OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the deaths of JTN and AJN**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Rockhampton
FILE NOs:	2008/565 & 2008/564
DELIVERED ON:	10 October 2011
DELIVERED AT:	Rockhampton
HEARING DATES:	01-05/10/2010; 02/12/2010; 09/09/2010
FINDINGS OF:	Ms Annette Hennessy, Coroner
CATCHWORDS**:**	Young children perished in house fire, Poor supervision, Poor living conditions, Access to Lighters, Previous intervention by Department of Child Safety, Queensland Health, whether authorities should have been involved with family at time of fire.
REPRESENTATION:	
Counsel Assisting:	Ms Alana MARTENS
Mother:	In person
Father:	In person
Dept of Communities:	Ms Lisa O'Neill, Crown Law (Inst/by Dept of Communities)
Qld Health and Susanne ENRIGHT:	Ms J Rosengren (Inst/by Corrs Chambers Westgarth)

These findings seek to explain, as far as possible, how the death of JTN and AJN occurred on 12 August 2008. Consequent on the court hearing the evidence in this matter where learnings indicate that changes can be made to improve safety and changes to departmental practice, recommendations may be made with a view to reducing the likelihood of a similar incident occurring in future.

I express my sincere condolences to the family and friends of JTN and AJN for their tragic loss.

THE CORONER'S JURISDICTION

1. The coronial jurisdiction was enlivened in this case due to the deaths falling within the category of "*violent or unnatural death"* under the terms of s8 of the Act. A Coroner has jurisdiction to investigate the deaths under Section 11(2), to inquire into the cause and the circumstances of a reportable deaths and an Inquest can be held pursuant to s28.

2. A Coroner is required under s45(2) of the Act when investigating a death, to find, if possible:-

- the identity of the deceased,
- how, when and where the death occurred, and
- what caused the death.

3. An Inquest is an inquiry into the death of a person and findings in relation to each of the matters referred to in section 45 are delivered by the Coroner. The focus of an Inquest is on discovering what happened, informing the family and the public as to how the death occurred, but not on attributing blame or liability to any particular person or entity.

4. The Coroner also has a responsibility to examine the evidence with a view to reducing the likelihood of similar deaths. Section 46(1) of the Act, authorises a Coroner to "*comment on anything connected with a death investigated at an Inquest that relates to – (c) ways to prevent deaths from happening in similar circumstances in the future."* Further, the Act prohibits findings or comments including any statement that a person is guilty of an offence or civilly liable for something.

5. Due to the proceedings in a Coroner's court being by way of inquiry rather than trial, and being focused on fact finding rather than attributing guilt, the Act provides that the Court may inform itself in any appropriate way (section 37) and is not bound by the rules of evidence. The rules of natural justice and procedural fairness apply in an Inquest. The civil standard of proof, the balance of probabilities, is applied.

6. All interested parties can be given leave to appear, examine witnesses and be heard in relation to the issues in order to ensure compliance with the rules of natural justice. In this matter, the parents and family

of the children appeared, and the Department of Child Safety and Queensland Health were represented at the Inquest.

7. I will summarise the evidence in this matter. All of the evidence presented during the course of the Inquest, exhibits tendered and submissions made have been thoroughly considered even though all facts may not be specifically commented upon.

8. Mr N and Ms D had been in a relationship since early 2003. They had three children, BJN (DOB 2004), JTN (DOB 2004) and AJN (DOB 2006). They resided in Bundaberg for a time and following separation, Ms D returned to Rockhampton with the children to reside with her parents.

9. On 12 August 2008, JTN and AJN tragically perished in a fire at their residence in Rockhampton. Following the fire there were concerns raised regarding the state of the house the children resided in. During the course of the investigation and inquest it became clear the family had some previous involvement with the Department of Child Safety in 2004, Queensland Health in 2007 and Rockhampton Women's Health in 2007 and 2008. Mr N also claimed he had made a number of notifications to the Department of Child Safety identifying concerns regarding the children's welfare prior to the fire.

ISSUES

The issues investigated during the Inquest were:

A. the circumstances surrounding the fire including the adequacy of the supervision provided to the children;

B. the appropriateness of the Department of Child Safety's involvement in 2004;

C. the appropriateness of the involvement by Queensland Health in 2007; and

D. whether there was any involvement of the Department of Child Safety or notification of concerns provided to the Department of Child Safety between 2004 and the fire.

A. The circumstances surrounding the fire including the adequacy of the supervision provided to the children

10. Mr Graham Holden purchased the property at 13 A. Street, Rockhampton in 1998. The property was two storied, the ground level consisting of a laundry, garage and storage area. On the first level there was a kitchen, lounge room, bathroom, sleepout, two bedrooms,

a computer room and a spare room. The property was subsequently leased to Mr D and Mrs D, Ms D's parents between 4 to 6 years prior to the fire.

11. Mr Holden was present at the property when Mr D installed a smoke alarm to the kitchen ceiling. This was fitted the day before the new legislation regarding smoke alarms came into effect. Mr Holden recalls at that time Mr Dy tested the smoke alarm and it was in working order. Mrs D confirms there was a smoke alarm in the kitchen area of the property.

12. Ms D recalled a smoke alarm being present near the kitchen and the smoke alarm would go off with just the slightest bit of heat. She recalled her father would take the battery out of the smoke alarm if he was going to be cooking.

13. According to Mr Holden's statement, he did not perform regular property inspections however he would visit the property once or twice a year to speak to the D family and see how they were going. Mr Holden last visited the property approximately 6 weeks prior to the fire as he wanted to speak to Mrs D about computer problems he was having. During the visit Mr Holden did not identify any problems with the state of the house. Mr Holden believed the house appeared to be a normal house that had a lot of children running around.

14. As at August 2008, Mr and Mrs D resided at the residence with their three children Kathleen (1994), Travis (1996) and Rhys (1999). Ms D, BJN, JTN and AJN also resided at the property.

