CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Jack Loh
Hearing dates:	7 to 9, 11 and 15 June 2021; 23 to 25 August 2021
Date of findings:	22 December 2021
Place of findings:	Coroners Court of New South Wales at Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, early childhood education and care, family day care, regulatory authority, Kidstart Pty Ltd, Department of Education, safe sleeping practices for infants and babies, persistent pulmonary hypertension of the newborn, National Quality Framework, Australian Children's Education & Care Quality Authority, Education and Care Services National Law, Education and Care Services National Regulations, child care rebate
File number:	2019/70629
Representation:	Ms K Richardson SC & Ms K Boyd, Counsel Assisting, instructed by Ms C Healey-Nash & Ms A Richards (Crown Solicitor's Office) Ms K Nomchong SC & Ms J Chapman for the New South Wales Department of Education, instructed by Moray & Agnew Mr B Eurell for Mr A Shamsin, Ms A Shamsin, Mr S Cheema (the directors of Kidstart Pty Ltd), instructed by Alpha Law Practice Ms E Sullivan for Ms H Rateau, instructed by Maksisi Lawyers

Findings:

Jack Loh died on 4 March 2019 at The Sydney Children's Hospital, Randwick NSW 2031. The cause of Jack's death was unrecognised pulmonary hypertension in a setting of unsafe sleeping conditions, which occurred when Jack was placed down to sleep by an educator at a family day care centre.

Whilst cardiac investigations prior to 4 March 2019 likely would have identified Jack's underlying pulmonary hypertension, there was no clear indication from Jack's two previous presentations to hospital, or from his general medical history, for such investigations to be performed.

It is most likely that placing Jack to sleep on 4 March 2019 fully clothed and loosely wrapped; in a bassinet that was inappropriate and unsafe for his age, size and stage of development, and that contained extraneous bedding material; in a room which was poorly ventilated and not temperature appropriate; and in circumstances where Jack was not regularly checked on, were all contributory factors to Jack's death.

Recommendations:

See Appendix A

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1. Introduction

1.1 On the morning of 4 March 2019 Margot Loh dropped her almost 7-month old son, Jack, at a family day care centre. During the day, Jack was put down for a nap on two occasions. During the second occasion, Jack was checked on after about 35 to 45 minutes and found to be unresponsive and not breathing. Despite emergency services being called, and resuscitation measures being initiated, Jack could not be revived and was later tragically pronounced deceased.

1.2 The subsequent investigation into the circumstances of Jack's death raised a number of questions regarding the sleeping arrangements in place at the family day care centre on 4 March 2019, and more broadly. In addition, a number of questions were also raised regarding supervision and training of educators at the family day centre, and regulatory oversight of the family day care sector.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and the cause and the manner of that person's death.

2.2 Certain deaths are reportable to a Coroner. Some examples of reportable deaths are where the cause of a person's death is not due to natural causes, or where the cause or manner of person's death may not immediately be known. In Jack's case, although a postmortem examination was able to identify a medical cause of Jack's death, the circumstances in which he was put down for a sleep on 4 March 2019 required further investigation. The results of this investigation identified a number of broader issues relating to safe sleeping practices for infants, the regulatory framework within which the operation of family day care centres exists, and the supervision and training provided to Educators at the family day care centre where Jack was enrolled. For all of these reasons, an inquest was required to be held.

2.3 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

2.4 It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a lengthy one. The impact that such a process has on family members who have

many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated.

2.5 Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made to organisations and individuals in order to draw attention to systemic issues that are identified during a coronial investigation, and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable. Where an inquest is able to identify issues that may potentially adversely impact upon the safety and well-being of the wider community, recommendations are made in the hope that, if implemented after careful consideration, they will reduce the likelihood of other adverse or life-threatening outcomes.

3. Recognition of Jack's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

3.2 Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Some brief words written by someone who never met Jack can in no way completely reflect who Jack was as a person, nor the enormous loss felt by his parents and those who loved him the most. However, it is hoped that these words recognise and acknowledge Jack's life in a meaningful way.

3.3 Jack was born on 6 August 2018, the first child of Margot and Joseph Loh. Jack's parents describe this day as the best day of their lives, and that Jack was perfect. Upon meeting their son for the first time, the hearts of Margot and Joseph were filled with enormous love.

3.4 Margot and Joseph were devoted to Jack and provided a loving and nurturing upbringing for him. Jack was also enormously loved by his extended family members and family friends, and surrounded by other children of his generation who he was meant to grow up with.

3.5 Jack was a very social baby and enjoyed going on outings with his parents. Margot and Joseph both fondly recall that Jack was always wanting to walk before he could even crawl. Jack enjoyed playing in his bouncer, playing with his toys, and being in the simple company of, and spending time with, his parents.

3.6 Margot and Joseph describe Jack as seeming to have a "*very developed soul*". They would often look at his face and fall deeply into his bright blue eyes, whilst he would look back with his smile always so knowing.

3.7 The 7 months that Margot and Joseph had with Jack were a true blessing. Despite their brevity, these seven months were filled with a lifetime of special memories that will always be treasured. It is truly heartbreaking to know that Jack's life was so tragically cut short at such a very young age. The promise and years of life that Jack had yet to fulfil, which has now been taken away, is devastating.

3.8 It is some small comfort to know that Jack's all too brief life enriched the lives of those who loved him the most. Jack brought so much love and happiness to his parents, his family, and those who now feel his loss most deeply.

4. Jack's medical history[1]

4.1 Margot's pregnancy with Jack was complicated by breach presentation and intrauterine growth retardation. An antenatal ultrasound at 37 weeks showed a mass adjacent to Jack's bowel, which at postnatal assessment was found to be normal.

4.2 Jack was born on 6 August 2018 at 38 weeks gestation at the Royal Hospital for Women, Randwick, via emergency caesarean. He weighed 2.5 kilograms at birth.

Heart murmur and cardiac assessment

4.3 On 28 August 2018, paediatric surgeon, Dr Vincent Varjavandi detected a heart murmur in Jack during a routine examination. Jack was subsequently referred for cardiac assessment and reviewed by Dr Stephen Cooper, paediatric cardiologist, on 4 October 2018.

4.4 An echocardiogram (**the October 2018 echocardiogram**) was performed which Dr Cooper noted revealed no "*important abnormality*". In a letter to the referring clinician at the Royal Hospital for Women, Randwick, Dr Cooper further noted:

> There is a right super vena cava draining normally to the right atrium and there is a left superior vena cava draining to coronary sinus. As you know, this is considered a normal variant. I could see at least two pulmonary veins entering each side of the left atrium suggesting to me that the pulmonary venous return was normal. The atrial septum was quite nicely seen and I did not confirm any definite atrial septal defect. There was a small amount of drop-out high up in the sinus census region, but I could not confirm any flow across this area and on balance I think he does not have an atrial communication….
>
> At this stage, I think that Jack has a structurally normal heart with a left superior vena cava draining to coronary sinus. I do not have a definite explanation for his right ventricular dilation. Occasionally children who have a dilated coronary sinus have a relatively small left ventricle and a correspondingly large right ventricle related to foetal haemodynamics. With time this usually resolves.

4.5 Dr Cooper recommended that Jack be reviewed again at 12 months, and noted that earlier review could be conducted if any concerns were raised regarding his clinical progress prior to that time.

Consultation at Sleep Disorders Clinic

4.6 On 19 October 2018 Jack was reviewed by Dr Greg Blecher at the Sydney Children's Sleep Disorders Clinic following concerns that Jack was seeming to sleep excessively (compared to his infant peers), and that he had episodes of panting and increased work of breathing during sleep. On examination, Dr Blecher noted the following:

> There was no increased work of breathing, no obstructed breathing, no cardiac murmur, the femoral pulses were palpable and there were no abdominal masses. There was a gunky left eye. The rest of the examination was normal.

[1] This factual background has been drawn from the helpful closing submissions of Counsel Assisting.

4.7 Oxygen monitoring on Jack was conducted over two nights, with the results found to be normal. According to Joseph, Dr Blecher "*was quite satisfied*" with Jack's oxygen levels from this testing and sought to reassure him and Margot that Jack's raspy breathing was part of normal development for children.

Hip ultrasound

4.8 In November 2018, Dr Srinivas Bolisetty at the Sydney Children's Hospital made a note that Jack's first hip ultrasound showed mild dysplasia left, but this had resolved at the time of the appointment. At that time, Jack had caught a viral upper respiratory tract infection, with a mild wheeze but no fevers.

Admission to the Sydney Children's Hospital for bronchiolitis

4.9 On 6 January 2019, Jack was admitted to the Sydney Children's Hospital with bronchiolitis, on a background of six days coughing, coryza, wheezing and reduced oral intake. The progress notes from the admission indicate that the treating clinicians were aware of Jack's heart murmur and the earlier echocardiogram conducted by Dr Cooper.

