why these issues could not be specifically raised in a Safe Sleeping practice policy.

102. Due to government funding cuts Centacare has made a decision to surrender the service approval is for its family day care schemes effective of 20 December 2014.

103. Joan Ellen Fleming also provided a statement. She is the senior coordinator and nominated supervisor for SCFDCS. She is a registered nurse and has a diploma in Early Childhood Education and Care. She supervised and monitored about 62 family day carers and would visit each

carer on a 3-4 weekly basis. She stated she only had limited involvement with Centacare on a day-to-day basis but would receive support and guidance as required.

104. The scheme's policy and procedures are set out in a Policy Handbook, a copy of which all educators are provided. She was responsible for ensuring the policies were compliant with the National Laws in force from time to time. The policy handbook was reviewed every 12–18 months. Every 2 years, as part of the re-licensing process, the Office of Early Childhood Education and Care would audit carer's homes and review the policy and procedures.

105. At the time of Indianna's death there was a Policy Handbook in force. From 1 January 2012, the National Laws came into effect in Queensland, and a new version of the Policy Handbook was finalised in early 2013 and remains in force. Copies of both Handbooks were provided to my office.

106. Ms Fleming stated that until July 2013, the scheme conducted its own training and induction of educators. Relevantly, educators have for a number of years been provided with a SIDS and Kids Safe Sleeping Booklet and a link to the SIDS and Kids website as part of the induction. She has no reason to believe that Mrs Cross would have been an exception to this practice. The scheme did not otherwise provide specific training on the supervision of sleeping babies or SIDS.

107. Once an educator had been engaged, the coordinator would undertake home visits every week for the first 6 weeks and thereafter every 3–4 weeks or as required. Approximately on annual basis scheme would undertake a comprehensive home safety audit. The scheme would also provide educator or is with information concerning relevant regulatory, care and safety matters and copies or access to the National Laws and quality standards framework documents.

108. Mrs Cross was engaged as an educator from July 2004. The records show home visits were conducted regularly since 2004 and reports completed. No significant concerns in relation to the level of care was noted. She is not aware of any significant issues that arose in relation to the quality of care provided and considered Mrs Cross as a very dedicated and careful educator. Home safety audits were conducted annually. The annual re-registration process was also completed satisfactorily. Mrs Cross had a current first aid and CPR certificate.

109. The portable cot used for Indianna was provided by the scheme. All of the cots complied with Australian Standards and were checked during home audits.

110. In August 2014, Centacare made a decision to surrender service approvals held for its family day care schemes, a decision that apparently was undertaken in response to funding cuts. Mrs Cross ceased being a day carer with the scheme in July 2013.

Review of SCFDCS and Centacare Policies

111. The Policy Handbook for SCFDCS in existence at the time of Indianna's death did not appear to provide for a separate section on safe sleeping, supervision and SIDS. It was brought to my attention during the inquest that in fact there was reference to safe sleeping policy at page 85 of the

Policy Handbook where it was stated that "educators are to ensure each individual child has access to adequate bedding, which is safe, hygienic, culturally and age appropriate." That reference appears under what seems to be a procurement policy titled "Selecting, Using and Purchasing Cots and Bedding". At one part of the policy there is reference to the fact that equipment must have a 5 point harness, which is hardly consistent with a bedding policy. In fairness, Mr Burns, Counsel for Centacare, conceded that the inquest had revealed deficiencies in the policies and Centacare supported the submissions made for there to be changes to the National Laws mandating written policies on these issues.

112. A supervision policy for SCFDCS was developed as a result of the introduction of the National Laws in March 2012 for review in July 2013. No-where in that policy is there any reference to supervision during sleeping times.

113. Centacare now has a Sleep and Rest Policy with reference to the National Laws. The policy states that it will maintain current information on SIDS. There is a specific section for safe sleep practices for children under 15 months and again makes reference to SIDS prevention. It is in this policy that there is a somewhat disconnected reference to a 15 minute check but no other policy seems to mandate this and Ms Crouch agrees this could be placed in the supervision policy. In all other respects the policies appeared to be appropriate.

114. The issue as to whether policies and/or the National Laws and Regulations should mandate specific 10 or 15 minute checks was raised during the course of the inquest and in submissions.

115. Section 165 of the Education and Care Services National Law 2010 provides that an approved provider, nominated supervisor or family day care educator must ensure children are adequately supervised.

116. Regulation 81 of the Education and Care Services National Regulations provides that an approved provider, nominated supervisor or family day care educator must take reasonable steps to ensure that the needs for sleep and rest of children being educated and cared for by the educator as part of a family day care service are met, having regard to the ages, development stages and individual needs of the children.

117. The published Guide to the National Law and Regulations makes specific reference to the policy for sleeping children in these terms:

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

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. Supervision windows should be kept clear and not painted over or covered with curtains or posters.