15. At the time of the fire, Mr and Mrs D slept in the sleepout area, Ms D and Kathleen shared a room with bunk beds and the four boys (BJN, JTN, Travis and Rhys) slept in the central bedroom where there was one set of bunk beds. At this time, both Ms D and her mother indicated Ms D was coping with the children reasonably well and managing the children's needs.

16. Mrs Thomasson, a neighbour of the D's, was of the opinion the children's physical appearance was good. She observed they were dirty but indicated all children were dirty. Mrs Thomasson observed AJN with a soiled nappy however she held no concerns regarding the supervision of the children despite BJN and JTN playing in the street with older children and in her back yard unsupervised. Mrs Thomasson was of the opinion Ms D struggled to cope with children however all parents struggle with their children. She was of the opinion Ms D was an "amazing" mother however she was unable to provide evidence that formed this assessment other than to indicate she made the assumption every parent is a good parent.

17. Mr, Mrs and Ms D were all regular smokers who smoked inside and outside the home. The evidence suggests the children were familiar

with cigarette lighters and JTN had previously been observed attempting to activate a cigarette lighter.

18. The photographs of the house following the fire, particularly the rooms unaffected by the fire, depict the house in a dishevelled and unclean state. Bags of rubbish can be seen in the kitchen. In almost every room there are piles of clothing. In the bathroom there was a substantial amount of dirty clothing, to the extent the entire bathroom floor was covered. Whilst it was difficult to ascertain as a result of the extent of the fire, the house appeared dirty and grimy.

19. Ms D conceded during evidence the state of the house immediately prior to the fire was a mess. She indicated she and her parents were in the process of attempting to rearrange the house to create more room for the children. Ms D gave evidence the state of the house at the time of the fire was far worse than previously. Mrs D indicated the photographs of the sleepout, kitchen, bathroom, Ms D's and Kathleen's room were an accurate description of their state prior to the fire. She believes the photographs of the spare room were messier than at the time of the fire.

The fire

20. Mrs D recalls playing computer games on 12 August 2008. Ms D asked her mother to keep any eye on the children as she was starting to feel dizzy. Mrs D agreed and asked Ms D to make her a cuppa. Ms D did this and then went to lie down and fell asleep. At this time, AJN had been down for a nap prior to this however was in the process of getting up whilst Ms D was going to have a rest.

21. Whilst Mrs D continued on the computer, BJN, JTN and AJN were watching Shrek in the lounge room. Mrs D said that she was able to see into the lounge room from the computer room and she had a direct line of sight to the children. Ms D indicated where Mrs D was in the office area, she would not have direct line of sight to the boys, she would have to move backwards to be able to see the children.

22. Mrs D indicated she would occasionally check on the children whilst she was on the computer and it had been approximately 10 minutes since she had last checked on the children. BJN came out to Mrs D crying. BJN was trying to tell her something however Mrs D was unable to understand what he was trying to say.

23. Mrs D got up to see what was wrong. When she arrived at the door of the central room all she could see was a mattress on fire. The mattress from the top bunk had been pulled down and it was lying on its side up against the bunk beds. The fire was burning in a three quarter circle around JTN and it appeared as though he was sitting in the middle of the fire.

24. Mrs D grabbed JTN and dragged him out of the room into the lounge room. JTN was holding a purple cigarette lighter. Mrs D then went to the kitchen to get some water. Whilst she was doing this she screamed to Ms D. Ms D recalls being awoken by her mother screaming. She immediately attempted to assist her mother extinguish the fire.

25. Mrs D used an oversized coffee mug to take water to the central bedroom to try and extinguish the fire. Mrs D could not see where JTN was. At this point, Mrs D realised AJN was in the room on the bottom bunk. Mrs D was concentrating on putting the fire out so she could get to AJN. The mattress was entirely on fire. At this point, Mrs D was completely focused on rescuing AJN. She did not have any knowledge of where BJN and JTN were.

26. Ms D indicated she did not consider calling emergency services; her main focus was on rescuing AJN. Ms D believed at one stage she saw JTN on the recliner. At one point during the attempts to extinguish the fire, Ms D exited the house (to obtain a hose) and BJN followed her outside. Ms D instructed BJN to wait outside.

27. Upon noticing the fire, Mrs Thomasson from next door immediately went to assist. In her statement to police made the day after the fire, Mrs Thomasson indicated she saw BJN and JTN in the front yard and Mrs Thomasson told BJN to stay where he was. She recalled that BJN and JTN were always together. At the inquest Mrs Thomasson said that she still believed she saw both JTN and BJN outside however she only recalls telling BJN to stay where he was. She indicated she cannot be 100% certain she saw JTN out of the house on the day of the fire. It is likely from the other evidence that she did not.

28. Mrs Thomasson attempted to assist Ms and Mrs D to extinguish the fire. At some point, Mrs D opened the windows near the couch in the lounge room to try and get the smoke out and let more light in. She did not appreciate this action provided more oxygen to the fire. Whilst she was doing this, Mrs D did not hear or see JTN. Mrs D continued to try and extinguish the fire until further help arrived with little success. As the fire grew, it became increasingly difficult to see and enter the lounge room area.

29. During the fire, there was no discussion between Mrs D and Ms D as to the location of the children. Ms D does not recall ever seeing JTN exit the house. She also believed if JTN had exited the house it would have been difficult for JTN to get back into the lounge room due to the extent of the fire and the smoke.

30. Mr Thomasson also attended the house to help extinguish the fire and rescue the children. Despite several attempts, he was unable to enter the house very far. Prior to doing this he called 000. Records indicate this call was received at 2.24pm.

31. A number of Queensland Rail employees working nearby also attended and attempted to assist. They attended the property with fire extinguishers from their workplace. Unfortunately when they got to the front fence line of the house there was what sounded like a loud explosion and the front windows of the house blew out and the front door blew shut. They withdrew from the fire and at this point the Fire Service arrived.