4.10 Dr Arjun Rao, senior medical officer, reviewed Jack in the Emergency Department. On examination, dual heart sounds with no murmur was noted, together with *"differential of cardiac but no clinical signs of cardiac failure and reassuring to know ECHO report from 4/10/18"*.

4.11 Jack was admitted under the care of Dr Elizabeth Argent, general paediatrician. High flow nasal prong oxygen and nasogastric tube feeds were administered. Subsequent testing was positive for rhinovirus.

4.12 On 7 January 2019, Jack was assessed by Dr Argent and Dr Carmen Macdonald, junior medical officer. Dr Macdonald's progress note recorded that Jack was improving and had dual heart sounds, and a clear chest with good air entry.

4.13 On 8 January 2019, Jack was discharged with a recommendation for follow up with his general practitioner within 48 hours for a progress review.

4.14 Following this, Margot thought that it took Jack three to four weeks for the symptoms of bronchiolitis to subside. Joseph observed that Jack got better after he was discharged, but that his breathing was still raspy until about the end of January 2019.

Consultation at the Helmut Therapy Clinic

4.15 On 25 January 2019, Jack was examined by Dr Erica Jacobson, neurosurgeon, at the Helmut Therapy Clinic after his parents noticed that his head was getting asymmetrical "*from preferring the right from the age of one month old"*. After being given some advice on turning Jack's head, and using a pillow, some improvement was noted. Dr Jacobson considered that Jack would continue to improve and did not require a follow up appointment.

Admission to the Sydney Children's Hospital for vomiting

4.16 On 26 January 2019, Jack presented to the Sydney Children's Hospital Emergency Department on a background of six episodes of vomiting, a cough and fever. Jack was assessed by Dr Hannah Wilson, paediatrics registrar, who noted Jack's history of a heart murmur and the results of the echocardiogram. Dr Wilson ordered paracetamol, oral fluids and a chest x-ray, which revealed *"generalised increased marking with some fluids in transverse fissure, no organomegaly"*.

4.17 Dr Wilson discussed Jack's case with Dr Elizabeth Berger, paediatrician. The impression formed was that Jack had mild dehydration due to not tolerating fluids, secondary to viral infection. Early bronchiolitis was queried. It was noted that Jack was clinically not in respiratory failure, but that it was difficult to ascertain the significance of his work of breathing and heart murmur without further information regarding his cardiology background.

4.18 Dr Wilson documented a plan which involved Jack being admitted overnight, fluid review and review of his respiratory status, querying the need to discuss his case with the cardiology team for consideration of a repeat echocardiogram.

4.19 Jack was admitted overnight, and assessed by Dr Berger the following day. Dr Berger noted that Jack's observations and blood results were normal and that he had had no further vomits or fevers. No cardiology consultation took place, and Jack was later discharged, with advice for his parents to return to the Emergency Department if Jack showed any signs of fever, lethargy, decreased oral intake or increased work of breathing. According to Joseph, the clinicians were satisfied that Jack was receiving enough oxygen when he was discharged.

Visit to general practitioner on 7 February 2019

4.20 On 7 February 2019, Jack was reviewed by his general practitioner, Dr Graham Brierley, for a routine check-up. On examination, Jack was noted to be "*a healthy thriving infant*".

5. Events of 4 March 2019

5.1 At around 8:30am on 4 March 2019 Margot dropped Jack off at the Rhythm and Rhyme Family Day Care Centre (**Rhythm and Rhyme Centre**). This was Jack's fourth time being cared for at the Rhythm and Rhyme Centre.

5.2 The Rhythm and Rhyme Centre was run from a single storey house at 19 Ravenswood Avenue, Randwick (**the Randwick Property**). Ms Helen Rateau, the registered Educator for the Rhythm and Rhyme Centre, lived at the Randwick Property with her family. The Randwick Property consisted of three bedrooms:

(a) a master bedroom for Ms Rateau and her husband (**the Master Bedroom**);

(b) a bedroom for Ms Rateau's two daughters with a set of bunk beds (**the Second Bedroom**); and

(c) a bedroom used as a sleeping room, for the children attending the Rhythm and Rhyme Centre which was set up with four full-sized portable cots (**the Sleeping Room**).

5.3 A garage at the Randwick Property had been converted for use as an additional playroom for children attending the Rhythm and Rhyme Centre.

5.4 On 4 March 2019, Jack was wearing a blue onesie with a dinosaur print, a Huggie's brand nappy, bib and shorts. Margot also gave Ms Rateau a sleep suit for Jack to wear while napping. Margot gave evidence that the "*whole purpose*" of using a sleep suit (instead of a wrap) was to prevent Jack from getting tangled or there being loose objects in the bed. Jack was noted to be healthy and happy when he arrived at the Rhythm and Rhyme Centre.

5.5 On 4 March 2019, three other children were being cared for by Ms Rateau:

(a) "FR", a 10 month old girl, who had been dropped off at 7:30am;

(b) "HI", a 10 month old boy, who had been dropped off at 8:15am; and

(c) "BM", a 2 year old boy, who had been dropped off at 8:20am.

Jack is put down to sleep for the first time

5.6 At 9:00am, Ms Rateau put Jack down for a nap in a bassinet which was positioned on the floor in the middle of the Second Bedroom. Jack was placed face down on his tummy, reportedly because (as Ms Rateau would later informed the police) "*he just sleeps better like that*". There was a pillow in the bassinet.

5.7 At around the same time, Ms Rateau put FR and HI down for a nap in two of the four cots located in the Sleeping Room. Despite there being a cot available for Jack, it appears that one was not used because Ms Rateau considered that an infant would be more comfortable in a bassinet. Further it appears that both the Sleeping Room and Second Bedroom were used so that different children

could sleep at different times. Ms Rateau would sometimes put Jack down for a nap in a cot, and at other times he would be placed in the bassinet. However, it was Ms Rateau's usual practice to put smaller infants in the bassinet, and the larger infants and toddlers in the cots.

5.8 Despite this practice, Ms Rateau did not inform Jack's parents that he would be put down to nap in a bassinet. Margot had previously told Ms Rateau that Jack slept in a cot at home, and assumed that he would similarly be placed in a "*proper cot*" at the Randwick Property. When Jack's parents conducted a tour of the Randwick Property before enrolling Jack, they did not see, nor were shown, a bassinet.

5.9 At around 9:45am, Jack woke from his nap and was bottle-fed 200mls of cold formula in the playroom while seated on Ms Rateau's lap.

Tour by Alison Ingram

5.10 At around 10:30am, Ms Ingram attended the Rhythm and Rhyme Centre with her son for a tour. After Ms Rateau invited Ms Ingram in, she walked through the house to the living room and saw a boy, approximately 6 to 7 months old, sitting on the floor of the play area. Ms Ingram observed that the little boy appeared well and happy at the time. It is most likely that this was Jack given that the only other boy of a similar age at the Randwick Property that day was HI, who at the time was still taking a nap during Ms Ingram's tour.

5.11 During the tour, Ms Rateau described the sleeping arrangements at the Rhythm and Rhyme Centre, informing Ms Ingram that children were put to sleep in the Sleeping Room. The door to the Sleeping Room was closed during the tour, and Ms Rateau did not open it, informing Ms Ingram that she did not want to disturb the children asleep inside. At some stage during the tour, Ms Rateau and Ms Ingram walked past the Second Bedroom, which had its door open. Ms Rateau explained to Ms Ingram that the Second Bedroom belonged to her daughters, and that she sometimes put older children to sleep in the room. Ms Ingram did not recall seeing a bassinet or Moses basket inside the Second Bedroom.

5.12 At 10:37am, three photographs of Jack were taken using Ms Rateau's iPad, showing Jack sitting upright by himself, playing with toys.

5.13 At around 10:45am, Ms Rateau's daughter (age 6 at the time), was dropped home early from school by her grandmother, Marlene, as she had been feeling unwell. Marlene remained at the Randwick Property until around 11:15am. Following this, Ms Rateau's daughter played on her iPad in the Master Bedroom.

5.14 At around 11:15am, Ms Ingram's tour finished and she left the Randwick Property. Ms Rateau gave Jack and FR some mashed up avocado and banana.

5.15 At 11:12am, Ms Rateau rang her husband, Jean-Charles, to ask him to come home to look after their daughter. Jean-Charles did not later leave work until around 1:30pm.

