STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Braxton Slager
Hearing dates:	28 August 2017 – 1 September 2017
Date of findings:	27 March 2018
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of child in out of home care, drowning, non-compliant swimming pool
File numbers:	2014/270933
Representation:	Mr G Craddock SC, counsel assisting, instructed by Ms J Murty Crown Solicitors Office Ms K Nomchong SC, instructed by Ms E Roberts of Curwoods for Ms Tarlinton Mr M Lynch, instructed by Ms E O'Brien of FACS Legal for the Department of Family and Community Services Ms M Barnett, instructed by Ms S Ariyaratne of Kennedys for Life without Barriers (LWB) and individual LWB workers Mr B Kelleher of counsel instructed by Ms R Hosking of Colin, Biggers and Paisley for Mr McBride Mr J Prus-Butwilowicz of counsel, instructed by Mr M Heffernan of Heffernan Legal for Ms Naumovska (and amicus for Mr J Slager)

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Introduction

1. On 13 September 2014, Braxton Slager was found floating in a swimming pool in the back yard of his foster carers' house at 58 Sentry Drive, Stanhope Gardens, NSW. Resuscitation efforts failed and Braxton was pronounced dead at Westmead Children's Hospital later that morning. He was only 22 months old. Braxton had been in temporary care for just over three weeks and his father was working towards regaining the care of his son in the near future. Braxton's death is a terrible tragedy and his parents have been devastated by their loss.

2. At the outset, I acknowledge the heartbreak and anger Braxton's family feel and I thank them for their participation in this inquest. His parents described Braxton as a unique and affectionate little boy who loved playing and being out of doors. He was full of laughter and joy. FACS workers recorded the special bond between Braxton and his father and how happy Braxton seemed during his family contact visits. Both Braxton's parents spoke of their unbearable grief and how the tragedy of their son's death had pushed them to question their own survival.

Role of the coroner

3. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] Given that Braxton was in care at the time of his death,[2] the legislature requires that the inquest is conducted by a senior coroner.[3]

4. A coroner may also make recommendations in relation to matters that have the capacity to improve public health and safety in the future.[4]

5. In this case, there is no real dispute in relation to the identity of Braxton, or to the date and place or medical cause of his death. For this reason, the inquest focussed on the manner and circumstances surrounding his death. In particular, the inquest examined the safety of the environment Braxton had been placed in and the level of the care that he was provided immediately before his death. It was also necessary to closely examine some of the policies of Life Without Barriers (**LWB**), the agency that provided Braxton's out of home care pursuant to an agreement with the Department of Family and Community Services (**FACS**). However, it is important to remember that the purpose of an inquest in these tragic circumstances is not to apportion blame to individuals involved in Braxton's care, but rather to see if it is possible to identify opportunities to reduce the kinds of risks that Braxton faced.

6. Coronial recommendations are constrained by the factual circumstances arising from the death under investigation. Final submissions provided by legal representatives for the family ranged well beyond the evidence presented in this inquest and touched upon matters well beyond my reach or indeed knowledge. They also contained significant factual

[1] Section 81 Coroners Act (2009) NSW.
[2] Braxton was the subject of a temporary care agreement which granted care responsibility to the Secretary, Section 24(3)(b) *Coroners Act* (2009) NSW.
[3] Section 24 Coroners Act (2009) NSW.
[4] Section 82 Coroners Act (2009) NSW.

inaccuracies. It is most unfortunate if legal representatives have provided a grieving family with unrealistic expectations in relation to the power this office commands.[5]

The evidence

7. The court heard oral evidence over five days and received extensive documentary material in nine volumes. The material included witness statements, expert medical reports, medical records, photographs, recordings and policy documents. At the conclusion of the evidence detailed written submissions were prepared by the parties.

8. A detailed "Outline of Facts" document was prepared by those assisting me[6]. Each party was encouraged to notify counsel assisting of any areas of disagreement in an attempt to narrow contentions. A final document was then produced. I rely heavily upon the resulting document in outlining a brief chronology of events.

Brief background and chronology

Background

9. Braxton Nicholas Slager (born Braxton Nicholas Lewin) was born on 24 October 2012 at Nepean Hospital, New South Wales[7]. He was the son of Vanessa Naumovska and Johnny Mark Slager.

10. Braxton's parents are separated. Until he was four months old, Braxton was under the care of his mother, Ms Naumovska.[8]

11. From the age of four months until he was approximately seven months old, Mr Slager, became involved and alternated taking care of Braxton with his mother.[9] From the age of seven months, Mr Slager took over as Braxton's full-time primary caregiver.

Vanessa Naumovska and Johnny Slager

12. Vanessa Naumovska and Johnny Slager each had a history of drug abuse which affected their capacity to provide adequate care for Braxton.[10]

13. Several months before Braxton's death, Mr Slager's ongoing use of drugs, became the focus of FACS workers involved with the family.[11]

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[5] It is beyond the scope of these brief reasons to catalogue all the inaccuracies to which I refer. Many of the inaccuracies contained in the submissions prepared for Ms Naumovska and Mr Slager are set out in detail in Counsel Assisting's Submissions in reply, dated 18/1/18 and in further submissions from those appearing for LWB, Ms Tarlinton and FACS.

[6] I thank counsel assisting, Mr G.Craddock SC and solicitor Ms J.Murty for their extensive work in summarising the material contained in nine volumes.

[7] Birth certificate (registration number 695/2014), Tab 58.

[8] ERISP transcript of Johnny Slager, Tab 35, page 2, question 11.

[9] ERISP transcript of Vanessa Naumovska, Tab 36, pages 10-11, questions 94-97.

[10] ERISP transcript of Vanessa Naumovska, Tab 36, page 11, questions 100-104.

14. Concerns over Mr Slager's history of drug and substance abuse combined with incidents of alleged domestic violence prompted FACS to conclude that Mr Slager was not suitable, in his then current state, to be a primary caregiver for Braxton.[12] Enquiries were made to determine an appropriate respite carer for Braxton during times when Mr Slager was affected by drugs. Mr Slager's nominations were considered unsuitable due to their own history of drug use, unavailability or because they lived too far away.[13]

15. Ms Naumovska and her mother were also considered unsuitable due to their previous history with FACS in relation to drugs and removal of children from their care.[14] Ms Naumovska's nominations were also rejected as FACS could not be satisfied that the nominees were responsible individuals.[15]

16. FACS decided to remove Braxton from Mr Slager's custody. They offered Mr Slager a temporary care agreement with the threat that, should he refuse, they would consider placing the matter before the Children's Court with a view to obtaining orders for the removal of Braxton from his father's care.[16]

17. On 20 August 2014, Mr Slager signed a voluntary temporary care agreement at the FACS office in St Marys, NSW.[17]

18. After Braxton was removed from his care, Mr Slager worked with FACS and his drug and alcohol psychologist, Dr Rick Turner, to resolve his drug issues.[18] He cooperated with FACS in applying to a rehabilitation program. He also returned to the Methadone program he had been on previously.[19]

19. On the night of 20 August 2014, Braxton was placed into the care of his paternal uncle, Matthew Slager.[20]

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[11] ERISP transcript of Johnny Slager, Tab 35, pages 2-3, questions 15-29.
[12] Statement of Erin Toutounji, Tab 45, pages 1-2, [4]-[5]; ERISP transcript of Johnny Slager, page 4, questions 31-33.
[13] Statement of Erin Toutounji, Tab 45, page 2, [4].
[14] Statement of Erin Toutounji, Tab 45, page 5, [13]; ERISP transcript of Vanessa Naumovska, pages 13-14, questions 118-119.
[15] Statement of Detective Senior Constable Allan, Tab 7, [47].
[16] Statement of Erin Toutounji, Tab 45, pages 2-5, [5]; ERISP transcript of Johnny Slager, page 4, questions 33-35.
[17] Statement of Karina Woodward, Tab 46, pages 2-3, [6].
[18] Statement of Karina Woodward, Tab 46, page 6, [15]-[16]; ERISP transcript of Johnny Slager, page 4, questions 34-35.
[19] Statement of Erin Toutounji, Tab 45, page 4, [9].
[20] Statement of Karina Woodward, Tab 46, page 3, [6].