32. Queensland Fire and Rescue Service employees arrived at the property at approximately 2.30pm. They attempted to extinguish the fire and locate JTN and AJN who were identified as still being in the house. JTN was located deceased sitting in the far right hand corner of the lounge room between the couch and television cabinet. AJN was later located deceased in the centre bedroom.

Post mortem examinations

33. Dr Nigel Buxton performed the post mortem examinations of AJN and JTN on 14 August 2008. He concluded they both died as a result of the fire. Dr Buxton commented that JTN appeared well cared for and there was no evidence of trauma to JTN prior to his death.

Fire investigation report

34. Mr Budd, a Safety Assessment Officer with the Queensland Fire and Rescue Service, investigated the incident and provided a report on the cause of the fire. Mr Budd was retired by the time of the inquest however had investigated the cause of fires for 17 years prior to his retirement.

35. Mr Budd was of the opinion the origin of the fire was in the central bedroom (which was the bedroom the boys slept in and where AJN was located after the fire). This was because this was the room with the most severe fire damage and had the highest and lowest level of damage suggesting the fire burned in this room for a longer period of time than any other room.

36. Mr Budd was of the view the stored material in the house (furniture, clothing, linen, electrical equipment) was a factor contributing to the spread and speed of the fire, also making the fire difficult to contain. Mr Budd indicated opening windows/doors provides a fire with oxygen and would generally aid in the growth of a fire.

37. Mr Budd noted in his report the fuse board under the house indicated the single light circuit for the house had tripped which would suggest the fire quickly compromised the electrical wiring for the light circuits possibly at ceiling height within the house.

38. During his investigation, Mr Budd was able to locate a smoke alarm bracket in the kitchen/dinning room of the house however he was unable to locate a smoke alarm or the remains of a smoke alarm. There was no outline of a smoke alarm which would have been expected had the smoke alarm fallen or been removed after the fire. He was of the view a smoke alarm was not operational at the time of the fire. Mr Budd was questioned as to how many smoke alarms were required at the property (see section below). He indicated this was difficult to assess for properties where rooms were converted etc and depended on an interpretation of the standard.

39. Mr Budd indicated that generally, if a fire occurs during daylight hours, the occupants of the house identify the fire before the smoke alarm is activated. He was provided with Mrs D's description of what she observed when she first identified the fire and he believed it would be safe to assume the fire was identified prior to when a smoke alarm would have been activated if one had been operational at the time of the fire.

Police investigation

40. Detective Sergeant Hanlen attended the property on the day of the fire and saw BJN. She recalled BJN was relatively clean and healthy and was not malnourished. She did not have any concerns for BJN based on his physical appearance.

41. Detective Sergeant Hanlen was of the opinion the state of the house at the time of the fire was very untidy and messy and may have been cause for police and Departmental intervention had they been aware of the situation. Detective Sergeant Hanlen indicated if she had observed the house in that state she would have notified the Department.

42. Detective Sergeant Hanlen determined that no criminal action be taken against the occupants at the time of the fire.

B. <u>The appropriateness of the Department of Child Safety's involvement in 2004</u>

43. Shortly following BJN's birth at the Rockhampton Base Hospital, BJN developed a large bruise on his right leg from his groin to his knee. As a result of his injuries, BJN was admitted to hospital. The treating doctor, Dr Roper, observed bruising and swelling to BJN's upper right thigh and hip area. Ms D disclosed to Dr Roper that she shook BJN lightly when he would not settle and she had become frustrated. She also indicated she had attempted suicide whilst pregnant due to depression.

44. Dr Roper subsequently notified SCAN, the Queensland Police Service ("QPS") and the Department (on 13 February 2004) of BJN's injury. The SCAN referral team was concerned about how BJN's injury occurred, Ms D's ability to care for a young child, her level of depression and whether this impacted on her ability to care for BJN.

45. The Department recorded the information as a child protection notification which required the Department to undertake an investigation and assessment of the information. Ms Leonie Keitley, a Child Safety Officer ("CSO"), was allocated the matter to investigate. The investigation took place between 16 February 2004 and 23 February 2004. During the course of the investigation, Ms D was willing to engage with the Department and QPS and provided information freely (including disclosing an incident where she had shaken BJN after becoming frustrated). During the investigation, Mr N indicated he believed Ms D was coping and doing a good job looking after BJN.

46. The outcome of the investigation was that there was substantiated risk of harm to BJN due to his young age and high vulnerability, Ms D's young age and having limited experience caring for a baby and Ms D's level of stress and sleep deprivation with caring for a newborn. There was also a concern Ms D was depressed which may impact on her ability to care for BJN when stressed.

47. It was determined that the Department would provide support to Ms D, Mr N and BJN and link the family in with the Departmental Family Resource Worker ("FRW") associated with Queensland Health's Family Care Program where a child and family health care nurse would provide support to the family until BJN turned 12 months of age and the mother with counselling.

48. The involvement of the FRW was known as the Intensive Family Support Program ("IFS") which aimed to assist families to link into supports and try and prevent a family from needing more active involvement from the Department. Between 16 March 2004 and October 2004, a number of FRW's visited the family home on approximately 9 occasions and conducted a number of telephone consultations concerning BJN's progress and the financial position of the family (which was dire at that time).

49. Ms D was provided with parenting skills and support and discussed her depression and medication. She refused counselling as she had not found it beneficial in the past but was linked in with a young mother's group for support.

50. During a visit on 12 May 2004, the house was described as being messy but not dirty and Ms D disclosed she was pregnant again and expressed some concerns about how she would cope with two children of very similar ages. By July 2004, Ms D was much happier and in

control of her life. There was also an indication the family seemed on track with their finances. The fortnightly FRW visits continued until the new baby was born.

51. On 9 September 2004, there was an IFS case review ("the review"). The review noted Ms D was off anti-depressants, pregnant again and had reformed her relationship with her mother. The review determined Ms D needed support/counselling for emotional needs. It recommended long term options for support for Ms D to develop networks be explored and a check of Ms D's history with the Department was recommended to determine if Ms D's mother posed any risk to BJN. The review concluded the case was to be closed only if an appropriate referral was available.