Jack is put down to sleep for the second time

5.16 At around 12:15pm, Ms Rateau went to put Jack down in the bassinet for a nap. She tried to wrap Jack in a green wrap/sheet (**the wrap**), but Jack was crying and wriggling so Ms Rateau removed the wrap and placed it in the bassinet, without tucking it in. Ms Rateau later told police that she "*just kind of threw [the wrap] down*" and that she "*didn't actually tuck the sides in*". The bassinet was on the floor in the Second Bedroom, placed next to a shoe rack and a school backpack. Again, there was a small pillow in the bassinet. Despite a portable cot being available, Ms Rateau chose to use the bassinet as she considered that it would be more comfortable for Jack.

5.17 Ms Rateau placed Jack faced down onto his tummy in the bassinet, on top of the wrap and the little pillow. Jack was crying and wriggling at this time. He was also not wearing the sleep suit that Margot had provided, and instead was wearing a onesie, nappy, shorts and a dribble bib.

5.18 Also at this time, BM got into the bottom bunk bed in the Second Bedroom. Ms Rateau then left the room and closed the door. The other two children at the Rhythm and Rhyme Centre that day (HI and FR) were awake and up from their earlier naps at this time.

5.19 Between 12:16pm and 12:19pm, Ms Rateau received four text messages from her husband. About 10 minutes later, at approximately 12:25pm, Ms Rateau heard Jack cry and returned to the second bedroom. She found Jack to be crying and moving around in the bassinet. Ms Rateau did not touch Jack or pick him up. After leaving the room, with the door ajar, Ms Rateau later heard Jack stop crying.

5.20 Mobile phone records reveal the following activity on Ms Rateau's phone:

(a) At 12:31pm, Ms Rateau sent a text message to Ms Ingram.

(b) Also at 12:31pm, records show a "data session" lasting 45 minutes on Ms Rateau's phone.

(c) At 12:43pm, Ms Rateau received a call from a prospective client, enquiring about childcare. This call lasted 11 minutes and 23 seconds.

(d) At 1:03pm, Ms Rateau sent a text message to her husband in which she asked if he would be in Rose Bay by 2:30pm.

(e) At 1:09pm, Ms Rateau called her sister, with the call lasting just over 10 minutes.

5.21 It is not apparent what the other two babies, HI and FR, were doing in the period between Jack being put down for his second nap and when Ms Rateau found Jack after this last phone call.

Jack is found to be unresponsive

5.22 At some point after 1:19pm Ms Rateau noted that Jack had been "*really quiet for a while*" and went to the Second Bedroom to check on him. Ms Rateau found Jack in the bassinet, face down in the wrap, unresponsive and blue. Ms Rateau later told police that Jack's face "*was really in there*"

meaning face down in the wrap. By this time, it had been approximately 35 to 45 minutes since Jack had been put down for a nap.

5.23 Phone records again reveal the following activity at this time:

(a) At 1:21:02pm, Ms Rateau called her mother, with the call lasting 0 seconds.

(b) At 1:21:30pm, Ms Rateau called Triple Zero from her mobile phone, with the call lasting 3 seconds.

(c) At 1:21:58pm, Ms Rateau called Triple Zero from the landline at the Randwick Property.

5.24 Ms Rateau picked Jack up from the bassinet, ran into the living room, and placed Jack on the floor. Ms Rateau described Jack as "*fully blue*" and "*totally blue*" to the Triple Zero operator, who instructed Ms Rateau to commence cardiopulmonary resuscitation (**CPR**).

Attempts to resuscitate Jack

5.25 At 1:26pm, the first New South Wales Ambulance (**NSWA**) paramedic crew arrived at the Randwick Property. Paramedic Andrew Robinson noted that he "*had to bang on the front door numerous and side door times [sic] and wait for the door to be open which took less than a minute*". Ms Rateau paused CPR in order to unlock the door for the paramedics, leaving Jack on the floor. Upon arriving in the lounge room and attending to Jack, the paramedics observed that Jack was on the ground in front of the lounge, that he did not have a pulse and was not breathing, and that there were approximately three or four other small children crawling around on the floor inside the house, with some in the living room.

5.26 The attending paramedics immediately commenced CPR. They advised the NSWA Control Centre that Jack was in cardiac arrest and requested the assistance of intensive care paramedics and a duty operations manager.

5.27 At 1:29pm, NSWA intensive care paramedics arrived on the scene. They observed that Jack was not breathing, centrally cyanosed, and that he did not have a pulse and was in asystole. Resuscitation efforts continued but Jack remained in asystole as he was transferred to the Sydney Children's Hospital, Randwick.

5.28 Upon arrival, Dr Melinda Berry, senior staff specialist, took over Jack's care. She observed that Jack was unresponsive with no pulse, that his pupils were dilated and not reactive to light, and that Jack was not breathing spontaneously. Cardiac monitoring showed no electrical activity in Jack's heart. Resuscitation efforts continued and further doses of adrenaline and Hartmann's solution were administered. A bedside ultrasound image showed that Jack's heart muscle was not making any movement.

5.29 Despite continued resuscitation efforts, Jack could not be revived and, tragically, was pronounced life extinct at 2:21pm.

6. Postmortem examination

6.1 Jack was subsequently taken to the Department of Forensic Medicine where a postmortem examination was conducted by Dr Bernard I'Ons, forensic and anatomical pathologist, on 6 March 2019. In the autopsy report dated 18 December 2019, Dr I'Ons noted the following findings:

(a) The heart was heavier than normal, with the weight above the 95th centile.

(b) There was evidence of right ventricular hypertrophy: the right ventricle was 4 mm in thickness (with normal thickness being 1.9 mm), with the left ventricle and septum being within normal ranges.

(c) The blood vessels within the lungs were markedly abnormal. As a result, the histology slides were reviewed by Dr Susan Arbuckle (a specialist paediatric pathologist at the Children's Hospital, Westmead) and Dr Jill Lipsett (a specialist paediatric pathologist at the Women's and Children's Hospital, Adelaide, with particular expertise in pulmonary pathology). Dr Arbuckle noted that the intra-acinar pulmonary arterioles showed medial muscle increase similar to the features seen with persistent pulmonary hypertension of the newborn (**PPHN**) and would constitute pulmonary hypertension. Dr Arbuckle further noted that the findings of right ventricular hypertrophy and cardiomegaly were consistent with such a finding.

6.2 Ultimately Dr I'Ons opined that the cause of Jack's death is "*pulmonary hypertension in the context of prone position*".

6.3 In the autopsy report, Dr I'Ons also noted the following:

> The placement of [Jack] in a prone position in a bassinet with a loose fitting sheet may have resulted in an increased difficulty of breathing. There are no physical findings expected or found in such instances. Its role as a contributing factor is possible, however not proven.

7. What issues did the inquest examine?

7.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues for consideration at inquest, in addition to the required statutory findings pursuant to section 81 of the Act:

(1) Was the condition that may have caused Jack's death (pulmonary hypertension – "his condition") diagnosable prior to death? If so, should it have been diagnosed following one of his presentations to medical practitioners prior to his death?

(2) Whether Jack being put to sleep on his tummy was a contributing factor to his death, particularly in light of his condition?

(3) Whether the bassinet Jack was put in was appropriate for a child his age and size, particularly in light of his condition?

(4) Did the Rhythm and Rhyme Family Day Care Centre have appropriate safe sleeping practices in place; and if so, were they complied with? This issue directs attention to whether the following circumstances reflected reasonable, appropriate and/or best practice sleeping practices:

(a) The use of a bassinet at the Rhythm and Rhyme Centre, including the placement of the bassinet on the floor;

(b) Placing Jack in a prone position, with a blanket and pillow underneath him, while still wearing his clothes and a bib;

(c) The circumstances of the room in which Jack was put down to sleep, including temperature, ventilation, access to the room by other children;

(d) The frequency with which Jack was checked.

(5) Did Ms Rateau respond in an appropriate and timely manner when Jack was found unresponsive on 4 March 2019?

(6) Was the supervision of the Rhythm and Rhyme Centre provided by Approved Provider, Kidstart Family Day Care Pty Ltd, in accordance with the National Law, reasonable, and in accordance with good practice? If not, did any failures impact on the events that culminated in Jack's death?

(6A) What type of background and qualifications does a person (or the persons with management and control of an entity) need in order to obtain permission to become an Approved Provider and Approved Service under the National Law? What background and qualifications did the persons with management and control of Kidstart have?

(7) Was the regulatory oversight of Kidstart by the Department of Education (**the Regulator**) in accordance with the National Law, reasonable, and in accordance with good practice? If not, did any failures impact on the events that culminated in Jack's death? This issue directs attention to the matters including the following:

(a) What is the regulatory framework applicable to the Regulator, including the National Law and the National Quality Framework?

(b) What is the role and function of the Australian Children's Education & Care Quality Authority?

(c) What is the role and function of National Quality Standards ratings? What are the requirements that those ratings be published or presented on signage at family day care centres?