20. On 21 August 2014, Braxton was placed into foster care with Julie Tarlinton and Greg McBride at 58 Sentry Drive, Stanhope Gardens, NSW.[21]

21. While Braxton was in temporary care, he had contact visits with his parents. These visits were initially supervised and then unsupervised. They took place four days per week for two hours on each occasion.[22] Mr Slager was always in attendance while, on occasion, he and Braxton would be joined by Ms Naumovska. In FACS officers' observations, Braxton had a good relationship with his father. Mr Slager was punctual with appointments and Ms Woodward's observation was that Braxton was always excited to see his father.[23]

Julie Tarlinton and Greg McBride

22. Julie Tarlinton and Greg McBride are carers who have been registered with LWB since May 2006.[24]

23. LWB is a not-for-profit organisation contracted by FACS to arrange the placement of children removed from parental custody into foster care.[25]

24. At the time of the incident, Ms Tarlinton and Mr McBride had most recently been re-authorised as foster carers by LWB on 10 June 2014.[26]

25. Ms Tarlinton and Mr McBride had received training for first aid in 2011 and Ms Tarlinton had done further training in autism and giving medications in 2013.[27]

26. At the time Braxton was placed into their care, both of them had current first aid certificates.[28]

27. Ms Tarlinton and Mr McBride lived at 58 Sentry Drive, Stanhope Gardens, NSW. The property is located on a battle axe block and had a pool in the backyard. The pool was not registered as required by s.30B of the *Swimming Pools Act 1992*. There were several baby gates located throughout the house.

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[21] Statement of Karina Woodward, Tab 46, page 3 [7].
[22] Statement of Karina Woodward, Tab 46, page 4, [8].
[23] Statement of Karina Woodward, Tab 46, page 5, [12]-[13].
[24] Statement of Rikki Taylor, Tab 42, page 5, [10].
[25] Statement of Rikki Taylor, Tab 42, page 2, [4].
[26] Statement of Detective Senior Constable Allan, Tab 7, page 58, [99] .
[27] Life Without Barriers, Carer Review Record (7 November 2013), Tab 66, page 15 of 36 (page 1252 of the brief of evidence).
[28] Statement of Detective Senior Constable Allan, Tab 7, page 66, [115].

28. Also in residence at the time of Braxton's death were Ms Tarlinton's and Mr McBride's daughters, Fiona McBride and Emma McBride. Emma McBride's partner and fiancé Mitchell Burgess and their 20-month-old son RB were also staying in the home.

29. In addition to the family, two more foster children were also under their care of Ms Tarlinton and Mr McBride. One was a 6-week-old infant, BB and the other was 9-year-old TJ. TJ was a child in need of special care and attention. He was diagnosed with a multitude of medical conditions including Severe Language Disorder, Attention Deficit Disorder, Autism Spectrum Disorder, Oppositional Defiant Disorder, Mixed Receptive-Expressive Language Disorder and Moderate Intellectual Disability.[29]

Braxton Slager

30. Braxton Slager was described by his father, Mr Slager, as "a fun-loving kid who was full of energy."[30] Ms Tarlinton described him as "full of beans"[31] and "very active"[32]. His FACS case worker, Ms Woodward described Braxton as being "very playful and active" as well as "really busy and curious". She said that he "loved being out in the open", and being "able to run and walk".[33]

31. Braxton was described as a climber, able to use stools and chairs to climb onto tables, kitchen benches, the TV cabinet and his cot.[34] While Braxton was adept at climbing upwards, it is not clear whether he was as proficient at climbing back downwards. Braxton would cry for assistance to get out of his cot.[35]

32. Braxton did not have any known health conditions and was up to date with his immunisation schedule.[36]

Events of 12 and 13 September 2014

33. On Friday 12 September 2014, the residents at 58 Sentry Drive, Stanhope Gardens had a takeaway dinner together at home around 6:30pm. They were joined by some friends.

34. Braxton was put to bed at 7:30pm by Ms Tarlinton and went to sleep approximately 20 minutes later.[37] Before she went to sleep at around 11:00pm, Ms Tarlinton checked in on Braxton and made sure he was tucked in.[38]

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[29] Statement of Detective Senior Constable Allan, Tab 7, pages 35-26, [52].
[30] ERISP transcript of Johnny Slager, Tab 35, page 4, question 36.
[31] ERISP transcript of Julie Tarlinton, Tab 30, page 7, question 75, (page 231 of brief).
[32] ERISP transcript of Julie Tarlinton, Tab 30, page 8, question 83.
[33] Statement of Karina Woodward, Tab 46, page 7, [18], (page 688 of brief).
[34] ERISP transcript of Julie Tarlinton, Tab 30, pages 7-8, questions 78-83; ERISP transcript of Johnny Slager, Tab 35, page 6, question 61.
[35] ERISP transcript of Julie Tarlinton, Tab 30, page 8, question 83.
[36] ERISP transcript of Johnny Slager, Tab 35, page 5, questions 45-46.
[37] ERISP transcript of Julie Tarlinton, Tab 30, pages 12-13, question 122.

35. Greg McBride, Mitchell Burgess and Chris Martin sat out on the back deck watching the football on TV and drinking beer.[39]

36. Sometime between 10:30pm and 11:30pm, most of the residents, with the exception of Mr McBride and the visiting Mr Martin went to bed. Eventually, Mr Martin was collected by his partner and they went home while Mr McBride stayed outside in the backyard.[40] At 10:30pm, Mr McBride said he checked that the pool gate was locked.[41]

37. On 13 September 2014 at around 3:00am, Emma McBride got up and went to the kitchen to make herself a piece of toast. At that time, Ms McBride noticed that her father, Mr McBride was still outside watching television.[42] She saw that the door to Braxton's bedroom was ajar, as usual, but did not see Braxton nor check in on him in case she woke him up.[43] She then went back to sleep.

38. Mr McBride went to bed at 3:30am. He said that before he went to bed he closed and locked the glass sliding door to the backyard and checked that all the baby gates were locked.[44]

39. At 5:00am, Ms Tarlinton woke up in order to prepare a baby bottle for BB and she said that she made sure the baby gates were shut before returning to bed.[45]

40. Mr Burgess woke up at 6:50am to go to work. He checked in on Braxton Slager and saw that he was still asleep.[46] A little later, as he was getting his things to leave for work, Mr Burgess saw Braxton was awake and standing at the baby gate between the kitchen and the dining room.[47] There was no baby gate between Braxton's room and the kitchen. He told Braxton to "go back to bed buddy" and after seeing him return to his room, he checked the baby gate was locked.[48] Everyone else in the household was still asleep.[49] Mr Burgess left for work around 7:30am.[50]

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[38] ERISP transcript of Julie Tarlinton, Tab 30, page 13, question 122.
[39] Statement of Christopher Martin, Tab 34A, page 3, [9],
[40] Statement of Christopher Martin, Tab 34A, page 3, [8].
[41] ERISP transcript of Greg McBride, Tab 32, pages 15-16, questions 169-177.
[42] ERISP transcript of Emma McBride, Tab 31, page 13, question 138.
[43] ERISP transcript of Emma McBride, Tab 31, pages 13-14, questions 141-146.
[44] ERISP transcript of Greg McBride, Tab 32, pages 9-10, question 98.
[45] ERISP transcript of Julie Tarlinton, Tab 30, page 20, questions 185-186.
[46] Statement of Mitchell Burgess, Tab 33, page 2, [10].
[47] Statement of Mitchell Burgess, Tab 33, page 2, [12].
[48] Statement of Mitchell Burgess, Tab 33, page 3, [12].
[49] Statement of Mitchell Burgess, Tab 33, page 3, [12].
[50] Statement of Mitchell Burgess, Tab 33, page 3, [14].

41. Ms Tarlinton saw Braxton Slager at approximately 7:45am when she changed his nappy and took him to the back room to watch television.[51] She noted that TJ was also awake and there at the time.[52] According to TJ Braxton was awake before he was.[53] After taking a shower, Ms Tarlinton took Braxton back to his room, changed his nappy again, took off his pyjamas and dressed him.[54] Leaving the television on for Braxton to watch, she took the pyjamas to the laundry and then went to the bathroom for some time.[55] She says that she made sure the baby gate was shut behind her.[56] She then went to the lounge where she stayed for a time checking Facebook before noticing Braxton was "too quiet."[57] She quietly opened the baby gate and checked Braxton's room to find he was not present.[58] Exiting his room, Ms Tarlinton saw that the back sliding door was open and upon entering the backyard she found Braxton in the pool.[59]

42. Ms Tarlinton says that she pulled Braxton from the pool, laid him on the grass and attempted to perform cardio pulmonary resuscitation ("CPR") on him, during the course of which she says that Braxton vomited on her.[60] From the moment she discovered Braxton, Ms Tarlinton began to scream, alerting her neighbours as well as waking up the other residents of the household.

