QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Emelia Jade**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
DATE:	12/01/2022
FILE NO(s):	2020/636
FINDINGS OF:	Jane Bentley, Deputy State Coroner
CATCHWORDS:	CORONERS: child in care, pool fence safety, foster carers, placement capacity.

Contents

Background

1. Emelia Jade was one year and eleven months old at the time of her death. She was born on 21 February 2018.

2. At the time of her death she was on a Child Protection Order, under the guardianship of the Chief Executive, Department of Child Safety, Youth and Women's Services (the department) and living with foster carers FC1 and FC2. Also staying at the residence were five other children – three in the foster care of FC1 and FC2 – B1 (4 years), B2 (6 years), B3 (8 years), the grandson of FC1 and FC2, GS (11 years) and G1 (3 years) had been staying there for respite care for the previous week.

3. The residence of FC1 and FC2 is on seven acres of land. It is a single level, four bedroom house. There is a big patio at the back of the property which is fenced with a gate on the side. That gate has a bolt lock and a rubber band that keeps it from being opened. The house opens to the back patio through a glass sliding door. There was a child gate between the lounge and the kitchen.

Circumstances Surrounding the Death of Emelia Jade

4. On the morning of 13 February 2020 FC2 woke at about 6.15am and got breakfast ready. Emelia Jade woke up shortly after that and was watching television in the lounge room. The family went about their daily routine getting the older children ready for school. Whilst they were doing this Emelia Jade and G1 were in the lounge room.

5. FC1 went to find Emelia Jade and saw that she was not in the lounge room. The family looked around the house and surrounds for her.

6. Sometime after 8am FC1 saw that the patio gate was open. She told the boys to see if Emelia Jade was outside.

7. B3 went to the pool and saw her in the water and yelled out and pulled her out of the pool. FC1 ran to the pool and commenced CPR then carried Emelia Jade inside. FC2 called 000 at 8.17am.

8. Queensland Ambulance Service paramedics attended and also attempted to resuscitate Emelia Jade but they were not able to do so and she was pronounced

deceased at the house at 9.11am.

9. An autopsy was performed and the Forensic Pathologist concluded that Emelia Jade died from drowning. I agree with that conclusion. Emelia Jade's death was due to accidental drowning.

10. Police officers attended and observed that the pool gate was out of alignment and was not self-locking.

11. Later that day officers from Logan City Council attended the residence and conducted an examination of the pool fencing, including the gate and locking mechanism. They found that the gate and the lock were out of alignment causing the lock not to engage when the gate was closed.

12. FC1 and FC2 were asked about this and advised that the older children would open the pool gate by standing on the bottom rung of the gate to allow them to reach the lock. Over time this could cause the gate and the lock to be misaligned. FC2 would realign the gate and lock when he noticed that it was not locking. He said that B2 and GS had gone for a swim the previous evening and may have caused misalignment of the lock when entering the pool area. They had left the pool when heavy rain commenced and he did not check the gate after that. He said that he checked the patio gate after they came in from the pool and it was locked and secured.

13. Police officers concluded that it is likely that Emelia Jade made her way through the child gate between the lounge room and the kitchen, onto the patio area and then through the patio gate to the pool. Police believe that the patio gate was opened by the other children when they were getting ready to go to school. The pool gate was not locked properly due to the locking mechanism not latching properly after the boys had been swimming the evening before. FC1 believed that Emelia Jade and G1 were in the lounge room. She was getting another child ready for school. FC2 was with the two other children outside the house at the time.

14. Emelia Jade and G1 were left unsupervised for a short time whilst FC1 and FC2 believed they were behind a secure child gate.

15. Investigators noted that FC1 and FC2 had responsibility for six children aged under ten years at the time of Emelia Jade's death.

16. Investigators also commented that the Department of Child Safety had no mechanism in place to ensure that foster carers had ongoing compliance with regards to pool

fencing regulations.

17. Council records indicated that the pool fencing had been fully inspected on 27 April 2016 and a pool safety certificate issued on that date. The expiry date was 2018 but there was no requirement to have a further inspection unless the property was sold.