(d) What steps was the Regulator required to take in relation to the granting of Provider approval and Service approval in respect of Kidstart? What steps were actually taken in relation to the granting of Provider approval and Service approval in respect of Kidstart?

(e) What steps was the Regulator required to take in respect of assessing and monitoring Kidstart? What steps were actually taken in relation to assessing and monitoring Kidstart, including given its in NQS rating of "working towards"?

For the avoidance of doubt, these issues are not intended to limit the inquisitorial process of the inquest, nor the possibility that other relevant issues that arise during the inquest may be investigated.

(8) Should any changes to the National Law concerning safe sleeping practices of children in day care be recommended? This issue directs attention to the matters including the following:

(a) What was the National Law concerning safe sleeping practices as at March 2019?

(b) Have any changes to the National Law concerning safe sleeping practices occurred since March 2019?

(c) Are there any (or any further) changes to the National Law concerning safe sleeping practices recommended? If so, what is the process required to bring about a change to the National Law?

(9) Should any changes to either the regulatory regime governing, or the manner in which, the Regulator provides regulatory oversight of Approved Providers of family day care Services, and the way the Regulator and Approved Providers provide oversight of the Educators engaged by those family day care Services, be recommended?

7.2 Each of the above issues is discussed in further detail below and in a different order. In order to assist with consideration of some of these issues, opinion was sought from the following experts as part of the coronial investigation. Each of the experts provided reports which were included in the brief of evidence, and some of the experts also gave evidence during the inquest:

(a) Dr Susan Arbuckle, paediatric perinatal pathologist, Sydney Children's Hospital at Westmead.

(b) Dr Megan Dishop, Division Chief of Pathology and Laboratory Medicine, Phoenix Children's Hospital.

(c) Professor Heather Jeffery, paediatric neonatologist and an Honorary Professor of International Maternal and Child Health, University of Sydney.

(d) Associate Professor Andreas Pflaumer, paediatric cardiologist, Royal Children's Hospital Melbourne.

8. Issue 1 – Was Jack's condition diagnosable?

Features of persistent pulmonary hypertension of the newborn

8.1 In the autopsy report Dr I'Ons noted that PPHN occurs when pulmonary vascular resistance (**PVR**) remains abnormally elevated following birth. In children, this is most commonly associated with underlying primary cardiac or lung disease, but may also be idiopathic or familial. Dr I'Ons also noted:

> Major circulatory adjustments occur at birth as the organ of gas exchange changes from the placenta to the lung. Under normal circumstances, a progressive fall in pulmonary vascular resistance accompanies the immediate rise in systemic vascular resistance (SVR) that occurs after birth. For a short period, a transitional circulatory pattern exists that combines features of both the fetal and adult circulatory patterns. Conditions that interfere with the normal postnatal decline in the PVR/SVR ratio cause the transitional circulation to persist and result in PPHN.

8.2 Three types of abnormalities of the pulmonary vasculature underlie PPHN:

(a) Underdevelopment: This occurs with a number of conditions, including fetal growth restriction, which was present in Jack's case. With underdevelopment, the cross sectional area of the pulmonary vasculature is reduced, resulting in a relatively fixed elevation of PVR.

(b) Maldevelopment: This includes abnormal thickening of the muscle layer of the pulmonary arterioles, and extension of this layer into small vessels that normally have thin walls and no muscle cells.

(c) Maladaptation: This occurs where the pulmonary vascular bed is normally developed, but adverse perinatal conditions cause active vasoconstriction and interfere with the normal postnatal fall in PVR.

8.3 Dr Arbuckle, Dr Dishop, Dr I'Ons, and Professor Jeffery all gave evidence concurrently in a conclave (**Conclave**) during the inquest.

8.4 Dr Arbuckle, Dr Dishop, and Professor Jeffery all agreed with Dr I'Ons' finding of pulmonary hypertension as the cause of Jack's death.

8.5 A significant finding from the autopsy was that part of Jack's arteries, namely the arterioles, were abnormally muscularised. Arterioles, which normally have a relatively thin muscular wall, are a small branch of an artery leading into capillaries where oxygen transfer takes place. In Jack's case, these arterioles were much thicker than normal. This muscularisation occurs when the muscle develops in order to cope with pressure or some type of abnormality.

8.6 The right ventricle is the lower chamber of the heart on the left side. It is responsible for pumping blood from the right ventricle to the lungs, after which blood returns to the left ventricle before being pumped out to the rest of the body. At autopsy, right ventricular hypertrophy was observed macroscopically.

8.7 Hypertrophy describes an increase in the bulkiness of muscle cells, which indicates that such cells are working harder than they should be in order to get blood out. Right ventricular hypertrophy is a chronic condition, whereby the increase in bulk and the size of muscle cells occur over time. Right ventricular hypertrophy also causes cardiomegaly, which was present in Jack's case.

8.8 None of the experts participating in the Conclave identified an underlying cause for Jack's pulmonary hypertension, and agreed that it is best described as idiopathic. In particular, Dr Arbuckle indicated that she could not recall seeing a case of pulmonary hypertension in a child of Jack's age, where there was not an underlying cause, in her 30 years' experience. Professor Jeffery explained that the more typical presentation of pulmonary hypertension in children is immediately after birth.

8.9 Associate Professor Pflaumer described idiopathic pulmonary hypertension as a very rare disease, with presentation in a child under the age of six months to be extremely rare. Dr Arbuckle expressed a similar view that the first presentation of pulmonary hypertension in a child of Jack's age was very unusual. Associate Professor Pflaumer explained that the most frequent symptoms of pulmonary hypertension in children is breathlessness with activity, and syncope, both of which can be caused by other harmless or less severe conditions. Whilst medication therapy can slow down the progress of the disease, it cannot stop it and the risk of sudden death therefore remains high. Due to the rarity of its presentation, there are no reliable statistics for children under the age of four, however Associate Professor Pflaumer offered a broad estimation that the five year survival rate for this age group is 50% or less.

8.10 Dr Arbuckle expressed the view that pulmonary hypertension would have impacted upon Jack's ability to cope with adverse conditions. Relevantly, blood pressure in Jack's arteries would already be high, with any decrease in oxygen placing increased pressure on his whole system. Similarly, Professor Jeffery indicated that a sudden increase in blood pressure in the arteries of Jack's lungs was "*likely precipitated by the unsafe sleeping conditions*" and possibly elevated body temperature. Professor Jeffery noted:

> I would liken it to they're really on a tightrope and they can easily fall off and the way in which they fall off is some sort of trigger and the most common triggers we see in young infants and, indeed, in the literature where this is described not many times, I might say, but in babies of Jack's age where – or older of younger. It's particularly things like exertion, crying, agitation, that may produce – or some sort of obstruction which may produce a sudden fall in oxygen in the blood because they're not getting it – say, they're obstructed – and immediately the pulmonary pressures will go up and basically you've then got a situation when you're going right to left. You're not getting any blood or very little into the lungs and so your oxygen then plummets rapidly.

8.11 Professor Jeffery went on to explain that this rapid decrease in oxygen to the body and brain can rapidly cause death, even in a child such as Jack who appeared healthy and happy the day that he died.

Previous cardiac investigations

8.12 As to the detection of a heart murmur, Associate Professor Pflaumer indicated that, in retrospect, the results from the October 2018 echocardiogram could be interpreted as a very early sign of pulmonary hypertension. However, given that it is very unusual for this condition to develop in a child as young as Jack, Associate Professor Pflaumer considered that Dr Cooper's diagnosis that Jack had a normal variant was reasonable. Further, Associate Professor Pflaumer expressed the view that it was also reasonable, given the absence of any red flags and the lack of any clinical symptoms, to recommend that Jack's progress be checked after 12 months.

8.13 Professor Jeffery opined that, in retrospect, these cardiology investigations likely revealed physical indications of pulmonary hypertension. Professor Jeffery expressed the view that if an echocardiogram had been performed in January 2019, it likely would have indicated positive findings of pulmonary hypertension. This in turn may have led to a different approach in Jack's treatment. Notwithstanding, Professor Jeffery expressed the view that there are still poor survival rates for children with underlying pulmonary hypertension. Ultimately, Professor Jeffery did not express the opinion that Jack's pulmonary hypertension ought to have been diagnosed as at October 2018.

8.14 After Jack was noted to be panting and working hard to breathe while sleeping, sleep studies were undertaken. Professor Jeffery expressed the view that the results of the sleep studies were normal and reassuring, and the fact that no heart murmur was detected on presentation suggested that it was benign.

Jack's previous presentations to hospital

8.15 As for the admission to the Sydney Children's Hospital for bronchiolitis in January 2019:

(a) Professor Jeffery noted that Jack appeared to recover quickly and that his parents raised no concerns regarding his recovery. On this basis, Professor Jeffery opined that nothing about Jack's presentation indicated anything other than moderate bronchiolitis.