43. At about 10:00am, neighbours, Elise Antoinette Hammond and Stephen Hawksworth and Mr Hawksworth's friend Wayne Batson, heard Ms Tarlinton's screams. Mr Hawksworth jumped the fence between the properties to assist. Mr Batson took longer to arrive as he went around the front and came through the side timber gate that was pushed open by Mr Hawksworth to allow him in. Three people, Ms Hammond, Ms McBride and Mr Hawksworth, on behalf of a panicking Ms Tarlinton who kept dialling the wrong number, rang triple 0.[61] Receiving instructions from a triple 0 operator over the phone, Mr Hawksworth and Mr Batson took over, from Ms Tarlinton, the performance of CPR.[62]

44. At 10:16am, the first ambulance arrived[63] and was subsequently followed by another two ambulances. Six paramedics took over CPR on Braxton.

45. Police arrived shortly afterwards.

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[51] ERISP transcript of Julie Tarlinton, Tab 30, page 13, question 125.
[52] ERISP transcript of Julie Tarlinton, Tab 30, page 13, question 125.
[53] ERISP transcript of TJ, Tab 34, page 11, questions 97-100.
[54] ERISP transcript of Julie Tarlinton, Tab 30, pages 13-14, question 127.
[55] ERISP transcript of Julie Tarlinton, Tab 30, page 14, question 127.
[56] ERISP transcript of Julie Tarlinton, Tab 30, page 19, questions 173-176.
[57] ERISP transcript of Julie Tarlinton, Tab 30, page 14, question 127.
[58] ERISP transcript of Julie Tarlinton, Tab 30, pages 21-22, questions 202-206.
[59] ERISP transcript of Julie Tarlinton, Tab 30, page 22, question 207.
[60] ERISP transcript of Julie Tarlinton, Tab 30, page 14, question 127. It is likely that this was not actually vomiting, but just the expelling of fluid from his mouth and throat.
[61] Statement of Steven Hawksworth, Tab 38, page 3, [12].
[62] Statement of Steven Hawksworth, Tab 38, page 3, [14].
[63] Statement of Nicole Williams, Tab 24, page 1, [4].

46. At about 10.22am, Careflight personnel arrived via helicopter and began supervising the treatment of Braxton. They injected Adrenaline and proceeded to intubate him.[64] Treatment was continued during extrication and transportation to Westmead Children's Hospital.[65] For the entire duration of treatment, Braxton's "heart never changed from asystole."[66]

47. Around 11:05am[67], the ambulance arrived at Westmead Children's Hospital and Braxton was handed over to hospital staff. At 11:25am, further treatment was considered futile, CPR was stopped[68] and Braxton Slager was pronounced life extinct by Dr Raymond Chin.

The state of the premises

48. It was observed by multiple individuals who attended the premises that the cleanliness of the residence was substandard. Police who attended the scene described the house as "messy and untidy" and the backyard as "messy, dangerous to children and similar to a dumping ground".[69] In particular, it was noted that the backyard contained multiple items, such as discarded building materials, tools, nails, metal objects, alcohol and beer cans.[70] Paramedics described the property as "untidy and unkempt"[71] and "messy and dark".[72] The water in the pool was green and appeared not to have been maintained or cleaned in a long time.[73]

49. There were three baby gates within the premises located to prevent the resident infants from wandering into the kitchen, the bathroom or out the front door.

50. The gates were located at the entrance to the kitchen from the dining area[74]; blocking the entrance to the meals area in the hallway from Emma McBride and Mitchell Burgess's room[75]; and blocking the entrance to the meals area in the hallway from Ms Tarlinton and Mr McBride's room[76]. These gates were difficult to open[77] and assistance would be required for those unaware of how they worked.[78] There was no gate between Braxton's room and the kitchen.[79]

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[64] Statement of Nicole Williams, Tab 24, page 3, [8].
[65] Statement of Matthew Chapman, Tab 25, page 3, [10], Statement of Nicole Williams, Tab 24, page 3, [9] (page 205 of brief).
[66] Statement of Nicole Williams, Tab 24, page 4, [14], p. 206 of the brief.
[67] Statement of Matthew Chapman, Tab 25, page 3, [11].
[68] Body tag of the deceased, page 3.
[69] Statement of Detective Senior Constable Allan, Tab 7, page 66, [113].
[70] Statement of Suzan Horton, Tab 8, page 4, [12].
[71] Statement of Nathan Sheraton, Tab 23, page 3, [21].
[72] Statement of Matthew Chapman, Tab 25, page 4, [13].
[73] Statement of Nathan Sheraton, Tab 23, page 3, [20].
[74] Crime scene photographs at Tab 73, pages. 2282-2285; plan at Tab 7, page 113.
[75] Crime scene photographs at Tab 73, page 2281; plan at Tab 7, page 113.
[76] Crime scene photographs at Tab 73, pages 2267, 2278; plan at Tab 7, page 113.
[77] Statement of Detective Senior Constable Allan, Tab 7, page 63, [108].
[78] Statement of Rhondele Mayo, Tab 40, page 8, [25].
[79] ERISP transcript of Greg McBride, Tab 32, page 10, questions 102-107.

The swimming pool

51. The swimming pool was an unregistered pool that had never received approval from Blacktown City Council.[80]. The pool was installed in October 2012[81]. It was essentially installed for a previous foster child, JB. She was sporty and her carers wanted an outlet for that at home. Installation was completed just a few weeks after the home environment checklist was carried out on 5 September 2012.

52. Neither the pool nor the enclosing fences complied with the Australian Standard.[82]

53. Andrew Bromley, the support of carer (**SOC**) for the foster carers, was responsible for completing a housing safety checklist on 5 September 2012 and also a carer review at the end of 2013.[83] As part of the latter review, Mr Bromley was required to check that the housing safety checklist was current. As he was not aware of any major changes to the house (including the installation of the pool) since he had prepared the checklist the previous September, Mr Bromley checked the box stating that it was. He says that he was not notified about the pool and he says it was not in any of LWB's files[84].

54. The record of the home visit conducted by Gizelle Daniel and Hamish Fasan of LWB on 2 September 2014, likewise does not mention the pool[85].

55. It seems that two other LWB staff members (Cathryn Bastick, clinician for TJ and Donna Wood, Case Manager for a previous foster child) were aware of the pool's existence but had not directly informed Mr Bromley or any of their managers until after Braxton's drowning.[86] Ms Bastick made notes about TJ enjoyment of the family pool in a March 2013 report concerning TJ.[87]

56. The swimming pool has since been removed from the residence.

The decision to take Braxton into temporary care

57. During his short life, Braxton came into contact with FACS in a number of different ways. Even before his birth his family had significant contact with the child protection system over generations, with both his mother and a sibling having been removed from their family of origin.[88] Braxton was reported to FACS on 11 occasions before his death, ten of these reports were categorized as demonstrating a risk of significant harm or ROSH. Two of the

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[80] Statement of David Apps, Tab 47, [6].
[81] Statement of David Apps, Tab 47 and the Nearmap evidence, see also the evidence of Emma McBride, Transcript 29/8/17, page, line 15
[82] Statement of Detective Senior Constable Allan, Tab 7, page 46, [75].
[83] LWB files, Tab 66, page 1237.
[84] Statement of Rikki Taylor Tab 42[15]; LWB files, Tab 66, page 1237.
[85] LWB files, Tab 63, page 950.
[86] Statement of Rikki Taylor, Tab 42, page 7, [16].
[87] Statement of Cathy Bastick, Tab 77B, page 2, [15a], annexure B (page 2457.9 of the brief).
[88] See the comprehensive history of these tragic events in Joint Child Death Review report, Exhibit 3.

reports occurred before Braxton was even born.[89] The first four were closed under "current competing priorities". Taken together Braxton's sisters had been reported 49 times.[90] FACS had already removed one half-sister and the other remained in the care of Ms Naumovska. This was clearly a family in need of significant support if any of the children were to remain safe.

58. The range of issues identified over the 11 reports in relation to Braxton were varied and included reports about chronic substance abuse by his both his parents, domestic violence against a previous partner by his father and physical and supervisory neglect and emotional abuse by his father. However, when FACS finally started working with Mr Slager in October 2013, the focus appears to have been almost entirely on the potential impact of Mr Slager's drug use on Braxton. Given the range of issues reported, it is difficult to understand why.

59. The Court was greatly assisted by the Senior Practitioner, Ms Kate Alexander, both in her oral evidence in relation to these issues and by her careful analysis of the background contained in the Joint Child Death Review report. I accept her view that Braxton was a "vulnerable child who needed a well-integrated service system so that he could be safe."[91] Unfortunately, the response he received was disjointed and superficial at best.