52. There is a handwritten note on the review "grandmother appears to be a significant risk". There is a further handwritten note in the file noting Ms D's history with the Department in 1991 and 1993, Ms D's mother was a significant risk and that Ms D's mother was looking after BJN one day a week.

53. On 9 September 2004 a referral for Ms D was made to Anglicare to be placed on the family support program for parenting skills training. It is unclear whether Anglicare ever made contact with Ms D.

54. There was a further visit by an FRW on 24 September 2004. During this visit it was identified Ms D had formed a good relationship with her mother and felt confident she could manage two children under one. Mr N had obtained a full time job which had improved the family's financial situation. Ms D was attending a mother's group and now had social outings and supportive friends.

55. The final visit by an FRW occurred on 7 October 2004. The case note recorded the house being very messy and Mr N sweeping old biscuits from the floor. Ms D was not resistant to continued monitoring by the Department however she had reformed a good relationship with her mother who she was now visiting three times a week. The FRW discussed Anglicare family visiting/care program however Ms D was of the opinion this was not needed as there are other people to help her such as her doctor/child health nurse. Ms D was congratulated on her progress with parenting, recognising when she needed outside assistance and working on her relationship with her family. The case note recorded the case was to be closed and on 21 December 2004, the case was formally closed by the Department.

56. The case notes reflect that Ms D appeared to enjoy the visits with the FRW's. Ms D recalled the visits ceased prior to 12 months because the FRW's felt Ms D was coping. Ms D gave evidence she felt more comfortable and the visits helped however she was not 100% better when they ceased. Ms D was of the view she would have liked the

visits to continue however she did not raise this with the FRW's at the time.

57. Mr N claimed in his statement that at no time did he speak to anyone from the Department, nor was he aware the Department had an ongoing plan and were monitoring Ms D however when giving evidence he indicated he was aware the Department were visiting the house. When queried, Mr N indicated he knew someone was coming around to visit but he did not know what organisation they were from. He later indicated he believed it was a child health nurse from the hospital. During this period of time, Mr N indicated during evidence he was not concerned regarding Ms D's ability to cope and as a result he did not need to discuss this issue with any of the individuals who were visiting the house to provide assistance.

Bundaberg

58. In April 2005 the N/D family moved from Rockhampton to Bundaberg. After staying with Mr N's parents for a few weeks they rented a property near the show grounds. The evidence provided by Mr N's mother, Mrs N, and Mr N suggests that upon moving to Bundaberg the state of the house was messy, the hygiene of the entire family (including Mr N and Ms D) was lacking and Ms D was, over time, increasingly struggling to cope with the care of the children (which included AJN following her birth in September 2006).

59. Mr N claimed Ms D also started getting bouts of depression and would tell Mr N she was going to cut herself. Mr N indicated in evidence he was of the view Ms D was not coping with the care of the children. He did not take any action and they were arguing regarding Ms D's inability to cope and the state of the family home. Mr N gave evidence he was unable to assist any further because he was working extremely long hours and the short periods of time when he was at home he spent cleaning, sleeping or cooking. The evidence suggests by the start of 2007 the state of the house and Ms D's ability to cope with three small children for long periods of time had deteriorated significantly.

60. The following observations were made by Mr N, Mrs N and a friend of Mr N, Ms J (who later became Mr N's partner following the breakdown of the relationship between Ms D and Mr N):

    a. the house was often filthy;
    b. the house stank of urine;
    c. there were dirty nappies left around the house;
    d. the walls had faeces smeared over them;
    e. there were maggots in the kitchen sink, dishes, kitchen table;
    f. there were maggots in JTN's nappy; and
    g. the children were often locked in rooms for time out or to have a rest because they would not listen to Ms D.

61. Ms J became so concerned about the state of the house and Ms D's ability to cope that she raised her concerns with Mr N on a number of occasions. She initially wanted Mr N to provide Ms D with more support and provide more assistance.

62. Ms D gave evidence that whilst in Bundaberg she struggled to cope with the three children. She indicated a number of people, including Mr N, raised concerns with her regarding the physical and emotional well being of the children and the state of the house. Ms D agreed with the above observations however denied maggots were ever in any of the children's nappies. Ms D indicated one of the reasons she did not seek assistance with her depression and ability to cope was possible repercussions for care of children. She also conceded she did not want psychological or psychiatric treatment.

63. Eventually at some stage between February and May 2007 Ms J contacted the Queensland Police Service who advised her to contact the Department. Ms J claimed she then contacted the Department on the telephone (on at least one occasion, possibly twice) and enquired as to the process of making a complaint as she was concerned about Ms D's depression, the state of the house and how Ms D was coping with the children. Ms J claims she provided the Department with Ms D's full name and the first names of the children. Ms J was told the information would be forwarded on and looked into if it needed to be followed up further. Ms J did not make a formal complaint because she hoped the small amount of information she had provided would be considered and actioned. No notation of this conversation was located in the Department's files.

64. In March 2007, Mrs N was so concerned about the state of the house and the ability of Mr N and Ms D to care for the children that she arranged for the children to be minded and she engaged in a very frank discussion with her son and Ms D. Mrs N told the parents they could go to the Bundaberg Neighbourhood Centre for counselling or she would contact the Department. Mrs N was of the opinion if the state of the house did not improve then it was worthy of notifying the Department. Mrs N asked Ms D whether she would like to see a counsellor for assistance. Mrs N recalled Ms D jumped at the opportunity. Mrs N was focused more on ensuring Ms D received assistance because she was the primary caregiver of the children. Mrs N decided not to notify the Department because Mr N and Ms D gave the impression they wanted to improve the situation and were willing to engage with the Bundaberg Neighbourhood Centre.

65. Ms D and Mrs N attended the Bundaberg Neighbourhood Centre on 6 March 2007. As a result of their attendance, Ms D was referred to the Bundaberg Base Hospital for an assessment. Arrangements were also made through the Bundaberg Neighbourhood Centre for Ms D to attend a mothering course and arrangements were made for the

children to be placed in day care for two days a week for Ms D to have some respite and time to clean the house.