(b) Dr Dishop noted that there was no evidence of persistent bronchiolitis or airway fibrosis to suggest a chronic complication of a respiratory infection. Dr Dishop also found no evidence of persistent bronchiolitis or any inflammation of Jack's airways.

(c) Associate Professor Pflaumer noted that Jack's presentation and the findings are very common in children his age, and that the absence of a heart murmur being heard was neutral and not of any relevance. Further, Associate Professor Pflaumer noted that Jack presented with an obvious airway issue and viral infection, and that there was no indication for any cardiac investigations to be performed.

(d) Professor Jeffery expressed a similar view that Jack did not present with any specific symptoms which indicated the need to investigate the possibility of pulmonary hypertension.

8.16 Notwithstanding, given that this presentation was approximately two months before Jack's death, Associate Professor Pflaumer considered it likely that if an echocardiogram had been performed it likely would have shown that Jack's right ventricular hypertrophy had progressed (not regressed), which would have likely led to a diagnosis of pulmonary hypertension. Dr I'Ons and Dr Arbuckle similarly expressed respective views that from around the age of seven months onwards, cardiac investigations would have identified right ventricular hypertrophy, leading to a diagnosis of pulmonary hypertension.

8.17 As to Jack's presentation to the Sydney Children's Hospital on 26 January 2019 for vomiting, cough and fever, Associate Professor Pflaumer noted that such a presentation is very frequent for children in Jack's age group, and that there was no indication for an underlying cardiac issue. However, whilst Associate Professor Pflaumer considered that Jack's mild cough was probably a subtle sign of pulmonary hypertension, he noted that it might also have been a result of Jack's recent bronchiolitis, noting that viral infections in children of Jack's age are frequent. Associate Professor Pflaumer considered that the recognition of a possible need for a repeat echocardiogram demonstrated that a thorough history had been taken. Associate Professor Pflaumer also expressed the view that the fact it was considered, but not ordered, was an omission which could only be seen in hindsight. In particular, Associate Professor Pflaumer noted:

> At that time the probability of an abnormal finding was very low given the mild symptoms and the extreme low incidence of idiopathic pulmonary hypertension.

8.18 Overall, both Professor Jeffery and Dr Arbuckle indicated that it is not uncommon for infants to suddenly die of pulmonary hypertension, without it being known that they have that condition.

8.19 **Conclusion:** If an echocardiogram had been performed in January 2019 it is likely that this would have led to a diagnosis of pulmonary hypertension. However, during Jack's two presentations to hospital in January 2019, there were no clear indications for cardiac investigations to be performed. Whilst Jack's cough during the second presentation might be considered to be a subtle sign of pulmonary hypertension, this consideration is only possible with the benefit of hindsight. Further, given the rarity of idiopathic pulmonary hypertension in a child of Jack's age, it cannot be said that the care and treatment provided to him was neither reasonable nor appropriate.

9. Issue 2 – Did putting Jack on his tummy to sleep contribute to death?

Issue 3 – Was the bassinet that Jack was put in appropriate for a child of his age and size?

9.1 It is convenient to deal with these two issues together.

Background regarding Jack's sleeping arrangements

9.2 The evidence indicates that until at least the age of two months, Jack was placed to sleep in a supine position:

(a) When he was seven days old, Jack's check-up records note the following: "*Baby is sleeping on their [sic] back in bassinet in parents' bedroom as per SIDS recommendations*";

(b) Medical records from when Jack was two months old indicate that he "*still has a preference to sleep with his head rotated to the right side for up to 6 hours during the night*". Physiotherapist notes indicate the following, "*[…] encourage midline positioning of head in supine for sleep time*".

9.3 Joseph gave evidence that once Jack began moving around, he would thump his legs on the bed when put down to sleep. Once Joseph and Margot noticed this, they began placing Jack to sleep in a prone position, as this would calm him down and help him to go to sleep more easily. They also noticed that Jack would often roll onto his back during sleep.

9.4 Around the time that Jack was five months old, Margot would put him to sleep on his tummy. According to Margot and Joseph, Jack's GP, Dr Brierley had no concerns with this practice given that Jack was rolling and he had space to move around in his cot at home. Dr Brierley does not recall speaking with Jack's parents regarding safe sleeping.

9.5 Before enrolling Jack at the Rhythm and Rhyme Centre, Margot and Joseph met with Ms Rateau at the Randwick Property. On that day, Joseph recalls that there were seven or eight children at the property. According to Margot, the door to the Sleeping Room was closed during the tour, and Ms Rateau did not inform Margot or Joseph that children were put to sleep in the Second Bedroom.

9.6 By way of background, before Jack started at the Rhythm and Rhyme Centre, Margot provided Ms Rateau with a schedule of his preferences and routines. The schedule noted the following:

> He sleeps better on his stomach so we always put him down on his front […] Best to continue rolling him on his stomach.
> […]
> Jack seems to have sensitive skin and will easily break out in a rash from grass, heat and possibly washing powders.

9.7 Jack slept in a full-sized cot at home which was constructed with slats that allowed free airflow around it, and which contained a firm fitting mattress. According to Margot, Jack could move from one end of the cot to the other while he slept. Joseph gave evidence that both he and Margot knew

that babies should be placed in a full-sized cot as soon as they started to move around. Accordingly, Margot told Ms Rateau that Jack *"sleeps on his stomach in cot but rolls around. I made it clear that he was a moving baby and I assumed she would put him in a proper cot".* As noted above, Ms Rateau did not tell Margot or Joseph that she would put Jack to sleep in a bassinet.

Environmental factors

9.8 The bassinet that Jack was put down to sleep in on 4 March 2019 was manufactured by the company, "Love n Care", and measured 81 cm in length and 38 cm in width. It contained a mattress that measured 78.5 cm in length and 35.5 cm in width, and was 5 cm thick. The bassinet was positioned on the floor in the Second Bedroom on 4 March 2019.

9.9 For comparison purposes, Jack was 68 cm in length and weight approximately 8 kg.

9.10 Bureau of Meteorology weather reports indicate that the temperature on 4 March 2019 at

(a) Sydney Airport AMO was 28.6°C at 1:00pm and 28.7°C at 1:30pm; and

(b) Sydney (Observatory Hill) was 26.8°C at 1:00pm and 27.4°C at 1:30pm.

9.11 On 4 March 2019 the windows to the Second Bedroom were closed, and there was no fan, baby monitor or air conditioning inside the room.

9.12 It is noted that there is conflicting evidence as to whether Ms Rateau had a baby monitor at the Randwick Property. However, there is no dispute that Ms Rateau did not use any such monitor on 4 March 2019. Relevantly, Ms Rateau told Ms Ingram during her tour of the Rhythm and Rhyme Centre that she did not use a monitor because she could usually hear the children from wherever she was in the house.

Ms Rateau's awareness of safe sleeping practices

9.13 During the course of the criminal prosecution, Ms Rateau agreed that she had failed to adequately supervise Jack whilst he slept on 4 March 2019. In evidence, Ms Rateau accepted the following:

(a) that she was aware of safe sleeping practices from when her daughters were babies;

(b) that she had been given a Red Nose Australia (**Red Nose**) booklet on Sudden Infant Death Syndrome (**SIDS**);

(c) that she knew, from her studies to be qualified as an Educator, that a sleeping baby should be checked every 10 to 15 minutes; and

(d) that extraneous bedding material, such as pillows and sheets, should not be placed in a cot with an infant.

9.14 The evidence indicates that Ms Rateau did not check on Jack for between 30 to 45 minutes after she last opened the door to the Second Bedroom. During that period, Ms Rateau made two phone calls lasting more than 10 minutes each, and was caring for two infants who were awake and out of their cots, as well as her own daughter who was home sick from school.

Expert evidence and manner of death

9.15 Each of the experts who participated in the Conclave considered that the sleeping environment that Jack was placed in on 4 March 2019 was unsafe, and a risk factor that likely contributed to the circumstances leading to his death. In particular, Professor Jeffery opined that:

(a) Jack should not have been wrapped or placed in a bassinet, because he was known to be able to roll himself from front to back;

(b) It was unsafe for Jack to be placed in a prone position, with a pillow and large sheet positioned loosely underneath him;

(c) It was not recommended that Jack be put to sleep while still wearing his dribble bib, as it could become caught on other objects and compromise his airway;

(d) The bassinet that Jack was placed in had an imperfectly fitting mattress that barely accommodated Jack's height and width, which would have impacted his ability to turn from a prone position to a supine position;

(e) Jack's body temperature and the temperature in the room where he was put to sleep were likely to be raised given that the door and window in the Second Bedroom were closed, there was no fan or air conditioning in the room, and Jack was dressed when put down for his nap. The circumstances were likely a stressor, and a precipitant adding to the concerns with how Jack was put down to sleep;

(f) It was unsafe for Jack to be placed to sleep in the same room as a two-year-old child due to the risk that the older child might inadvertently engage in unsafe behaviour.