60. In my view, having done very little to support Braxton's wider family in a holistic manner over years, FACS caseworkers began to focus on Mr Slager's drug use, to the exclusion of all other concerns. However, even then instead of assisting Mr Slager with a long term, properly managed case plan to address his chronic addiction issues, the approach was haphazard and largely reactive. It is well beyond the scope of this inquest to critique in any detail the quality of the support offered to Braxton's carers before he entered out of home care (**OOHC**), however I am confident that it can be characterised as piecemeal and inadequate. I have no doubt that Mr Slager would have been a challenge to work with, given the entrenched nature of his problems, but FACS's contact with him came in fits and starts, visits were irregular and developed plans were largely unrealistic.[92]

61. Subsequently, caseworkers appear to have taken the view that nothing further could be done until Braxton had been removed. At the same time, they failed to give Mr Slager a clear idea of what was ahead if he did not get the help he needed. On any reading of the material, Mr Slager's addiction issues were by then chronic and relapsing. Any sensible person could see that they were never going to be solved in a couple of weeks. No rapport was developed between Mr Slager and those charged to keep Braxton safe. In August 2014, FACS caseworkers made a fairly sudden decision that Braxton needed to be taken into temporary care, immediately.

62. The push for a temporary care order was in my view both ill-conceived and poorly executed. Ms Alexander suggests that while it was "well intended", given the nature of the entrenched risk Braxton was exposed to, it could never have been successful within the kind of limited time-frame available. I am of the view that whether or not it was technically

[89] FACS Internal Child Death Review report, Exhibit 3, page 26.
[90] Joint Child Death Review report, dated Exhibit 3, page 6.
[91] Joint Child Death Review report, dated Exhibit 3, page 6.
[92] For detail of FACS work with Mr Slager from September 2013 to August 2014 see Joint Child Death Review report, Exhibit 3, pages 29-42.

legal, the temporary care order was flawed from the start. Informed consent was never obtained from Ms Naumovska and it is perfectly clear that Mr Slager only agreed because it was indicated to him that if he didn't agree it would likely be worse for him. I have no doubt that Mr Slager's fear and mistrust of the court process was the only reason he signed the paperwork. For Mr Slager, it was in effect a deal with the devil. He signed in an attempt to stave off care proceedings where he thought he was even more likely to lose the son he loved.

63. There is no doubt that a temporary care agreement is a legitimate and useful option in statutory child protection work, but it must be a voluntary agreement and should be undertaken carefully and consensually. Mr Slager's consent was flawed by what he saw as coercive pressure and Ms Naumovska did not give her consent at all. Further it is hard to reconcile the fact that Ms Naumovska appears to have been rejected, without formal assessment, by FACS as a possible carer for her own child, Braxton, while the Department left her daughter [redacted] in her care, despite all the reports that had by then been made. In my view, given the known views of Braxton's parents the matter should have been placed before a Children's Court and the parents offered comprehensive legal advice.

64. The relevance of the way Braxton came into care is obvious. There was no real planning, nor in my view was Mr Slager given an appropriate length of time to find an alternative. The situation had certainly been developing for months but the final denouement must have appeared sudden to Mr Slager, who up until that point had been successfully holding FACS at bay with promises to take decisive action in relation to his addiction.

65. The agreement was signed on 20 August 2014 and it was only after that time that FACS approached a number of services looking for an urgent placement for Braxton.[93]To my mind, it is both surprising and somewhat contradictory, given that the need for out of home care was so considered urgent, that within days Mr Slager was offered unsupervised access to his son.

66. In any event, the rushed nature of this whole process, once it finally happened, meant that there was no chance to properly consider the appropriateness of where Braxton was to be placed. Given that FACS had been aware of the potential risks in Braxton's life since the first prenatal reports, it is disappointing that so little time and care went into this life changing decision.

The decision to place Braxton with Julie Tarlinton and Greg McBride

67. The court heard that once the temporary care agreement was signed, FACS requested the placement occur the same day, as an "emergency placement". Under the OOHC funding contract, LWB was required to respond to "emergency referrals" from FACS within four hours.[94] Braxton Slager stayed with his paternal uncle overnight on 20 August 2014 and was placed with Julie Tarlinton and Greg McBride on 21 August 2014.

[93] Joint Child Death Review report, dated Exhibit 3, page 5.
[94] Client Death Review, LWB, Tab 84, annexure V, page 5.

68. According to the LWB Client Death Review report, the Operations Manager gave verbal approval for the placement of Braxton Slager to go ahead[95]. The relevant risk assessment document was not filled out until the following day, 22 August 2014[96] and was not approved by the Operations Manager until 28 August 2014.

69. There were a number of irregularities in the process. Ms Gizelle Daniel was the intake officer at the time Braxton was referred to LWB. She completed a document entitled "Unrelated Placements Risk Assessment", relying heavily on information provided by Bethany Standen.[97] There was no physical inspection of the premises and certainly no record of any discussion with the out of home carers about what to expect, prior to "dropping off" Braxton. Ms Daniel had not met the carers herself at the time she completed the document.[98]

70. Most significantly Ms Daniel approved the placement believing it was for a "very short time". In court she clarified that at the time the decision was made she thought it was "at the most a week or two weeks".[99] She was not surprised that Ms Tarlinton seemed to think she had been told it would be three days[100]. On the other hand, Mr Slager reported that he was told it would be reviewed on 4 September 2014 and then every two weeks.[101] Ms Toutounji's evidence was that a temporary care agreement might last as long as three months[102]. It is evident that right from the start there was a lack of clarity or perhaps a lack of transparency in the arrangement being made.

71. At the time of Braxton's placement, Ms Tarlinton was approved to provide care for two unrelated placements and one respite placement[103]. Once Braxton's placement went beyond three days, it was a short term placement, and clearly took Ms Tarlinton and Mr McBride outside the arrangement for which they had been authorised. Mr Best, the current State Director at LWB gave evidence that once the placement extended beyond three days a further assessment should have been conducted. [104]

72. It is well recognised that there is a real shortage of out of home carers in NSW.[105] LWB did not have a lengthy list of carers to carefully consider and then choose the best match for Braxton. In fact there is no evidence that there were any other options considered. In effect, there was no genuine consideration of whether the placement was well suited to Braxton's particular needs. Even leaving aside the state of the premises, there were a number of factors which, if properly considered, should have indicated potential risk. Each of these factors should have been known to LWB during the assessment procedure. They included:

    - JB had only recently left the placement after approximately seven years. Ms Tarlinton had treated this child "like a daughter" and does not appear to have

[95] Client Death Review, LWB, Tab 84, annexure V, page 6.
[96] LWB Unrelated Placements Risk Assessment (NSW Screening Tool) Exhibit 1, Volume 3, page 975 onwards.
[97] Ms Daniel, Transcript 28/8/17, page 81, line 25.
[98] Ms Daniel, Transcript 28/8/17, page 76, line 20.
[99] Ms Daniel, Transcript 28/8/17, page 82, line 20.
[100] Ms Tarlinton, Transcript 30/8/17, page 106, line 45.
[101] Joint Child Death Review, Exhibit 3, page 43.
[102] Ms Toutounji, Transcript 30/8/17 page 57, line 37 onwards.
[103] Exhibit 1, Vol 4, Tab 66, page 1130.
[104] Mr Best, Transcript, 1/9/17, page 39, line 30 onwards.
[105] See for example evidence of this fact from Mr Best at Transcript 1/9/17, page 36, line 20 onwards.

had any counselling or support in relation to her departure. There was no SOC worker in place. Ms Tarlinton agreed that with hindsight she was suffering from grief.[106]

- A new born baby, BB, who required feeding throughout the night, had been placed with Ms Tarlinton about a week before Braxton Slager's arrival. Ms Tarlinton would have been adjusting to the level of care required as she had not cared for a baby in many years. The whole family would have been adjusting to the arrival of a newborn.
- TJ, a child with autism, language difficulties and a moderate intellectual disability was already living with the family and also required a high level of care. It is possible that he was also adjusting to JB recent departure.
- Ms Tarlinton's grandchild, RB, also a toddler, was living in the house, along with his parents. This does not appear to have been known or properly factored in.
- Ms Tarlinton and Mr McBride were living separately under the same roof. He had significant financial problems. It is most unlikely that he was able to offer Ms Tarlinton any significant support during this period of great change.

73. The lack of support provided for Ms Tarlinton is a real issue in relation to Braxton's death. She was always recognised by the agency as the primary carer in the situation. This is clear from the way LWB related to the couple over many years. She was offered little support from Mr McBride.[107]

74. On the basis of the evidence of Mr Bromley and Ms Daniel at the inquest, it is also clear that there was no genuine assessment given to the question of whether Ms Tarlinton was in a proper state to take further children at the time she accepted BB and Braxton Slager. LWB had not provided a SOC worker to her after JB left. With hindsight, Ms Tarlinton accepted that she herself did not realise the extent to which she had been grieving this change in family circumstance. Mr Bromley had previously been in the role of SOC, but he failed to notice much more than that Julie was "angry and upset". There was no attempt to provide her with further support or counselling in relation to this significant issue.