For further advice on safe sleeping practices, contact SIDS and Kids *http://www.sidsandkids.org/*

118. The guide also makes reference to what is adequate supervision. In the section relating to a centre-based service it was stated that adequate supervision might mean that the children remain in close proximity to the adult who is supervising them. With babies and toddlers who are sleeping, educators need to be able to see and hear the children. In a family day care service, some children may be playing in different parts of the family day care residence or venue and the educator will need to consider how these children will be supervised. The guide sets out a number of determining factors which may relate to the adequacy of supervision.

Training

119. Mrs Cross was a family care educator who provided child care services at her home at Caloundra, under the terms of a contract between her and SCFDCS. It is evident that Mrs Cross had completed a Certificate III and Diploma in Early Childhood Education and Care and was completing an advanced diploma. Prior to 1 January 2014, a family day care educator was not required to hold or be working towards any qualification. Now a family day care educator must hold or be working towards an approved Certificate III qualification or higher.

120. My office has confirmed with TAFE that the Certificate III course contains a core subject in relation to caring for babies and toddlers. In the unit there is an element regarding promoting safe sleep. Specific performance criteria needed to demonstrate achievement of the core element includes such things as reaching agreement with families on how sleep and rest will occur; check that cots, bedding and equipment meet approved standards; implement safe sleep practices and explore and implement quality sleeping environments. There is specific reference to the *SIDS and Kids Infant Safe Sleeping Child Care Kit for Education and Care Services.*

Conclusions on the Issues

121. It was submitted by the lawyers representing Mr and Mrs Hicks and Mrs Cross that I should find that the cause of death should be stated as “unknown” rather than as a category of SIDS. However, SIDS has been utilised as a category of cause of death for well over a quarter of a century, and for the reasons that I have stated at the commencement of this decision, it is preferable for such categorisation to continue particularly where the autopsy has been conducted by such an experienced forensic pathologist as Professor Ellis.The opinion of Professor Ansford further fortifies that view.

122. 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.

123. There is no evidence to suggest that the wearing of the Amber teething necklace contributed, as there would have been some pathological

findings. However, Professor Young does not believe they have any real benefit and the choking and strangulation risks certainly far outweigh any benefit. I will raise as an issue for public awareness that the ACCC has issued a Warning Notice concerning Amber teething necklaces on the basis they pose a strangulation and choking hazard and if used, should be removed while sleeping during the day or night.

124. It cannot be said that the swaddling/wrapping of Indianna or the fact that she rolled onto her stomach were clear causal factors. They were matters raised on the evidence as risk factors for SIDS, no more or less. The same also arises with respect to the issue of supervision. Even if there had been a policy requiring a 10 or 15 minute direct supervision or checking on the sleeping infant, it cannot be said that this would have necessarily prevented Indianna's death, but it may have.

125. The issue of the utility of Baby Monitors was raised and the opinion of Dr Young is that for general use it is not recommended they be made mandatory in day care settings. Professor Young stated that in her opinion, current evidence does not indicate that baby monitors play a role in preventing or reducing the risk of sudden infant death. However for particular babies or in some settings they may still be of use provided that they are not used as a substitute to active monitoring and supervision with the ability to see and hear the baby.

126. On the issue of training it is evident that from 1 January 2014, all day carers are required to have formal education qualifications or are working towards them. The current Certificate III course has appropriate core components in the training with respect to safe sleeping practices. No recommendation is necessary in this respect.

127. With respect to the information gathered by Police and incorporated in the Form 1, the Office of State Coroner is constantly monitoring the information provided in the Form 1 and is actively engaged in improvements and amendments. In many respects the provision of such information may best be obtained from the clinical sources and noted in subsequent reports to the Coroner. Obtaining such information at the scene, where it is likely people will be distressed, may not be appropriate.

128. At the time the Approved Provider of the day care scheme, Centacare essentially had little day to day responsibility for how SCFDCS or Mrs Cross conducted their day care operations. That was clearly not desirable, but this has been rectified since July 2013 with the management of the scheme now directly in Centacare's control and subject to its policies and procedures. It is evident that SCFDCS will no longer operate from 20 December 2014, for funding reasons, but the principles remain and Centacare will still be operating other child care facilities.

129. The policies and procedures of SCFDCS were largely silent with respect to safe sleeping practices and supervision. The Centacare policies that have since been put in place are certainly much better, but consideration needs to be given to the supervision policy and how that relates to and interacts with the safe sleeping policy. It does need improvement in that respect.

130. Centacare's current policy refers to a 15 minute supervision period. Providing for a mandated period in which supervision/observation must occur is certainly one method an organisation could adopt. I am not

convinced I should make a recommendation to that extent. I have seen too many people in mental health units take their own lives when on 15 minute observations to think that a mandated time for observations will necessarily avoid adverse outcomes. I prefer the reference in the Guide to the National Law that states "*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."* Accepting this statement may be inspirational, policies should be adopted by each organisation and facility based on endeavouring to reach that principled position.

131. It was pleasing there was considerable unanimity from Mr and Mrs Hicks and all parties represented at the inquest, in supporting changes to the National Laws to require Approved Providers to have a written policy and procedure relating to sleep and rest and supervision. All parties adopted the submissions of Counsel Assisting Miss Cooper in this respect.