9.16 Dr Arbuckle similarly observed the following:

(a) Dr Arbuckle considered the size of the bassinet to be a "*major problem*", as it would have prevented Jack from rolling or moving easily;

(b) The presence of a sheet and pillow in the bassinet represented a hazard to Jack's face and, potentially, his airway. Dr Arbuckle noted that Red Nose recommends that pillows should not be placed in cots and particularly not in "*a bassinet with severely limited room to move*", as was used for Jack.

9.17 Dr I'Ons explained that in cases where the possibility of accidental suffocation is raised, it is typically not possible at autopsy to demonstrate any findings in support of such a hypothesis. However, Dr I'Ons went on to explain that the sudden death of children with no underlying medical

conditions typically occurs in the context of a modifiable extrinsic risk factor (such as an unsafe sleeping environment) or a non-modifiable intrinsic risk factor (such as being born small and underweight, or having an underlying condition that might predispose a child to sudden death). Dr I'Ons stated the following:

> We very, very rarely see a baby now who dies suddenly and unexpectedly who are normal weight and sleeping in a normal environment. That is very – it's a very rare thing to see.

9.18 It was submitted on behalf of the directors of Kidstart that:

> Although there is a temptation in this case to find that placing Jack in a prone sleeping position was causative of his death, the expert evidence does not rise to a level that makes such a finding more than speculative.

9.19 In making this submission, reference was made to the fact that the autopsy identified no physical findings to support the possibility that Jack's sleeping position resulted in an increased difficulty of breathing.

9.20 Similar submissions were advanced on behalf of Ms Rateau regarding the manner of Jack's death. In essence, it was submitted that whilst it is possible that one or more of the factors associated with unsafe sleeping arrangements may have triggered the fatal reaction on Jack's part, in the context of his underlying pulmonary hypertension, it is not possible to identify with any precision whether one of these factors, or another factor (such as crying, agitation or elevated temperature), operated as a trigger.

9.21 These submissions overlook the expert evidence in three important respects:

(a) difficulty of breathing and, as a potential consequence, accidental suffocation cannot be demonstrated at autopsy;

(b) it was not only the placing of Jack in a prone position but rather this factor, in combination with his size and ability to roll relative to the size of the bassinet, the extraneous bedding material and the lack of ventilation in the Second Bedroom which amounted to an unsafe sleeping environment; and

(c) the other factors (such as crying or agitation) referred to by counsel for Ms Rateau may have been a consequence of the unsafe sleeping environment that Jack was placed in.

9.22 In this regard, the opinion expressed by Dr Arbuckle in her report of 21 July 2020 should be noted:

> There may have been genetic factors contributing to [Jack's] death and probably the pulmonary hypertension with secondary right ventricular hypertrophy had a role to play in making him more vulnerable particularly where he could not change his position. I would imagine in the confined space of the bassinette it would have possibly been difficult for him to even turn to change the direction of his head particularly if there was also a pillow and sheet there.

9.23 Further, Professor Jeffery opined that the cause of Jack's death was:

Unrecognised pulmonary hypertension likely exacerbated by unsafe sleeping conditions ± elevated body temperature.

9.24 **Conclusion:** It is accepted that the combined expert evidence, appropriately, could not be definitive as to the terminal mechanism which caused Jack's death. However, the overwhelming evidence is that the conditions in which Jack was put down to sleep at 12:35pm on 4 March 2019 were unsafe, and not consistent with recognised safe sleeping practices. This makes it most likely that the unsafe sleeping conditions contributed to Jack's death, although the precise nature of this contribution cannot be determined on the available evidence.

9.25 At the time of his death, Jack was more than six months old, able to roll in bed and sit up. At home, Jack typically slept in a cot, wearing a sleep suit that kept his arms free and temperature cool. The Red Nose guidelines provide that a bassinet is not generally recommended for babies at all, and is inappropriate for babies four months and older who can roll from front to back.

9.26 The bassinet that Jack was placed in to sleep on 4 March 2019 was too small for him and had a poorly fitting mattress. These factors would have hindered Jack's ability to roll from a prone position to a supine position. Further, the bassinet itself was unsafe as it contained extraneous bedding material (a pillow, a wrap and a loose-fitting sheet) and Jack was put to sleep while still wearing his dribble bib. These items had the potential to compromise Jack's airway.

9.27 Although accidental asphyxia cannot be demonstrated at autopsy, Dr I'Ons, Dr Arbuckle and Professor Jeffery all considered that Jack's sleeping position and the sleeping environment in which he was placed on 4 March 2019 were precipitant factors to his death. These considerations are complicated by Jack's underlying pulmonary hypertension in circumstances where sudden death in children with this type of pathology often occurs in the context of an obstructed airway triggering a rise in pressure, and decreased oxygen flow.

10. Issue 5 – Did Ms Rateau respond in an appropriate and timely manner?

Lapse of Ms Rateau's CPR accreditation

10.1 Ms Rateau's first aid qualification in CPR had expired on 17 October 2018, approximately five months before the events of 4 March 2019. This expiration occurred despite Kidstart receiving alerts on 17 September 2018 and 3 October 2018 of the impending expiry. Further, on 16 October 2018, Ms Rateau sent an email to Ms Shamsin at Kidstart asking, "*Is it my cpr cert that needs updating?*". On the same day, Ms Rateau received an email in response from the Kidstart email address indicating, "*It's just the CPR that needs updating*".

10.2 Despite booking a CPR course, Ms Rateau did not attend, and did not make a rebooking. Further, Ms Rateau later told police that she had not made a rebooking, and that her CPR qualifications had lapsed "*a couple of months*" prior to 4 March 2019. When asked why this had occurred, Ms Rateau said, "*I just never had a chance to go and get it […] I know it's bad*".

10.3 Notwithstanding the above, Ms Shamsin gave evidence that she satisfied herself that Ms Rateau had updated her CPR certificate because of the following:

(a) Ms Rateau informed her that she had booked herself in to complete the requisite course; and

(b) She relied on Ms Trad completing a home visit checklist which confirmed (incorrectly) that a first aid certificate had been sighted and was current.

10.4 Set against the above evidence is the following:

(a) Ms Shamsin conceded that Ms Rateau never confirmed with her that she had completed a CPR course;

(b) Contemporaneous records suggest that Kidstart did not proactively monitor Ms Rateau's training status. For example, Kidstart only sent an email to Ms Rateau regarding the lapsed CPR qualifications after receiving two automated reminders. Further, Kidstart maintained a register for Ms Rateau which recorded the status of her training in first aid, anaphylaxis and asthma management, but did not refer to CPR training;

(c) The home visit checklists referred to by Ms Shamsin do not specifically refer to a CPR certificate; rather, they refer to first aid, asthma and anaphylaxis certificates being displayed;

(d) For Ms Shamsin to be satisfied that Ms Rateau had completed her CPR training, she had to rely on Ms Trad completing the home visit checklists appropriately. Ms Trad accepted in her evidence that she only checked the relevant box as complete because she had a conversation with Ms Rateau and Ms Shamsin, during which Ms Rateau said she was going to do CPR training "*that week or that afternoon*". Ms Trad conceded that she should not have checked that box in both the November 2018 and January 2019 checklists. Although Ms Shamsin gave evidence of having a telephone conversation with Ms Rateau about booking her CPR training, Ms Shamsin did not arrange a follow-up call to confirm that this had occurred, despite Ms Rateau indicating

that the training had been booked for the same day, or later in the week. On 8 March 2019, the Department identified that two other Educators were operating with expired CPR accreditation, with the first certificate having expired on 21 November 2018, and the second expiring on 24 April 2017.

10.5 **Conclusion:** The evidence establishes that Ms Shamsin did not, and could not have, satisfied herself that Ms Rateau had updated her CPR qualifications. In essence, Ms Shamsin relied on two sources – an assurance from Ms Rateau and checklists completed by Ms Trad – both of which were inherently unreliable, and neither of which Ms Shamsin sought to independently confirm. In addition, Ms Shamin's evidence on this issue, and in general, was frequently evasive and non-responsive. Ms Shamsin failed to take ownership of responsibilities which she bore as a director of Kidstart and a person with management or control of the Service. Instead, Ms Shamsin repeatedly sought to deflect these responsibilities onto others. To the extent that Ms Shamsin's credit has any bearing on determining the reliability of her evidence, it cannot be given any weight.