75. In my view, the risk assessment procedure which took place was not a genuine assessment and is more accurately described as a rubber stamp given to a decision which had effectively already been made based on a lack of other options. In my assessment, placing Braxton with Ms Tarlinton, no matter how experienced she was, was inappropriate at that time.

Were the premises appropriate?

76. It appears that the last formal OOHC Environment Checklist was undertaken on 5 September 2012.[108] According to the then LWB policy, another OOHC Home

[106] Ms Tarlinton, Transcript 31/08/17, page 22, lines 45-49.
[107] Ms Tarlinton, Transcript 31/8/17, page 23, line 1 onwards.
[108] Environment Checklist, Exhibit 1, Vol 4, Tab 66, pages 1279-1287.

Environment checklist inspection should have taken place before 5 September 2014, but this had not occurred.[109]

77. Braxton Slager was dropped off at Julie Tarlinton's home on 21 August 2014. No further home inspection took place.

78. On 2 September 2014 Ms Daniel and a student Mr Fasan visited the home. This was apparently Braxton Slager's first home visit. Ms Daniel had been to the home about a week before but only to drop off the new born infant, BB. The purpose of her visit on this second occasion was to "complete some documentations (sic) and try to form some bonds with the children in care".[110] She told the court that she brought some "little gift bags" and tried to talk with Braxton.

79. Significantly Ms Daniel did not go anywhere else in the house except the formal living area. She does not appear to have asked or been told where Braxton Slager would sleep. Had she made this basic enquiry, it would have been obvious that Braxton's sleeping arrangements were less than adequate. Since he had been found climbing dangerously on a television unit, days after his arrival, Ms Tarlinton had placed him in a bedroom adjacent to the kitchen. This easy access to the kitchen was full of risk for a boy who everyone says loved to climb. With hindsight, Ms Tarlinton agreed the placement of Braxton in this room was, in the circumstances, inappropriate.[111]

80. Had anyone looked beyond the backdoor, it would also have been clear that the backyard was also full of significant danger. Quite apart from the non-compliant, green coloured swimming pool, there were pieces of rusty metal, beer cans and broken equipment in all directions. Mr Best, the State Director of LWB for NSW and the ACT, agreed in evidence that the state of the backyard, as depicted in photographs taken on the day of Braxton's death, was "alarming" and contained "many, many really obvious dangers for small children". [112]It is clear that unless Braxton Slager was supervised 24 hours a day, there was a real risk that alone, or perhaps assisted by another child, he could be exposed to significant harm in the back yard. All it would need was for someone to forget to close the backdoor or for another child to open it for him.

81. It is important to make very clear, that the court is not suggesting that the house or garden was merely untidy. Many caring parents provide safe homes for children which are quite untidy. The photographs[113] in this case demonstrate an environment that is full of genuine risk for an active toddler. On the day Braxton died the outdoor area was replete with danger. Cords were hanging precariously in the decked area, tools were unattended, lighters and cigarette packets were lying around. Police who attended described the danger as "similar to an unkempt building site where dangerous metal items, nails, tools etc could pose as a threat to a small child".[114]

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[109] For discussion of this issue see Submissions on behalf of Julie Tarlinton, [39].
[110] Ms Daniel, Transcript 28/8/17, page 76, line 40.
[111] Ms Tarlinton, Transcript 31/8/17, page 23, line 50.
[112] Mr Best, Transcript 1/9/17, page 19, 32 onwards.
[113] Crime Scene Photographs, Vol 6, Tab 73, pages 2214-2239, 2338-2347, and photographs taken by Detective Senior Constable Detective Senior Constable Allan, Vol 6, Tab 74, pages 2375-2405.
[114] Statement of Senior Constable Horton, Exhibit 1, Tab 8, [12].

82. It is common ground that the swimming pool was unsafe. The pool was not registered as required and the pool fencing was non-compliant and wholly inadequate.

83. On the day of Braxton's death the water was filthy and green. On arrival, Senior Constable Horton noted that there was a set of home-made wooden steps leaning against the side of the pool. There were pool chemicals on the platform. Floating on the water were three pool noodles, a volleyball, a floating chlorine dispenser device and a couple of other items.[115]

84. Ms Tarlinton gave evidence that the back yard was essentially "Greg's domain". She explained that she went out there rarely and that she had a "general rule that the children didn't go in the backyard and we played in the front yard". Nevertheless she accepted that she should have followed up on the arrangement she made with Mr McBride to contact council to ensure that the pool was properly compliant. For a curious and active child, reputed to love playing outdoors, it is easy to see that if Braxton saw an opportunity, through the glass door, to investigate what was outside, he would have taken it.

85. Taking into account the placement of Braxton's bedroom with his ready access to the kitchen and the backyard, it appears clear that the premises, as they stood at the time of the placement, were inappropriate for an active toddler.

86. Ms Taylor's evidence demonstrates that the information systems operating at that time within LWB contributed to the poor understanding of the environment in which Braxton was to be placed. Significant information gaps were created by the segregation of carer files from foster children files and between LWB's various location areas. The compartmentalised system meant for example that there could be clear reference to a family pool in a foster child's file, without there being any cross-referencing to the carer's file. [116]

87. LWB also relied upon a system where carers were expected to voluntarily disclose changes to their homes. That system did not work and Braxton was placed in an unsafe environment.

How did Braxton gain access to the pool?

88. As has been stated, the poor information systems used by LWB meant that while some LWB employees clearly knew there was a swimming pool at the 58 Sentry Street, that information was not properly recorded and no appropriate checking took place. Mr Bromley stated that he did not know of a pool, but given the evidence of Emma McBride, I find it hard to accept. It was certainly not at the forefront of his mind. By the time Braxton arrived at the house, the pool does not appear to have been in regular use, but it remained full and existed as an ongoing hazard.

89. I have carefully considered all the evidence before the court in relation to how Braxton ended up in the pool. Unfortunately, it remains unclear, except to say that for a short period of time Braxton was not directly supervised. Ms Tarlinton accepts that this was the case.

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[115] Statement of Senior Constable Horton, Exhibit 1, Tab 8, [13].
[116] Ms Taylor, Transcript 30/8/17, page 41, line 46 to page 43, line 19.

90. It is difficult to now know exactly how long Braxton was unsupervised. When Ms Tarlinton spoke to ambulance officers immediately after the discovery of Braxton, she seemed to suggest that he had only been out of her sight for a matter of minutes[117]. On careful review of her later evidence, it must have been over half an hour, possibly over an hour when one takes into account what she did. I accept Ms Tarlinton's evidence that she last saw Braxton alive in his room. She changed his nappy and then "laid him on his bed, because he was a bit whingy and he hadn't slept well the night before."[118] She then put on a DVD for Braxton to watch and left him there with half a bottle of milk. Ms Tarlinton explained that Braxton seemed happy and that she saw him again very briefly when she went back to get his pyjamas to put in the washing machine. She then took the dirty nappy out to the bin at the front of the house, went to the toilet, looked at her emails, checked Facebook and put a game that she sometimes played on "automatic". Then she did a couple of things including putting some clothes in the dryer.[119] It appears that these are the same clothes she had earlier put on a 30 minute wash.[120] Later she watched a bit of TV in the back lounge room. She states that she thought TJ was in his room as she could hear his Playstation.

91. Ms Tarlinton explained to the court that she "sat there for a little while and I thought – I just thought, no this is too quiet, so I just got up and had a look".[121] She opened the baby gate to the kitchen area and could immediately see that Braxton was not in his room. She then noticed that the kitchen sliding door was "ajar about 18 inches" and she commenced to call his name. Ms Tarlinton scanned the backyard and then looked over to the pool. She saw Braxton in the far corner of the pool and went through the gate towards him.[122] Ms Tarlinton thought he was floating on his back but she was not certain.[123]

92. I accept Ms Tarlinton's evidence that she saw Braxton that morning, took care of some of his needs and then left him briefly unsupervised. I observed her give evidence before me and I accept that she now feels great sorrow in relation to his death.

93. There are a number of possibilities to how Braxton gained access to the pool and they all involve speculation. TJ may have opened the sliding door or someone may have inadvertently forgotten to close it at an earlier time. Once outside Braxton may have climbed over the decking fence by using a chair, or even climbed over the hurricane wire fence. It is possible that TJ opened the pool gate for him and then shut it after him. TJ intellectual disability is such that he would not have foreseen the risks Braxton might face. On the other hand, Braxton was able to climb into the cot in his room, so it is always possible that he climbed the fence at the pool gate himself. Once beyond the gate he must have climbed up the stairs. From there all it would have taken is for Braxton to reach for one of the floating pool noodles to have fallen into the water and been unable to climb out.