66. Mrs N remained in Bundaberg for a week or a week and a half. When Mrs N left Bundaberg, she believed Ms D was getting counselling and an appointment had been made with the Department to come around and check the house. Mrs N believes the information about the Department visiting came directly from Ms D and she had indicated "CPU" or "CPS" would be visiting. Mrs N assumed this was a reference to the Department. By the time Mrs N departed Bundaberg she was of the view the situation had improved (whilst the house still smelled, it had been tidied up) and she was confident that a number of different services had been engaged to assist the family.

C. The appropriateness of the involvement by Queensland Health in 2007

67. On 9 March 2007, Registered Nurse Janelle Grills assessed Ms D and ascertained she had post natal depression in the high range and fulfilled the criteria for intervention by an early intervention specialist ("EIS") social worker ("SW"). The purpose of the intervention by an EIS SW was to provide early intervention and parenting initiatives by working intensively with targeted families with complex needs using evidence based strategies. The EIS SW provided parenting and family support. The ultimate aim of the intervention was to increase family protective factors and reduce family risk factors associated with parenting.

68. In early 2007, the role of the EIS SW was being performed by Ms Susanne Enright who operated in this role 5 days a fortnight. Ms Enright recalled the role was busy and she worked with approximately 10 to 12 client's (which may include the entire family) at a time. At the same time, Ms Enright also worked with the Department as a CSO 5 days a fortnight. Ms Enright had worked for the Department for over 10 years and had extensive experience in all aspects of the various roles a CSO might perform. Ms Enright agreed due to her employment with the Department she would be more alive to issues relating to child safety and the types of situations that are reported to the Department.

69. There was no mandatory requirement under the relevant legislation for social workers to provide information to the Department however Queensland Health had implemented a policy which required any staff to do so when there was a reasonable suspicion of harm to a child. Harm was identified as any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing. The notification was to occur within 24 hours of the harm being identified.

70. Ms Enright conducted three home visits (on 20 March, 28 March and 18 April 2007) and spoke to Ms D on the telephone a number of occasions (3, 11 and 24 April and 1 and 5 May 2007). Ms Enright's

general recollection of the house was that it smelled of stale urine, however this was not uncommon in some families with young children. The lounge room resembled a comfortable well used family area and she did not recall it being particularly messy. Ms D was friendly and cooperative however she was resistant to receiving mental health treatment and taking medication.

71. Ms Enright's general recollection of the children was that BJN and JTN behaviour was inappropriate, they were hyperactive and constantly fighting and the household was chaotic. Ms Enright's general impression of Mr N was that he worked long hours and was unable to assist Ms D with the children.

72. Ms D's involvement with Ms Enright was entirely voluntary and she could have ceased her involvement at any time. On all visits and telephone calls (with the exception of 11 April 2007, see below), Ms Enright was of the opinion Ms D was cooperative, engaged well with her, was open and honest in the information she provided and appeared willing to receive assistance from Ms Enright.

73. The notes from 20 March 2007 record Ms D identifying she was depressed. Ms Enright observed that Ms D was not focused on the children's needs or management. She identified that Ms D was living in isolation and the children were not mixing with other children. Ms Enright's assessment from this visit was that Ms D did not have an understanding there was a problem with the care of her children. She intended to visit in a week and encourage Ms D to attend a playgroup or something similar to up skill Ms D's parenting skills.

74. Ms Enright indicated she would have liked to have involved Mr N in her plans (to support Ms D and assist with making referrals) however he was not present at that stage.

75. On Ms Enright's visit on 28 March 2007 she recorded speaking to Ms D regarding her depression. Ms D indicated she had experienced unhappiness, sadness, difficulty sleeping and things had gotten on top of her. Ms Enright identified that Ms D's main issue stemmed from her relationship with Mr N. Ms Enright suggested counselling however Ms D believed this would be too difficult due to the children. Ms D also disclosed she did not discuss her feelings of depression with Mr N as it would cause arguments. Despite this information, Ms Enright's assessment later in her notes recorded she was of the opinion Ms D was coping well that day.

76. During the visit, Ms Enright recalled thinking BJN and JTN seemed not to have reached age appropriate milestones. Ms Enright believed Ms D was more involved in the children's care however she still required some instructions from Ms Enright to attend to AJN. Ms Enright's concerns for the children at this visit were that the house smelled, JTN had a smelly nappy and she had to instruct Ms D to attend to AJN. Ms

Enright was of the view the concerns she had did not warrant notification to the Department. She was also concerned regarding Ms D's ability to cope with her depression.

77. Upon completing the session, Ms Enright realised Mr N was present at the residence. She recalls introducing herself (by her name and title) to Mr N. Ms Enright believes she would have advised Mr N she was helping with parenting support. Ms Enright does not recall the discussion she had with Mr N but had not recorded that he expressed any concerns. Mr N was of view at this point in time Ms D was not coping. Despite his concerns, Mr N did not take the opportunity to raise these concerns with Ms Enright or at least identify to Ms Enright he had concerns and arrange for a more convenient time to discuss them. Mr N claimed he was unable to do so because he worked long hours and had a potential buyer travelling down to meet him regarding the sale of a motor vehicle.

78. Ms D telephoned Ms Enright on 11 April 2007 as Ms D was still unwell from a medical procedure. From Ms Enright's records, it would appear this was a lengthy telephone discussion. Ms D indicated that her depression was improving. Ms D disclosed injuries BJN and JTN had suffered. During the phone call Ms Enright recalls hearing the boys fighting over uncooked meat in the fridge they wanted to eat. Ms Enright's notes record that Ms D was appropriate in interrupting the phone call to diffuse the boys' fighting. During the phone call, Ms D was not interested in talking to Ms Enright and she did not appear to want to engage however the phone call still appeared to be lengthy.