Ms Rateau's response upon discovering Jack to be unresponsive

10.6 Upon discovering Jack to be unresponsive, it appears that Ms Rateau did not immediately commence CPR. As noted above, Ms Rateau rang her mother at 1:21:02pm before contacting Triple Zero and being connected to the emergency operator at 1:21:58pm. This resulted in a short delay in the commencement of CPR and the despatch of NSWA paramedics.

10.7 The phone call made by Ms Rateau to her mother is not referred to in either Ms Rateau's interview with police, or in her mother's statement to police. Following the incident, Ms Rateau accompanied Detective Senior Constable Kurt Tillman to Maroubra police station. At around 4:30pm, whilst collecting Ms Rateau's details, Detective Tillman observed Ms Rateau to be scrolling up and down on her mobile phone, before the following exchange occurred:

Ms Rateau:	Oh I'm sorry, I just accidentally deleted my recently called list.
Detective Tillman:	All good.
[…]	
Ms Rateau:	I just, I feel like it was my fault, I killed him. It is my fault. Life will never be the same after this.

10.8 On 5 April 2019, Ms Rateau completed a report to her insurer regarding the circumstances of Jack's death. In the report, Ms Rateau wrote that she "*started CPR while calling for an ambulance*". However, the transcript of the Triple Zero call is not consistent with Ms Rateau's description of these events. The transcript records the following:

> P1. OK. Are you with, are you with him now?
> V1. Yes. I'm with him, I'm trying to get him ---
> P1. Ok. How old is he?
> V1. He's, um, 6 months.
> P1. OK. Now, is he awake?
> V1. No, no, he's blue, he's totally blue.

P1. OK. All right. I'm organising some help for you now. Stay on the line and I'll tell you exactly what to do next. Are you right by the baby now?
V1. Yes, yes.
P1. OK. Listen carefully, lay the baby flat on his back on the floor and remove any pillows.
V1. Yeah, OK.
P1. Kneel, OK, kneel next to the baby and look in the mouth for food or vomit.
V1. No, there's no, he's totally---
P1. Is it ---
V1. ---blue, he's totally blue.
P1. Is there any, is there ---
V1. He's totally blue.
P1. Is there anything ---
V1. He's not breathing.
P1. --- in the mouth?
V1. No.
P1. Ok. Place your hand on the baby's forehead, your other hand under the baby's neck and shoulders---
V1. Uh-huh.
P1. ---and slightly tile the head back. Now, put your ear next to his mouth, can you feel or hear any breathing?
V1. No.
P1. OK. I'm going to tell you how to give mouth to mouth…

10.9 In addition, Ms Rateau had to stop performing CPR in order to unlock the front door for the attending paramedics. This resulted in a slight delay which was noted in relevant records as follows: "*[…] ineffective CPR provided (ineffective due to fact care at open door for [ambulance officers])*".

10.10 It was submitted on behalf of Ms Rateau that the transcript of the Triple Zero call is consistent with answers given by Ms Rateau during an interview with police on 4 March 2019. In the interview, Ms Rateau referred to placing Jack on the floor in the living room and then commencing CPR before calling Triple Zero. However, this submission largely relies upon assumptions being made regarding what might have been said by Ms Rateau during the Triple Zero call which are not transcribed.

10.11 Further, it was also submitted on behalf of Ms Rateau that it is questionable whether Ms Rateau deliberately rang her mother prior to calling Triple Zero, and that this call is equally consistent with Ms Rateau having accidentally dialled her mother's number due to the stressful circumstance that she found herself in.

10.12 **Conclusion:** The available telephone records establish that Ms Rateau called her mother before calling Triple Zero. There is no direct evidence as to whether this call was accidentally made by Ms Rateau. However, what is not in dispute is that the fact that the call was made meant that there was a slight delay before emergency services were contacted after Jack was found to be unresponsive.

10.13 Further, whilst Ms Rateau asserted in her interview with police that she commenced CPR prior to contacting Triple Zero, this assertion cannot be independently verified. Rather, a plain reading of the transcript of the Triple Zero call, and listening to the call itself (without attempting to complete statements which have not been transcribed or which were not completed), suggests that Ms Rateau had not commenced CPR prior to making the Triple Zero call.

10.14 It is acknowledged that the stressful and traumatic situation confronting Ms Rateau on 4 March 2019 possibly bore upon her actions regarding the contacting of emergency services and initiation of CPR. However, it should be remembered that the lapsing of Ms Rateau's CPR qualification is also an important consideration. Whilst it is difficult to make an assessment of the extent to which the situation confronting Ms Rateau bore upon her actions, it is an objective fact that Ms Rateau's CPR qualifications had lapsed, and that she should not have allowed this to occur. In this regard, the absence of up-to-date CPR qualifications is consistent with Ms Rateau not immediately commencing CPR upon finding Jack to be unresponsive and, as the Triple Zero call demonstrates, requiring instruction from the Triple Zero operator in relation to the resuscitation efforts.

10.15 However, it is noted that any delay in contacting emergency services and the instituting of CPR was relatively minor, and measured in a matter of seconds. Further, there is no evidence to suggest that the absence of any delay in either respect might have materially altered the eventual outcome.

11. Issue 4 – Did the Rhythm and Rhyme Centre have appropriate safe sleeping practices in place and, if so, were they complied with?

Issue 8 – Should any changes to the National Law concerning safe sleeping practices of children in day care be recommended?

11.1 It is convenient to deal with these issues together. For doing so, it is necessary to understand the corporate and administrative structure of the Rhythm and Rhyme Centre, and the overarching legislative framework applicable to the regulation of day care centres.

Overview of the National Quality Framework

11.2 The Department of Education (**Department**) is the Regulator of childcare Services in New South Wales pursuant to the *Children (Education and Care Services) National Law (NSW*) (**National Law**) and the *Education and Care Services National Regulations (NSW)* (**National Regulations**). This legislation, together with nationally approved learning frameworks, establishes the National Quality Framework (**NQF**) for early childhood education and care.

11.3 The Quality Assurance and Regulatory Services Directorate for early childhood education and care Services is the Regulatory Authority within the Department.

11.4 Section 3(1) of the National Law provides that its objective is:

> to establish a national education and care Services quality framework for the delivery of education and care Services to children.

11.5 Section 3(2)(a) provides that one of the objectives of the NQF is:

> to ensure the safety, health and wellbeing of children attending education and care Services.

11.6 Section 3(3) recognises the following guiding principles, amongst others, of the NQF:

> that the rights and best interests of the child are paramount;
> […]
> that the role of parents and families is respected and supported;
> that best practice is expected in the provision of education and care Services.

11.7 The steps that must be met to operate any kind of childcare Services in NSW may be summarised as follows:

(a) A person/entity must seek and be granted Provider approval;

(b) A person/entity must then apply for and obtain Service approval, which may be subject to conditions;

(c) Each Service must have a Nominated Supervisor; and

(d) Each Service then employs/engages Educators, such as Ms Rateau.

11.8 Four types of childcare Services are covered by the National Law:

(a) Family day care;

(b) Long day care;

(c) Outside school hours care; and

(d) Preschools.

11.9 Under the NQF, the Department is required to monitor, assess and supervise Approved Providers and Services. In general, monitoring and supervision of Educators falls within the remit of Approved Providers.

11.10 The National Law sets out the mechanisms by which Provider approval and Service approval are granted together with the enforceable obligations which must be followed by Approved Providers and Services.

11.11 The Australian Children's Education and Care Quality Authority (**ACECQA**) is an independent national statutory authority. Section 225 of the National Law describes the functions of ACECQA as to:

(a) monitor and promote the consistent application of the NQF;

(b) support the children's education and care sector to improve quality outcomes for children; and

(c) support governments through the development, publication and promotion of guidance and other information about the NQF.

11.12 ACECQA publishes guidelines that provide practical guidance and general information as to what is required under the National Law and National Regulations. Those guidelines do not establish enforceable obligations (beyond that established by the National Law and National Regulations).

11.13 In February 2018, ACECQA published the *Guide to the National Quality Framework* (**ACECQA Guide**). The ACECQA Guide explains that:

> The National Quality Standard (NQS) sets a national benchmark for the quality of education and care Services and includes seven quality areas that are important to outcomes for children […]

Overview of the Rhythm and Rhyme Centre

11.14 As at March 2019, as regards the Rhythm and Rhyme Centre:

(a) the Provider approval and Service approval were held by Kidstart Family Day Care Pty Limited (**Kidstart**) ATF Kidstart Unit Trust;

(b) The persons with management or control of the Service were Sikander (also known as Sunny) Farooq Cheema and Aman Shamsin;

(c) Abdul Shamsin (who had been a person with management or control of Kidstart from 24 May 2013 to 19 January 2016) was an initial unit holder of the Kidstart Unit Trust;

(d) Faten Trad was the Nominated Supervisor for Kidstart and had been since 1 September 2014; and

(e) Ms Rateau was an Educator under the NQF.