18. Logan City Council inspected the pool after Emelia Jade's death and found four regulatory breaches:

    - The pool fence was too low;
    - The gate did not close despite trying the latch from different angles;
    - The hinges on the gate were incorrect;
    - There was a box on the inside of the pool yard.

19. It was identified that during flooding in January 2020 the ground had destabilized which had caused the gate to become misaligned and not shut properly.

Child Protection History

20. Emelia Jade's mother had a diagnosed intellectual impairment.

21. The department first received a report of concerns for her children in February 2019 and commenced an investigation which resulted in the finding that Emelia Jade's mother was unable to care for her and her sister. They were removed from the mother's care on 23 May 2019 and placed with FC1 and FC2 on an emergency basis.

22. FC1 and FC2 were highly experienced foster carers and had been carers for 36 years at the time of Emelia Jade's death. FC2 was 76 years old at the time of Emelia Jade's death and FC1 was 74 years old.

23. Emelia Jade was originally placed with FC1 and FC2 on a short-term emergency basis but the department was unable to find any other carers for her so FC1 and FC2 agreed to look after her for the duration of the child protection order. They made this decision because they wanted her to have stability. They concluded though that they could not care for her long term due to her young age and their advanced years.

24. The Child Death Review Board investigated the circumstances surrounding Emelia Jade's death and identified two system issues:

- Assessment of placement capacity to ensure household safety;
- Pool safety for children in care.

Placement Capacity

25. When FC1 and FC2 agreed to care for Emelia Jade for the duration of her two year child protection order, their foster care agreement was updated to allow three primary placements and one emergency placement. Previously it had allowed two primary placements and one emergency placement.

26. It was noted that the department stated that child safety officers were concerned about the capacity of FC1 and FC2 to care for all of the six children in their household particularly considering the young age of the children.

27. Foster carers must have the capacity and support to care for the children living with them and to provide safe supervision, especially if they have a pool.

28. The internal review of Emelia Jade's death by the department identified:

    The duty of care to the carers, specifically considering their age and the number of young children in their care …. The need for ongoing assessment of placement capacity and carer suitability was considered important, and particularly with experienced carers who ability and circumstances may change over time.

29. The department found that the monthly visit to FC1 and FC2 by the carer agency (the external agency funded by the department to support carers) was inadequate to support their needs.

30. Whilst departmental policies and procedures provide guidance on assessing a carer's capacity it is limited and does not provide for a maximum number of children to be placed with carers. That decision is dependent on the judgement of child safety officers and foster and kinship care staff depending on the circumstances of the carers and children.

31. The review noted that departmental records did not clearly document what information was provided to or taken into account by the Placement Services Unit when assessing the capacity of FC1 and FC2 to care for Emelia Jade and her sister.

32. Recommendation 24 of the Qld Family and Child Commission's *Foster Care System Review Report* recommended that:

[the department] updates its policies and procedures to require the decision-makers, in situations where there is not a best match between a child and his or her carer/s, to document:

- *Any identified gaps between the child's needs and the carer's capacity;*
- *The additional support the carer will need to help meet the child's needs (and who will provide it and when);*
- *The steps it will take to make sure the child's needs are being met.*

33. The department has confirmed that the recommendation has been fully implemented.

34. It was recognized that the decision to place Emelia Jade with FC1 and FC2 was influenced by a lack of available alternative placements. The department recognizes that there is a critical need for more foster and kinship carers. Since 30 June 2015 the number of children in care increased by 14.5% whilst the number of carer families increased by 6.6%.

35. The limited number of carers available is a known systemic issue within the child protection system. Since Emelia Jade's death the department has undertaken a foster care recruitment campaign. The recruitment campaign was launched on 6 July 2020.