79. Ms Enright conducted her last visit on 18 April 2007. During this visit an incident occurred with a taxi on the street. The taxi driver hassled Ms D who handled this situation well however BJN and JTN drifted out onto the road and Ms D was unable to get the boys to listen to her. The boys were still in soggy nappies and Ms D was active with the children however not in an appropriate way. Ms Enright gave evidence this suggested Ms D was improving.

80. Ms Enright re-enforced to Ms D that the boys needed constant constructive occupation. Ms D was not convinced of this however she was receptive to the information being provided by Ms Enright. Ms Enright was of the opinion the children would benefit from the stimulation and socialisation of childcare. Ms D saw the benefit of this however her health and the family finances restricted this from occurring.

81. On 24 April 2007 Ms Enright called Ms D. Ms D indicated the children had misbehaved and she had contacted a friend to mind the children so she could cope. Ms Enright viewed this action as a positive sign because Ms D had identified she was not coping and took steps to try and reduce her stress.

82. On 1 May 2007 Ms D advised Ms Enright she and Mr N had agreed to separate. Ms Enright planned to research out of hours relationship counselling.

83. On 14 May 2007 Ms Enright telephoned Ms D. Ms D indicated she was going to return to Rockhampton to be close to her parents. Ms Enright was aware Ms D was going to be caring for the children. Whilst she had non-specific concerns regarding Ms D's ability to cope there was nothing from her involvement that indicated the children should be cared for by someone else. Ms Enright indicated to Ms D she should seek follow up counselling in Rockhampton and take BJN to a GP for a paediatric referral so a determination could be made if BJN was physically and age appropriate. Ms D stated she would like to attend the Women's Health Clinic for counselling.

84. Ms Enright contacted the Rockhampton EIS SW to make a referral for Ms D. There are no records of this in the file however Ms Enright distinctly recalls making the telephone call because she recalled being surprised at the information she received. The Rockhampton EIS SW advised Ms D would not be automatically followed up however the referral would be considered and if necessary, the family would be followed up. On 21 May 2007 Ms Enright closed her file.

85. Ms D indicated she found Ms Enright's visits helpful and she had a positive relationship with Ms Enright however she later indicated she was unhappy Ms Enright told her how to raise the children and she did not want Ms Enright coming to house.

86. Ms Enright was of the opinion at no stage during her visits to the family home did she ever suspect the children to be at risk of imminent harm. Whilst she had concerns the children were being neglected (e.g., soggy nappies, boys speech delayed and Ms D not always being tuned into the children's needs), they were not to the degree that would require mandatory reporting. Ms Enright indicated she never saw faeces on walls or maggots in the children's nappies. She gave evidence if she had observed this she would have made an immediate notification to the Department. Ms Enright also viewed photographs of the D family house in Rockhampton following the fire. She indicated the family home in Bundaberg was in a remarkably better state than the photographs.

Breakdown in the relationship between Ms D and Mr N

87. In May 2007, Mr N and Ms D agreed to terminate their romantic relationship. It was agreed the children would live with Ms D. Arrangements were made between Mr N and Ms D in relation to their financial obligations. Mr N accepted the bulk of the family's financial debt.

88. In his letter to the Coroner, Mr N claimed he was unable to afford to take the children and the Department were monitoring the children. Mr N believed the children would be fine until he was able to clear the debt and file for custody. The only information he had the Department was monitoring the children was from Ms D.

89. Approximately 5 weeks after their separation, Ms D decided to return to Rockhampton to live with the children with her parents and siblings. Mr N indicated he did not agree with Ms D and the children moving to Rockhampton however he agreed on the basis Ms D was intending to obtain counselling and would have increased support from her family in Rockhampton. Mr N believed the only way he could have prevented Ms D from moving was to undertake some sort of legal action. Mr N stated he considered this however he did not take any action as the family was in substantial debt.

90. Mrs N was concerned when she learned Ms D and the children were moving to Rockhampton because she believed ongoing monitoring might not occur. Mr N and Ms D both informed Mrs N the Department would continue monitoring the family.

Engagement with Rockhampton Women's Health

91. Ms D moved to Rockhampton in June 2007 and in July 2007 she approached the Rockhampton Women's Health for assistance on a voluntary basis. Ms D attended counselling sessions with a counsellor, Ms Briggs, from July 2007 until May 2008. In addition, Ms D also attended two courses run by Rockhampton Women's Health.

92. Ms Briggs was of the understanding if she believed children were at risk of harm or neglect she was required to notify the Department. Ms D disclosed to Ms Briggs previous involvement by the Department so this heightened Ms Briggs' thought process to be aware of this issue.

93. During 2007, Ms Briggs recalled three of the appointments were at Ms D's residence (when the children would be present) and the remainder were at the office. On some occasions, Ms D would bring the children with her to appointments at the office. Ms Briggs estimated she probably saw the children on 5 or 6 occasions in 2007.

94. Ms Briggs was of the opinion when Ms D was with the children she brought something for the children to eat and drink, they were clean and dressed appropriately and she attended to their needs. Ms Briggs did not observe the children with lice or ringworm nor in clothes that were dirty or smelt. During home visits, Ms D would attend to the children's needs appropriately. Ms D often spoke to Ms Briggs about how she was coping with the children. There was never any information disclosed to Ms Briggs that Ms D was having difficulty caring for children.

95. On 28 May 2008, the structured counselling sessions terminated to allow Ms D to put skills she had learnt into practice. Ms Briggs indicated in evidence Ms D was getting better.

96. Ms Briggs was shown photographs of the state of Ms D's residence immediately following the fire. Ms Briggs indicated she had only ever observed the kitchen and lounge room area. Ms Briggs was of the opinion the photographs depicted more clutter than what she had observed however on her visits the house was cluttered. Ms Briggs formed the view the clutter was as a result of a number of people residing in the home. On all occasions Ms Briggs observed the children clean and dressed appropriately.

97. Ms D gave evidence her sessions with Ms Briggs assisted her depression and her ability to cope and by August 2008 she was coping well with the children.