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[117] See for example the account given to Inspector Sheraton from the NSW Ambulance Service recorded in the statement of Senior Constable Horton, Exhibit 1, Tab 8, [21].
[118] Ms Tarlinton, Transcript 31/8/17, page 31, line 31 onwards.
[119] Ms Tarlinton, Transcript 31/8/17, page 31 line 5 onwards.
[120] Ms Tarlinton, Transcript 31/8/17 page 32, line 25.
[121] Ms Tarlinton,Transcript 31/8/17, page 34, line 1 onwards.
[122] Ms Tarlinton, Transcript 31/8/17, page 37, line 20 onwards.
[123] Ms Tarlinton Record of Interview, Exhibit 1, Volume 1, Tab 30, questions 231-232.

94. The pool was effectively unfenced. While Mr McBride denied it, Braxton could have moved one of the light chairs on the decking to gain access. It is also possible that he could have climbed the wire fence. In my view Mr McBride was an unimpressive witness, he continued to refuse to take adequate responsibility for the dangerous state of the pool.

95. Unfortunately there is no firm evidence to support a definite finding as to exactly how Braxton came to be in the pool, except to say that if the back door was open, even a small way, he had the physical capacity and the curiosity to find his way there.

Did Braxton receive appropriate first aid?

96. Ms Tarlinton gave evidence that after removing Braxton from the pool she commenced CPR[124], for which she had been previously trained. The evidence of her neighbour, Ms Hammond confirms that, to some degree. Ms Hammond told the court that Ms Tarlinton "went to attempt CPR but kept kind of screaming"[125]. It was clear to Ms Hammond that Ms Tarlinton was in shock.

97. Luckily Ms Tarlinton was quickly assisted by her neighbours who were able to take over resuscitation attempts, while emergency services were called. Mr Marksworth and Mr Batson continued CPR until the ambulance arrived. They are to be commended for the help they gave.

98. The Court heard criticism of Ms Tarlinton's behaviour at this time, both in relation her initial reaction to seeing a child in the water[126] and later in relation to her interaction with ambulance officers. It was suggested she was unhelpful and perhaps unconcerned. I have considered the evidence and am satisfied that her behaviour is largely consistent with shock. I am also satisfied that the neighbours present provided high quality bystander CPR and did all they possibly could before professional help arrived.

99. The 000 telephone service operator gave timely assistance by way of clear directions as to how to carry out CPR, including the timing and depth of compressions. Members of the community ought to be encouraged to carry out CPR even if they have not undertaken training. Most people now carry mobile phones and direct assistance is readily obtainable.

100. Dr Skinner provided the court with a report outlining the extensive steps taken by the emergency and aeromedical retrieval team.[127] He notes that aside from remaining unresponsive, Braxton already had a very low core temperature by the time they arrived. This is likely to indicate that he had been submerged for some time.

101. No issues were identified with the service provided by the ambulance officers or the Careflight team. Tragically, I have come to the view that it is most likely that Braxton was dead before he was removed from the swimming pool and that nothing could have been done to save him, despite everyone's efforts.

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[124] Ms Tarlinton, Transcript 31/8/17, page 37, line 20 onwards.
[125] Ms Hammond, Transcript 29/8/17, page 15, line 10.
[126] Ms Hammond, Transcript 29/8/17, page 13, line 50.
[127] Statement of Steve Skinner, Volume 1, Tab 29A, page 3, [4]-[5].

How was cyproheptadine found in Braxton's blood post mortem?

102. There is no doubt that Mr Slager noticed that his son appeared different during a supervised visit on 1 September 2014. On 2 September 2014, Mr Slager was concerned enough to ask the FACs worker to check if Braxton had been given medication as he appeared drowsy the previous day.[128] Ms Woodward, a caseworker who was involved in the supervised visit apparently raised the issue with Ms Tarlinton, who denied that any medication had been given. The issue does not appear to have been raised again.

103. Toxicological testing of Braxton's post-mortem blood performed as part of the autopsy, revealed the presence of cyproheptadine at the time of his death.[129] This drug is marketed in Australia as Periactin.

104. Expert evidence was subsequently sought from Dr Michael Robertson, an experienced pharmacologist and forensic toxicologist.[130] He told the court that the medication was not recommended for use in children under the age of two. He described it as a serotonin and histamine antagonist and explained that it is used for the treatment of acute and chronic allergies such as dermatitis, eczema and seasonal allergies such as hay fever. It can also be used in the treatment of migraines and vascular headaches.

105. According to Dr Robertson, there are numerous potential side effects, each of which may be more intense when first using the drug or when a dose is increased. These side effects include sedation, dizziness, reduced coordination and confusion, among others. In young children antihistamines such as cyproheptadine may also cause restlessness and excitation.[131] The existence of side effects will depend on an individual reaction and will also depend on the size of the child and the size of the dose. Given that there has been no testing on children below the age of two, the safety of the drug in that age group has never been properly established.

106. According to Dr Robertson, the therapeutic concentration of cyproheptadine is reported to be 0.03 mg/L. Analysis of preserved and unpreserved heart blood taken from Braxton detected cyproheptadine at a concentration above 0.005 mg/L. This level is below the therapeutic level and certainly well below concentrations which would be regarded as in the toxic range. Dr Robertson was of the view that while he could not be sure, due to Braxton's age, given the level he would not expect "significant effects".

107. The medication had never been prescribed for Braxton Slager and should not have been in his system.

108. During the investigation it became known that JB, Ms Tarlinton's recently departed foster daughter had used this drug. It also became clear that Mitchell Burgess, Emma McBride's partner had used JB Periactin for his sinus problem.[132] Ms Tarlinton

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[128] See file note at Exhibit 7, Statement of Karina Woodward, Tab 46, page 685, [9].
[129] Autopsy Report for the Coroner, Dr Alex Olumbe, Volume 1, Tab 5.
[130] See his report at Volume 8, Tab 81.
[131] Report of Dr Robertson, Volume 8, Tab 81, page 6.
[132] Ms Tarlinton, Transcript 31/8/17, page 65, line 12, and Emma McBride, Transcript 29/8/17, page 99, line 10.

told the court that the drug was kept "above the stove in the little cupboard", where she kept Panadol, Panadeine and things like bandaids.[133]

109. There is no direct evidence as to how the drug came to be in Braxton's blood. There are a number of possibilities, all of which are disturbing. It may be that Ms Tarlinton put some of a crushed tablet in Braxton's bottle. Something she denied having done.[134] It would certainly have been a brazen transgression of her duties, given that she had already been asked about the issue by the FACS caseworker, after Mr Slager reported that Braxton looked drowsy. Nevertheless, it cannot be eliminated as a possibility.

110. I have carefully examined the evidence suggesting this theory. Mr Martin's statement lacks specificity. He recalls Ms Tarlinton "asking if it was ok to give Braxton sleeping tablets". But he was unable to recall exactly when this occurred and did not know if she ever gave them to Braxton. He remembered Ms Tarlinton saying that she did not.[135] The other possible source of information on this issue is even more unreliable. Mr McBride's daughter, Natalie told Detective Senior Constable Allan that Mr McBride had told her that Julie had given Braxton two tablets the night before he died. However, Mr McBride would not confirm this when approached. He is reported to have said that he believed "that there were holes in Julie's story"[136], however in court he moved away from this story and denied ever having seen Julie give Braxton a tablet, part of a tablet or a crushed tablet.[137] He went further to say that it didn't happen "to the best of my knowledge" and that he had no evidence of it. The original version was given at a time of significant family disharmony and breakdown and it is difficult to give it much weight.

111. Mr McBride or some other adult in the house also had the opportunity to give Braxton Periactin, but there is no evidence to support this. Mr McBride appears to have had ready access to the painkiller, Aspalgin[138], which could possibly be considered a "sleeping pill" as it contains codeine, but there is no evidence that this was found in Braxton's toxicological results. The theory that he was involved is highly speculative.

112. The other possibility is that Braxton took some of the drug himself. He certainly had access to the kitchen and there is every reason to think he could have climbed up onto the kitchen cabinet to reach for it. While toddlers often reject medicine and find it difficult to swallow tablets, it is possible he chewed a tablet. However, one would have thought that there might have been some evidence of this left behind.

113. The toxicological testing did not reveal the presence of the drug until some months after Braxton's death. For that reason there was no testing of Braxton's bottle nor any attempt to look for evidence of a partially chewed tablet.