36. On 5 October 2021 the department advised of the current situation in relation to foster carers as follows:

- The department's latest corporate data shows that as at 31 March 2021, there were 3591 approved foster carer families. This is an increase of 59 approved foster carer families compared to 30 June 2020 (the first quarter immediately prior to the launch of the campaign). There was also an 11.9% increase in first time foster carer families (327 for the year ending 30 June 2020, compared to 366 for the year ending 31 March 2021).
- The data reflects some of the issues inherent in the foster carer space – foster carer numbers are too low to meet the needs of children in care, there is regular turnover of carers and recruitment of foster carers is difficult. These recruitment and retention issues are exacerbated by the increase in children entering care.
- As well as ongoing ways to increase foster carer recruitment and retention, the department is focusing on ways to increase kinship care. This is a major priority for the department going forward with kin care preferred to foster and residential care.

Pool Safety

37. The Board noted that the whilst the department checks pool safety through its household safety study process, this process occurs at set intervals.

38. FC1 and FC2's foster care support worker advised that the pool fence and gate had been found to be compliant, with the fence height never noted as a concern. Departmental records indicated a household safety study was completed on 3 October 2019 and the pool was deemed to be safe and was registered on the Qld Pool Safety Register. However, after the ground destabilized in January 2020 there was no record of FC1 and FC2 informing the department or the support workers of that issue.

39. Following a previous coronial recommendation requiring training of foster carers in regard to water safety, the department developed and mandated a training module to create water safety awareness for foster carers which has to be completed in the first 12 months of becoming a carer.

40. However, the primary responsibility to ensure pool fencing compliance rests with the owner.

41. The last household safety study for FC1 and FC2 was completed on 3 October 2019 and no pool safety issues were identified at that time (the flooding occurred after that date).

42. The Board noted that there is currently no clear requirement for carers to notify the department of changes in household safety, although there are requirements to notify of other household matters e.g., persons living in the house.

43. If the department had been notified of the issue with the gate latch it could have supported the carers to organise for the gate to be fixed and, if required, for temporary care arrangements for the children.

44. The Board considered whether carers should have a strong requirement to advise the department of household and pool safety issues when they arise to enable the department to take action or provide support to have the matter resolved.

45. On 5 October 2021 the department advised of the current situation in regard to household safety studies as follows:

- The department has taken the opportunity to review guidance around pool safety.
    - Currently, a household safety study is done as part of a carer's initial approval and subsequent renewals (12 months and then every 2 years). If a carer changes address at any time, a new household safety study would also occur at this time irrespective of when the carer's renewal assessment may be due.
    - Opportunities to periodically review and observe issues relevant to carer's household safety, such as pool fencing and water safety or use of age-appropriate devices (such as guard rails around stairs) may occur as part of routine carer visits and placement agreement meetings and be documented in placement agreements. These meetings occur at least every six months. The Child Safety Practice Manual includes the following prompt in information relevant to placement agreement meetings:
        - "information about the child's swimming ability, particularly if the carer or care service has a swimming pool, spa or other water hazards such as creeks, dams, rivers, water troughs, in or near their premises. If needed, develop a strategy to manage any identified risks".
    - The department is reviewing the current household safety study form and processes used to support carers awareness to update or raise issues when there may be material changes to their household premises that are either planned such as renovations, or unplanned such as following a flooding or storm event. The CDRB findings will inform this review.
    - The department regularly sends out communiques to all foster and kinship care agencies, and Child Safety Service Centres have individual communication protocols with foster and kinship carers they are supporting. The department will take the opportunity to message out the importance of ensuring legal compliance with pool fencing and pool safety and encourage child safety officers to discuss this with carers.

Conclusions

46. I find that Emelia Jade died from drowning. Her death was due to accident. At the time of her death, she was being cared for by experienced foster carers who, due to a lack of foster carers, were responsible for six children under twelve years of age.

Findings required by s.45

Identity of the deceased –	Emelia Jade
How she died –	Emelia Jade drowned after obtaining entry to a pool through an unsafe pool fence.
Place of death –	Jimboomba
Date of death –	13/02/2020
Cause of death –	1(a) Drowning

I close the investigations.

Jane Bentley
Deputy State Coroner
CORONERS COURT OF QUEENSLAND - SOUTHERN REGION
12 January 2022