132. Mr and Mrs Hicks' lawyer, Mr Gnech properly submitted that it could be outside of my responsibilities (and indeed expertise) to decide what should be in such policies, and suggested that a working group be set up of relevant stake holders and funded by DETE to consider the recommendations of Professor Young and what should or should not be mandated. This was supported by Centacare.

133. Mr McMillan for DETE helpfully provided brief written submissions setting out the Department's position and these were as follows:

a. Any recommendations directed towards Approved Providers of Early Childhood Education and Care Services having documented Sleep and Rest policies should not specifically refer to SIDS and Kids safe infant sleeping recommendations, but rather should focus upon Approved Providers having a documented Sleep and Rest policy incorporating best practice principles;

b. A recommendation that relevant governments give consideration to amending the National Regulations to require Approved Providers to have a written policy and procedure relating to Sleep and Rest under the Education and Care Services National Regulations would not be opposed by the Department; however, the Department submits that any such recommendation should not be prescriptive in terms of the precise requirements of any Sleep and Rest policy so as to allow Approved Providers to maintain best practice principles based on contemporary best practice at any given time;

c. Consistent with a recommendation of that nature, current Regulation 168 of the Education and Care Services National Regulations should be reviewed to specifically require Approved Providers to have a written policy and procedure on Sleep and Rest for children and infants including the matters under regulation 81 of the Education and Care Services National Regulations.

134. Mr McMillan also stated that rather than setting up a working group, that may better be an issue that could be referred to the National Authority in the course of a review regarding the National Law framework which was currently taking place. I have had that matter checked and it is apparent that this review is current with written submissions to be provided by 16

January 2015. It is noted there is no reference to regulations 81 or 168 in the Regulation Impact Statement for proposed options for changes to the National Quality Framework. It is my view that this is a very good opportunity to refer my decision, particularly noting the unanimous support for change to the Regulations, to the National Authority for consideration in this review. I particularly note the Department's strong support for amendments to the regulations.

135. In relation the issue raised as to the extent to which any of my recommendations should be prescriptive or not in relation to the content of such policies, I note the evidence of Professor Young where she stated that regulations and guidelines should be principle based and not prescriptive, particularly given it is difficult to write a policy which dealt with all of the developmental changes that occurs in the first 12 months of an infant's life.

136. Given any legislative change, particularly nationally, will take some considerable time, all parties to the inquest agreed that there should be interim recommendations to Approved Providers to undertake a review of their Sleep and Rest and Supervision policies to ensure they meet current best practice, and if they do not have such a policy then one should be implemented as soon as possible. I note the Guide to the National Law refers people directly to the SIDS and Kids website and SIDS and Kids already have developed the *SIDS and Kids Infant Safe Sleeping Child Care Kit for Education and Care Services*, which includes a draft policy. That is clearly a good start for immediate action. I agree in part with the submission of Mr McMillan that in the end it is really a matter for each organisation to incorporate current best practice, and whether this should be from SIDS and Kids or some other form of authoritive advice is a matter for them.

137. It is my intention to forward a copy of these findings and recommendations to:
    - TAFE Queensland
    - Childcare Queensland
    - The Family Day Care Association of Queensland
    - The Australian Children's Education & Care Quality Authority

Findings required by s. 45

Identity of the deceased – Indianna Rose Hicks

How she died – Indianna was almost 5 months old when she died suddenly and unexpectedly in her sleep on her first day with a family day carer. She had been fully swaddled, as instructed by her mother, and placed on her back for an afternoon sleep. When she was found she was seen to be in the prone position on her stomach. Her death was categorised by a forensic pathologist to be Sudden Infant Death Syndrome. By definition this means there was no pathological finding of a specific cause of death.

Place of death – Caloundra Hospital West Terrace CALOUNDRA QLD 4551 AUSTRALIA

Date of death– 20 July 2012

Cause of death – 1(a) Sudden Infant Death Syndrome (Classic Type 1a)

Comments and recommendations

Consistent with the discussion and conclusions above I make the following recommendations:

1. It is recommended that Approved Providers of Early Childhood Education and Care Services ensure they have documented Sleep and Rest and Supervision policies incorporating best practice principles. SIDS and Kids has safe infant sleeping recommendations and has available for purchase the *SIDS and Kids Infant Safe Sleeping Child Care Kit for Education and Care Services* and this could be considered as a starting reference for any review of existing policies or in in the event there are no such policies in the course of implementing one.

2. It is recommended that relevant governments give consideration to amending the National Regulations and in particular current Regulations 81 and 168 to require Approved Providers to have a written policy and procedure relating to Sleep and Rest under the Education and Care Services National Regulations based on contemporary best practice principles.

3. I raise as an issue for public awareness that the ACCC has issued a Warning Notice concerning Amber teething necklaces on the basis they pose a strangulation and choking hazard and if used, should be removed while sleeping during the day or night.

I close the inquest.

John Lock
Deputy State Coroner
BRISBANE
12 December 2014