114. Submissions made by those representing the family urged me to find that Ms Tarlinton "drugged" Braxton and that she had a history of medicating her foster children.[139] Further it was suggested, "the inference could reasonably be drawn that Braxton was being difficult

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[133] Ms Tarlinton, Transcript 31/8/17, page 65, line 18.
[134] Ms Tarlinton, Transcript 30/8/17, page 73, line 36.
[135] Statement of Christopher Martin, Exhibit 2, Tab 34A, [10].
[136] Statement of Detective Senior Constable Allan, Tab 7A, page 4, [10].
[137] Mr McBride Transcript 31/8/17, page 103.
[138] Mr McBride, Transcript 31/8/17, page 90, line 20.
[139] "Submissions on behalf of Vanessa Naumovska and by amicus Johnny Slager", [43] and elsewhere.

the night prior to his death, Tarlington(sic) or at least someone else administered inappropriate medication, the Carer's (sic) continued their known partying antics, and Braxton did not in fact wake the following morning in which, he somehow was located in an aboveground pool with no stairs" The court was encouraged to refer the matter to the "Homicide Squad" in relation to the drug issue. It should be noted that it was never put to Ms Tarlinton or Mr McBride that Braxton "never woke up" or that his body was somehow tampered with or placed in the pool to cover up his death.

115. The evidence does not support such an approach. The family submissions grossly misrepresent Dr Robinson's opinion on the likely effect of the quantity of the drug found in Braxton's blood[140]. The presence of Periactin is disturbing and unexplained, but there is currently no evidence to suggest that it had a causal relation to Braxton's tragic death. While there may remain some suspicion that members of the family may have been involved in Braxton obtaining that drug, the evidence does not establish who was responsible.

116. Unfortunately, this is just one of the outlandish claims made in the family submissions, without the support of evidence. I have enormous sympathy for Braxton's parents, but on the basis of the submissions made to the court on their behalf I am disturbed by the quality of the legal advice they appear to have received.

117. I have carefully reviewed the evidence available to me on this issue. There is no direct reliable evidence as to how the drug came to be in Braxton's system.

Time and cause of death

118. From the moment that Braxton was first seen in the pool by Ms Tarlinton he appeared lifeless. There was certainly no evidence of struggling or gasping. Paramedic Williams described Braxton as extremely pale and very poorly perfused when she arrived at the house.[141] She told the court that he was lifeless and pulseless and that she was struck by his markedly fixed pupils.

119. No medical professional has been able to accurately estimate how long Braxton had been in the water. According to Detective Allen, the Careflight doctor, Dr Skinner estimated that it would have been more than ten minutes.[142] Taking into account Ms Tarlinton's evidence, it could have been substantially longer.

120. Braxton was not formally pronounced dead until 11.25am at Westmead Children's Hospital. However in my view, while it is impossible to say exactly when he died, his death is most likely to have occurred earlier that morning at 58 Sentry Drive, Stanhope Gardens, NSW, in the pool. I accept the forensic pathologist's opinion that his death is consistent with drowning.

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[140] For example the assertion "Dr Robertson clearly indicated that the drug found in his system in conjunction with the alleged (sic) does would (sic) have resulted in Braxton being comatose" "Submissions on behalf of Vanessa Naumovska and by amicus Johnny Slager" paragraph 30.
[141] Ms Williams, Transcript 29/8/17, page 5, line 15 onwards.
[142] Detective Senior Constable Allen, Transcript 30/8/17, page 5, line 30.

Was Braxton's death preventable?

121. Braxton's death was preventable. He should not have been placed with Ms Tarlinton and Mr McBride. The placement was inappropriate for a number of reasons. Ms Tarlinton did not have the emotional or supervisory capacity to take another child at that time, particularly an active toddler. She was not clearly informed about how long the placement might last. She was under-supported by Mr McBride and LWB. The premises she could provide at that time were unsafe, and this should have been picked up by LWB.

122. The presence of cyproheptadine in Braxton's blood is also extremely troubling. At best, if it were ingested accidently, it indicates a serious lack of supervision and drug control. If given to him by one of his carers or someone else in that house, in an attempt to make him sleep or quieten him down, it is clearly even more serious and indicates a complete lack of suitability to be involved in out of home care by the person or persons involved. Unfortunately, the evidence does not enable me to come to a final conclusion on that issue. While recognising that any amount of the drug constitutes a serious failing on the behalf of the carers involved, it is impossible to know if the small quantity found affected Braxton's behaviour on the day of his death. The medical evidence presented to me suggests the effect is likely to have been minimal. What is clear is that the risk of drowning existed, even if no drug had been found. The premises were unsafe and the necessary supervision was lacking.

123. Tragically, a child who went into care to improve his chance of living in a safe environment, found himself in a situation of enormous risk. His death appears to have been a preventable accident, which occurred against a background of inadequate care.

The need for recommendations

124. Section 82 of the *Coroners Act* (2009) NSW confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the particular death. However, where failings appear to affect a larger system, that cannot be ignored.

125. The evidence arising from this inquest demonstrates that there were significant failings identified in relation to the following,

- The level and nature of the support offered to Braxton's biological family before he was taken into temporary care
- The management of the decision to use a temporary care order and the way this process was carried out
- The processes used by the OOHC provider, LWB to choose a suitable foster carer
- The processes used by the OOHC provider, LWB to support the chosen foster carer

- The processes used by the OOHC provider, LWB to ensure Braxton was placed in a safe physical environment

126. In other words, the failings strike at the heart of the way we care for the most vulnerable children in this community. In my view, many of the issues identified, while specific to Braxton's death, also illustrate systemic problems. The ongoing scarcity of foster carers in the community is a serious issue that needs greater consideration than I can offer within the limited scope of this inquest. Tragically the ongoing inadequacy of resources allocated to the care system in general is once again demonstrated in a matter coming before this court and I once again urge governmental review of this issue.

127. The court was informed that there are approximately 18 000 children and young people in OOHC in NSW.[143] The system is complex and needs to cater for a wide range of needs. The court was rightly cautioned against making generalised recommendations based on a single factual situation. Counsel for FACS properly reminded the court that there have been three relatively recent inquiries much better placed to make recommendations to the NSW Government on these issues. Of course I accept the Wood Special Commission of Inquiry conducted over 12 months had a much greater opportunity to consider our child protection system than I have. The transition of OOHC from FACS to the non-government sector, a recommendation of that inquiry, is now widely supported by those with knowledge in the field. Equally, I accept that recommendations arising from the "Their Futures Matter" report which were designed to reduce the number of children in OOHC were formulated on the basis of much more detailed evidence than is before me. As were recommendations arising from the recent NSW Legislative Council General Purpose Standing Committee No.2 Report on Child Protection. There is no need for me to duplicate recommendations made from that process. Nevertheless, it appears appropriate for me to grapple with the significant failings I observe in this particular situation in the hope that it will assist those committed to improving the system achieve much needed change.

128. Braxton's death is regarded as a tragedy by all those involved in his care. It is a positive sign that both FACS and LWB each agreed to conduct a detailed review of their own involvement in Braxton's death and to combine their reports to the form a Joint Child Death Review Report. Each agency was critical of its own practice. Each agency has identified a range of issues for change and this has greatly reduced the need for formal recommendations in this matter.

The response of the Department of Family and Community Services

129. It appears that finally FACS has taken appropriate steps to address the issue of swimming pool safety for children in out of home care, from a government perspective[144]. It is extremely depressing that some of these changes, only recently made, should have been actioned directly after State Coroner Jerram's *Findings in the matter of Lachlan Leslie*, were published back in June 2013.

130. When first called as a witness in this inquest, Ms Morgan-Thomas was unable to inform the court as to any action taken following the death of Lachlan Leslie or even after the

[143] Submissions provided by the Department of Family and Community Services. (17 November 2017) paragraph 36.
[144] See the third statement of Ms Morgan-Thomas, dated 20/9/17.

subsequent death of Braxton Slager. In a later statement,[145] Ms Morgan-Thomas set out the steps that have now been taken by FACS in relation to swimming pool deaths as they relate to out of home care. The work, although now commenced, remains incomplete. However I am finally satisfied that further recommendations are not required and the issue is now being adequately addressed, albeit too late.

131. A number of recommendations came out of the FACS Internal Child Death Review. The court was also greatly assisted by the oral evidence of Kate Alexander, the senior practitioner in this regard. I was impressed and heartened by her comprehensive review of FACS's role in the tragedy. Professionals of her calibre must be supported within the organisation if we are to learn from the mistakes made in the past and I commend the openness with which she approached her task.

132. I do not intend to detail all of the changes recommended, in relation to the need for clear practice notes about the use of Temporary Care Agreements and other related issues. I support the recommendations set out and trust they have been fully implemented.

The response of Life Without Barriers

133. The independent consultants retained by LWB also provided a clear way forward to address some of the systemic issues identified when examining the circumstances surrounding Braxton's death.