The children's contact with Mr N and concerns held by Mr N and his family once the children resided in Rockhampton

98. Mr N stated in his letter he was informed the Department were still visiting Ms D, her counselling had been transferred to Ms Briggs and everything was going well. Mr N received a letter from Ms Briggs outlining Ms D's progress and the need for support. Mr N did not reply to this letter as they had separated. However in evidence Mr N claimed he had contacted Ms Briggs and outlined what had happened with the children over the previous years, the state of the house in Bundaberg and asked if Ms D could be monitored.

99. Mr N recalls receiving two phone calls where he was advised details of Ms D's counselling could not be provided however Ms D would be monitored. Mrs N recalls Ms D advising she was doing a mothering course or something similar and everything was going alright.

100. Mr N indicated upon visits to the D family home in Rockhampton the house was not great however it was not as filthy as their home in Bundaberg. He also indicated he never saw the D home in the state depicted in the photographs following the fire. Mrs N, Mr N, Ms J and Ms D all gave evidence Mr N and/or his parents were able to visit the children or have the children visit them as often as they pleased. On a number of occasions the children would spend weeks to a month with Mrs N and her husband.

101. During these visits, Mrs N observed:

a. the children lacked basic life skills like toilet training and hygiene;
b. the children were provided with clothes that were either dirty or too small;
c. AJN had nappy rash that had not been properly cared for;

d. the children had head lice and/or ring worm
e. the children were difficult to control;
f. the children had behavioural issues and were behind developmentally;

102. Mrs N indicated she was growing increasingly concerned regarding the children's welfare and was almost at the same level of concern as when she intervened in March 2007. Mrs N raised her concerns with her son. He indicated he was speaking to Legal Aid.

103. A short time (probably around 2 months) prior to the fire, the children were due to visit Mr N and Ms J for a week. Mr N returned the children to Ms D early because BJN and JTN were destroying property and not obeying instructions and were difficult to manage.

104. Prior to the inquest commencing, Mr N (in his statement to police and a letter to the Coroner) indicated the following:

a. as a result of inconsistencies provided by Ms D he got in contact with the Department regarding their visits and the welfare of the children. Mr N was advised by the Department that everything was fine;
b. each time the Department told "us" the Department did not have enough information to do anything even though "we" told them about the state of the house and mistreatment and neglect of the children;
c. he had spoken to the Department in Bundaberg in person and on the telephone about his concerns regarding the children's safety and wellbeing and about having the children removed and brought down to Bundaberg;
d. In April 2008 Mr N and Ms J went into the Department's Bundaberg office to speak to someone about removing the children. They were told there was no reason for the Department to intervene; and
e. he had discussed with the Department having the children for a visit, not returning them to Ms D and applying for orders to retain custody of the children.

105. During evidence it became clear the assertions made by Mr N were incorrect as he had never, prior to the fire, contacted or spoken with anyone from the Department directly. Instead he had requested his partner, Ms J to undertake these enquiries. Mr N believed Ms J undertook these enquiries as she would inform him of the information she had obtained.

106. Ms J's statement gives the impression that notifications or contact was made with the Department prior to the fire. Ms J even states in her statement that after the fire they were "furious as we had told child services this was happening and now because they didn't act two of the three children were deceased".

107. During evidence, Ms J gave evidence she and Mr N had discussed their concerns regarding the children and whether they should speak to the Department or Legal Aid. Ms J recalls Mr N requesting her to make an appointment with the Department. Ms J did not do this, and at no stage did she contact the Department. She made an appointment with Legal Aid as she believed this would be the best organisation to discuss the possibility of caring for the children full time.

108. Mr N recalls attending an appointment with Legal Aid prior to the fire. Mr N was instructed to obtain sufficient accommodation for his children and Ms J's (Ms J was the primary caregiver of two children from a previous relationship) and the next time the children visited he should refuse to return them to Ms D and apply for custody.

109. Mr N and Ms J both conceded Ms D was always willing for them to visit and care for the children. They were both asked why they did not simply ask to continue to care for the children (which it would appear Ms D would have been agreeable to) if they were so concerned regarding their welfare. Both agreed there was nothing preventing them from requesting this although Ms J indicated their house was not large enough and she was attending classes and working long hours so there needed to be further discussion and planning regarding the care of five children.

110. The evidence was consistent that the children were due to visit with Mr N and Ms J approximately two weeks after the fire.

D. whether there was any involvement of the Department of Child Safety or notification of concerns provided to the Department of Child Safety between 2004 and the fire.

111. Mrs N claimed during the time of Ms Enright's visits, Ms D would call to tell her the Department was attending the house to do spot checks. Mrs N claims Ms D was upset because she was being told how to raise her children. Ms D recalls providing this information to Mrs N however she was not sure of the name she used to describe the government agency the individuals were from. In evidence, Mrs N could not recall what organisation was visiting Ms D however she made an assumption they were from the Department.

112. Mr N claimed both Ms D and Mrs N advised him the Department was visiting and had indicated the household was fine. Mr N did not agree with this assessment however he did not take any steps to contact any of those individuals he believed were performing the assessments because he was not home when they visited and he believed they were continuing to monitor the family.

113. Mr N, in his statement to the QPS (and made under the *Justices Act 1886*), stated he had observed Ms D ring and postpone visits from

government agencies. However he indicated in evidence he never actually observed this occur directly, he was advised of this by other individuals and Ms D. Ms Enright gave evidence Ms D did not cancel appointments often and/or without a satisfactory reason.

114. The Department have strict policies and procedures regarding the recording of any information concerning children. These policies direct any information (in whatever form it is provided) detailing concerns regarding children be recorded. The Department conducted an extensive search and were unable to find any records suggesting involvement with the family or records of concerns held regarding the children between 8 October 2004 and 29 August 2008.

MATTERS REQUIRING FURTHER ATTENTION

Smoke Detectors

115. From 1 July 2007, smoke alarms became mandatory for all houses and units throughout Queensland. When this legislation was introduced, the QFRS embarked on a public awareness campaign. The owner of a building has the ultimate responsibility of installing smoke alarms and replacing batteries in smoke alarms however tenants must advise the lessor if a smoke alarm needs replacing. The legislation also creates an offence for any person who removes a smoke alarm, removes the battery from a smoke alarm or does anything that would reduce the effectiveness of the warning provided by a smoke alarm.

116. The location requirements for smoke alarms mirror the location requirements for smoke alarms contained in the Building Code of Australia for new homes. This requires there be a minimum of one alarm outside sleeping areas and one alarm on each level of the home.

117. The QFRS indicated it was currently seeking a review of the current penalty applicable for failing to comply with the provisions requiring smoke alarms with a view to increasing the penalty in instances where death or serious injury occurs as a result of failure to install smoke alarms.

FINDINGS OF FACT

118. Ms D gave full and frank evidence. She was honest in her recollections about her inability to cope with the children at various stages.

119. The Department's involvement with the family in 2004 was appropriate and appeared to have provided helpful support and assistance to Ms D. It would have been preferable for those determining to cease the IFS program to have been aware of the concern raised in relation to Mrs D (and conducted further enquiries) prior to ceasing involvement with the family. It also would have been preferable for IFS to have

continued, or for the Department to have ensured Ms D was engaged with Anglicare, until after the birth of JTN, to ensure Ms D was still coping adequately. However in the absence of specific concerns being raised at the time, it was appropriate for the Department to disengage.

120. There is no doubt by early 2007 Ms D was struggling to cope with caring for three small children. It would appear Mr N, who worked long hours, provided very little assistance with their care.

121. It is unlikely if Ms J contacted the Department prior to the relationship breaking down between Ms D and Mr N, or that she provided the Department with sufficient information to identify the family members. If such information had been provided, it would have been recorded on the Department's file. Mr N had an opportunity to raise his concerns with Ms Enright however he elected not to do so probably because his concerns were not as great as he later claimed.

122. The engagement of the EIS SW was appropriate. Ms D found this involvement helpful and despite Ms Enright's views regarding Ms D's depression rating, it would appear this involvement was a positive experience and assisted the family unit. However, the referral to the Rockhampton EIS SW might better have been made in writing rather than Ms Enright's phone call (especially in light of the negative response to Ms Enright during the call) to ensure that follow-up was made. But for Ms D's voluntary engagement with Rockhampton Women's Health, she would have been unsupported.

123. It is unlikely that Ms D ever advised Mr N or his mother prior to the relationship breaking down that the Department were involved. It is more likely a miscommunication occurred and Mr N and his mother made (a not unreasonable) assumption that the support being provided was from the Department.

124. Mr N's evidence about contact with the Department was in direct contradiction to the information he provided to the police and the Coroner prior to the inquest commencing. It is also difficult to accept the version provided by Ms J, particularly as to the timing of her contact with the Department, which was clearly not until after the fire.

125. There was absolutely no contact with the family nor any concerns raised regarding the family with the Department between October 2004 until after the fire.

126. It was obvious the state of the house at the time of the fire was such that the Department should have been notified and could have then possibly monitored the family (Det Sgt Hanlen and Ms Enright agreed on this). The responsibility for the state of the house rested with all of the adults occupying the house.

127. It was clear the supervision of the children on the day of the fire was inadequate. It was also evident that on the day of the fire, cigarette lighters were easily accessible by the children of the household. The children were left alone by Mrs D for a period of 10 minutes during which time they started a fire. It is clear from the Department's records that Mrs D was not an appropriate person to be supervising the children in any event.

128. On these two bases, Departmental action was necessary. However, in light of the lack of reportable circumstances being evident or known to any persons in a position to report to the Department and the lack of report from family members about concerns later stated to be held, the Department's attention was not drawn to the situation until after the fire.

129. The poor state of the house contributed to the speed with which the fire spread and the extent of the fire. The misguided attempts to extinguish the fire have also contributed, particularly the opening of the window.

130. It is more likely JTN, once removed from the central bedroom, remained in the lounge room area until his death. In the haste to attempt to rescue AJN, it would seem he was inadvertently forgotten by Ms D and Mrs D until it was too late.

131. With the benefit of hindsight it would have been better for Ms D and Mrs D to have attempted to rescue the children and worry about extinguishing the fire later. It is clear that Ms D and Mrs D were faced with a difficult situation and made every attempt to try and save JTN and AJN.

132. It is unlikely if a smoke alarm had been operational it would have prevented the tragic outcome.

FORMAL FINDINGS

175. I am required to find, so far as has been proved on the evidence, who the deceased persons were and when, where and how the persons came by their death. After consideration of all of the evidence and exhibited material, I make the following findings:

Identity of the deceased person– The deceased persons were JTN born on the 26th December 2004 and AJN born on the 17th September 2006.

Place of death – JTN and AJN died at 13 A. Street, Rockhampton.

Date of death – JTN and AJN died on 12 August 2008.

Cause of death –The formal cause of death in relation to each of the children was incineration from a house fire. The children were subject to poor supervision from a person, their grandmother, who had

previously been determined by the Department of Child Safety to be an inappropriate person to do so. The children had access to cigarette lighters in the house. JTN set the fire in a bedroom with bedding, mattresses and clothing in close proximity. AJN appears to have been asleep or playing on one of the mattresses. The house was unkempt and messy with clothing and other household items strewn through the house which provided fuel to the fire once lit. During an attempt to extinguish the fire by family members, a window was opened, providing oxygen to the fire. Possibly due to the stress of the situation or due to not knowing what to do, family members concentrated on the fire rather than rescuing the two young children until it was impossible to do so. AJN was discovered in the bedroom where the fire originated and JTN in an adjoining room in the corner. It appears that he was attempting to escape the fire but could not find his way out of the house or did not know what to do. Despite the efforts of family members, neighbours and nearby workers, the children were unable to be rescued.

In the circumstances of this matter I do not propose to make any recommendations or further comment. I close the Inquest.

A M Hennessy
CORONER