134. As a result of the review, LWB accepted that the organisation had some systemic failings which needed to be urgently addressed at a policy level. The kinds of changes identified fall into two broad categories, firstly changes in relation to placement practices and secondly changes in relation to home environmental safety checks.

135. A number of changes were set out in Roderick Best's statement and I do not intend to detail each of those matters.[146] Significantly new placements, that is children previously unknown to LWB, will not be placed in an "unrelated placement", as Braxton was. This means that new children will not be placed with carers who have pre-existing out of home care responsibilities, even when FACS is requesting an emergency placement and there are no other suitable options. Any exception will require the approval of a Regional or State Director. One hopes that this will prevent the kind of rushed placement that occurred in Braxton's case. The pressure for more junior staff to find an emergency placement for a child, in all circumstances, must be resisted.

136. The placement system used in the Sydney area has also undergone significant change. Since January 2017, placement matching panels are apparently now in use. New placement matching tools have been developed, along with other revised policies and procedures.

137. In relation to LWB's home environment safety procedures there have also been a number of changes. LWB informed the court that it had now taken steps to ensure that all carer

[145] Statement of Ms Morgan-Thomas, dated 20/9/17.
[146] Statement of Roderick Best, Exhibit 2, Volume 9, Tab 84.

households in NSW that have a pool are now compliant with state legislation and have a compliance certificate. This is enforced by strengthening the Carer Rights and Responsibility document to require immediate disclosure if they have a pool or spa installed and through other educative measures.

138. The court was also informed that the home safety checklist has been revised and made more comprehensive in relation to swimming pool risk. It now requires that the carer has received and discussed information on the NSW Swimming Pool Register, compliance, fencing and self-latching gates.

139. Housing inspections and home safety checklist are now conducted every two years, rather than every three and Mr Best gave evidence that staff would be encouraged to think of home safety as an ongoing responsibility arising even at monthly visits, not just when a formal review is completed.

Recommendations under consideration

140. I accept Counsel assisting's submission that there is no need for a formal recommendation pursuant to section 82 of the *Coroners Act* to provide a further catalyst for the reforms already identified. I accept a number of significant changes have already been made.

141. Counsel assisting put forward four proposed recommendations[147] aimed at issues that have not yet been addressed. Two appear to have been supported by all involved in the inquest and I intend to make them in the terms suggested. These recommendations serve to help raise and maintain the quality of care provided by LWB, by keeping the lessons learnt at this inquest at the forefront of the organisation's ongoing practice as it approaches reaccreditation as an out of home care provider. Changes and improvements have been foreshadowed, it is important that the reasons for them are fully understood by the LWB executive and Board.

142. Two other proposed recommendations did not receive unanimous support at the end of the proceedings.

143. The first was directed to a perceived lack of support for Ms Tarlinton in dealing with the grief she experienced after the breakdown of the caring relationship she had with JB, prior to Braxton's arrival and the effect that may have had on her capacity to care for other children. It is not that LWB caseworkers ignored Ms Tarlinton's stated need, although Mr Bromley does not appear to have given the matter much thought. It is clear that it was only with hindsight that Ms Tarlinton saw it herself and began to understand that perhaps she was not coping as well as she thought. The recommendation is directed towards providing a mechanism for professional input at this crucial time.

144. I am of the view that Ms Tarlinton's emotional state was one factor in her unsuitability to care for BB and Braxton Slager. She had been caring for JB for many years and by all accounts treated her "like a daughter". Previously she had the support of a SOC worker. Once JB left, that person was not replaced, although given TJ needs

[147] See Counsel Assisting's Submissions, attached to the court file.

it is hard to understand why. In my view, she should have been automatically offered psychological assessment and support.

145. The recommendation was not supported by FACS and LWB. Both were concerned by the potential expense and by the possibility that it could be considered intrusive by carers. It was also suggested that various other measures to support carers are already in place and that there is no real evidence that Ms Tarlinton would have been assisted by such professional help. I am not convinced by those arguments. In my view, if psychological assessment and support is at least *offered* in every case where a significant placement has broken down, it is more likely that potential problems are identified at an early stage. I intend to recommend the provision of that service.

146. The second proposal was directed towards including FACS in the initial home visit process to provide some additional and outside view of the suitability of the placement home. Clearly, in situations such as Braxton's, a FACS worker may visit the home, but currently not as a formal requirement[148]. There was considerable opposition to this recommendation. FACS suggested that it could send the wrong message to potential carers as to the role FACS have in monitoring care and could even jeopardise further the current shortage of carers, particularly in some specific communities where there is known distrust towards FACS. The current policy encourages the transition of care to the Non-Government sector and this would be potentially a backward step. It was suggested that it would be onerous, given the large number of children in short term care and that there are better mechanisms for ensuring agencies comply with their contractual obligations.

147. I have given the arguments raised considerable thought and remain of the view that while the current policies enshrine transitioning out of home care to the Non-Government sector, there remains a role for FACS in relation to home safety. However, the recommendation will be constrained to situations such as Braxton's where FACS retain care and case management responsibility. In these situations, particularly those involving short term care, it would not be unusual for a FACS worker to visit the home at some time, as occurred with Braxton Slager's case. Had that visit included formal oversight of the suitability of the home environment, even on a single occasion, Braxton may be alive today

Recommendations put forward by counsel for the family

148. Counsel for the family put forward a number of recommendations for consideration. I have carefully reviewed each and every one. Unfortunately some of them were based on a misstatement of the evidence or called for action beyond this court's power. I am sympathetic with a number of the family's concerns about the out of home care system ranging over 50 years,[149]however I am unable to fully address them. It may be that some of the concerns raised can be taken up in other forums.

149. I note that the family called for an investigation of Ms Tarlinton and Mr McBride's record of care in relation to other children. This too is beyond my power and touches on information I

[148] It is clear for example that a FACS worker attended the home to drop Braxton after child care and that Ms Woodward was present for at least part of the home visit on 2 September 2014. So it is clear that FACS workers will attend from time to time, particularly in relation to short term placements.
[149] See for example Recommendation 50.1.

am not privy to. I am satisfied that it is appropriate Ms Tarlinton's Carer's licence has already been permanently revoked.[150]

150. I note that the family offer their support for each of the recommendations put forward by counsel assisting.

Findings

The findings I make under section 81(1) of the Act are:

Identity
The person who died was Braxton Slager.

Date of death
He died on 13 September 2014.

Place of death
He died at 58 Sentry Drive, Stanhope Gardens, NSW.

Cause of death
He died from drowning.

Manner of death
Braxton was unsupervised at the time of his death. He was 22 months old and living in temporary out of home care. He drowned after gaining entry to a non-compliant swimming pool.

Recommendations

I make the following recommendations pursuant to s 82 *Coroners Act* 2009.

To the Office of The Children's Guardian

1. That LWB and other providers of Out of Home Care accredited by the Office of the Children's Guardian, ought, at the agency's expense, offer psychological evaluation and support when a foster carer ceases to be the carer for a foster child for whom the carer provided care for an extensive period. This should occur before any new child is placed with the carer. The undertaking to provide such psychological assistance should be made a condition of accreditation.

[150] For reference to this see, Submission of behalf of Julie Tarlinton, dated 20 December 2017, paragraph 3e.

To Life Without Barriers

2. That a copy of these findings, reasons and recommendations, together with i) tabs 7 & 7A and 73 and 74 of the Slager Coronial Brief, ii) the joint Child Death Report concerning the death of Braxton Slager and iii) the statement of Roderick Best dated 5/7/17 and the transcript of his evidence on 1/9/17 be provided by Life Without Barriers to the Office of the Children's Guardian for the purpose of the next reaccreditation of Life Without Barriers as a provider of out of home care.

3. That Mr Roderick Best, or the person at the time occupying his position, provide a copy of these findings, reasons and recommendations, together with i) tabs 7 & 7A and 73 and 74 of the Slager Coronial Brief, ii) the joint Child Death Report concerning the death of Braxton Slager and iii) the statement of Roderick Best dated 5/7/17 and the transcript of his evidence on 1/9/17 to each member of the Board of Directors of Life Without Barriers and advise the Coroners Court when this has been done.

To the Department of Family and Community Services

4. That where FACS retain care and case management responsibility of a child, FACS should undertake a visit, together with the accredited agency and with the foster carers at the carer's home to satisfy itself that the home environment is suitable and that the foster child is settling in and so that the foster parents have any opportunity to raise any issues with both FACS and the agency together.

Conclusion

Finally, I once again offer my sincere condolences to Braxton's family for their heartbreaking loss. I understand and acknowledge that these findings may bring them little comfort. Nevertheless, I thank them for their daily attendance during the inquest and for the generosity they have shown in sharing memories of their son.

I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
27 March 2018