11.15 By way of background to the events of 4 March 2019:

(a) on 24 May 2013, the Department granted Provider approval to Mr Shamsin pursuant to section 15 of the National Law;

(b) on 9 September 2013, Mr Shamsin obtained approval to operate a family day care Service, subject to two conditions:

(i) it was required to employ at least one full-time family day care coordinator for every 15 family day care Educators; and

(ii) it was not permitted to engage more than 60 family day care Educators in the first 12 months;

(c) on 23 October 2013, Kidstart was registered as a company. As regards the officeholders of Kidstart:

(i) on 23 October 2013, Mr Shamsin and Mr Cheema were appointed directors of Kidstart;

(ii) on 22 September 2015, Ms Shamsin was appointed as a director of Kidstart; and

(iii) on 12 January 2016, Mr Shamsin ceased to be a director of Kidstart.

(d) also on 23 October 2013, the Kidstart Unit Trust was established, with Kidstart as the nominated Trustee. The initial unitholders were:

(i) Mr Shamsin as trustee for Shamsin Family Trust; and

(ii) Mr Cheema as trustee for Cheema Family Trust;

(e) on 4 June 2014, Kidstart applied for Provider approval, and nominated Mr Cheema and Mr Shamsin as the persons with management and control of the Service;

(f) on 25 October 2015, Kidstart's Provider approval was transferred to Kidstart Family Day Care Pty Limited ATF Kidstart Unit Trust;

(g) on 4 December 2015, Ms Shamsin was appointed as a person with management or control of the Service;

(h) on 19 January 2016, Mr Shamsin notified the Department that he was to be removed as a person with management and control of the Service; and

(i) on 15 September 2016, Ms Rateau applied to Kidstart to become a registered Educator. Her application was approved that day, and she was engaged by Kidstart as an independent subcontractor.

11.16 At least two other people provided childcare services from the Randwick Property prior to Jack's death:

(a) Zuzana Hanuliakova worked at the Randwick Property between January 2018 and December 2018. She worked four days a week, Tuesday to Friday, and had a Certificate III in Child Care Services;

(b) Lucky Das was employed by Ms Rateau in around June or July 2017 as an Educator assistant. Ms Das had a Certificate III in Child Care and worked on Wednesdays, which was Ms Rateau's day off. Ms Das was still working at the Rhythm and Rhyme Centre in March 2019 but was not present on 4 March 2019.

11.17 After Jack's death, the following occurred:

(a) Kidstart's Provider approval was suspended on 8 March 2019 in accordance with section 28 of the National Law.

(b) Also on 8 March 2019, Ms Rateau was prohibited from providing education and care Services under the National Law, pursuant to section 187 of the National Law.

(c) Effective 8 June 2019, the Department cancelled Kidstart ATF Kidstart Unit Trust's Provider approval.

Obligations in relation to safe sleeping arrangements under the National Quality Framework

11.18 Section 51(1)(a) of the National Law provides that Service approval is granted subject to the condition that the education and care Service is operated in a way that:

> ensures the safety, health and well-being of the children being educated and cared for by the Service.

11.19 Part 4.2, Division 1 of the National Regulations provides for the health, safety and well-being of children. Relevantly, in relation to sleep and rest, regulation 81 provides that an Approved Provider, Nominated Supervisor and family day care Educator all:

> […] must take reasonable steps to ensure that the needs for sleep and rest of children being educated and cared for by the Service are met, having regard to the ages, development stages and individual needs of the children.

Sleep and rest for children

11.20 Regulation 168 provides that an Approved Provider of an education and care Service must ensure that the Service has in place policies and procedures in relation to health and safety, including sleep and rest for children. It is noted that an Approved Provider is to ensure that the policies and procedures of the Services it operates are readily accessible to Educators. Further, Approved Providers have a statutory obligation to take all reasonable steps to ensure that family day care Educators follow such policies and procedures.

11.21 The Schedule to the National Regulations provides that the National Quality Standard (**NQS**) is used to assess education and care Services to determine rating levels under Part 5 of the National Law. Section 133 of the National Law provides that:

> The Regulatory Authority that granted the Service approval for an education and care Service may at any time assess the Service in accordance with the National Regulations to determine whether and at what rating level the Service meets the National Quality Standard and the requirements of the National Regulations.

11.22 The NQS provides for seven quality areas against which education and care Services are assessed. Quality area 2, which relevantly deals with children's health and safety provides that "*every child's health and well-being is safeguarded and promoted*".

11.23 Element 2.1.1 of Quality area 2 provides that:

> Each child's well-being and comfort is provided for, including appropriate opportunities to meet each child's need for sleep, rest and relaxation.

11.24 Services are assessed in relation to this element by:

(a) observing "*sleep and rest practices that are consistent with current views about children's health, safety and welfare and that meet children's individual needs*";

(b) checking for evidence that *"babies who are asleep are checked at regular intervals"*;

(c) observing whether Educators are "*closely monitoring and regularly observing sleeping children, and that all sleeping children are within hearing range*"; and

(d) checking that "*safe sleep practices (according to Red Nose recommendations) [are] being implemented and the Service [is] using cots, other bedding equipment and accessories that meet Australian standards*".

11.25 The obligation to have a sleep and rest policy lies solely with the Approved Provider; there is no equivalent obligation imposed by the NQF on a family day care Educator.

Supervision of children

11.26 Section 165(1) and (2) of the National Law provides that an Approved Provider and Nominated Supervisor of an education and care Service:

> […] must ensure that all children being educated and cared for by the Service are adequately supervised at all times the children are in the care of that Service.

11.27 Section 165(3) of the National Law similarly provides that a family day care Educator:

> […] must ensure that any child being educated and cared for by the Educator as part of a family day care Service is adequately supervised.

11.28 The ACECQA Guide defines "*adequate supervision*" to mean:

- that an Educator can respond immediately, particularly when a child is distressed or in a hazardous situation;
- knowing where children are at all times and monitoring their activities actively and diligently.

11.29 The ACECQA Guide explains that adequate supervision of sleeping children in a family day care setting involves the following:

> The circumstance and needs of each child should be considered to determine any risk factors that may impact on the adequate supervision of sleeping children.
> […]
> Sleeping children should always be within sight and hearing distance so that Educators can assess the child's breathing and colour of their skin to ensure their safety and wellbeing.
> […]
> A family day care Service should have an agreed and documented practice for the supervision of sleeping children, tailored to the unique layout and safety considerations of each family day care residence or venue as well as the ages and development stages of the children in care.

Protection of children from harm and hazards

11.30 Section 167 of the National Law provides that an Approved Provider and Nominated Supervisor of an education and care Service, together with a family day care Educator, all:

> […] Must ensure that every reasonable precaution is taken to protect children being educated and cared for [by a Service] from harm and from any hazard likely to cause injury.

11.31 In addition:

(a) Regulation 103 of the National Regulations provides that the Approved Provider of an education and care Service must ensure that the education and care Service premises and all equipment and furniture used in providing education and care Service are safe, clean and in good repair.

(b) Regulation 110 provides that the Approved Provider of an education and care Service must ensure that the indoor spaces used by children at the education and care Service premises are well ventilated, have adequate natural light, and are maintained at a temperature that ensures the safety and well-being of children.

11.32 Quality area 3 of the NQS is concerned with physical environment, and ensuring that such environments are, relevantly, safe and suitable. Element 3.1.1 provides that outdoor and indoor spaces, buildings, fixtures and fittings are suitable for their purpose, including supporting the access of every child. According to the ACECQA Guide, assessors may observe whether a Service environment has "*quiet, comfortable and well-ventilated areas for sleeping and resting*".

11.33 The ACECQA Guide goes on to explain in relation to ventilation and natural light for physical environment:

> Indoor spaces must be well ventilated, have adequate natural light and be maintained at a temperature that ensures the safety and wellbeing of children. Natural ventilation can be provided by open windows and doors. If natural ventilation is insufficient or not possible, indoor space may be ventilated with an air conditioning system. Natural light may be let in through windows, doors and skylights. Indoor temperatures should be maintained at levels that keep children visibly comfortable. Consideration should be given to ambient temperatures and children and Educator response to the temperature. Children are more likely to show signs of distress at high temperatures rather than low ones.

11.34 Element 3.1.2 of the NQS is concerned with the upkeep of the physical environment and provides that premises, furniture and equipment should be safe, clean and well maintained. The ACECQA Guide provides that assessors may observe whether *"Educators [are] following safety advice from recognised authorities and manufacturers when arranging equipment, furniture and experiences"*.

Educator to child ratios

11.35 Family day care Services are subject to Educator to child ratios. Regulation 124 of the National Regulations provides:

> (1) A family day care Educator must not educate and care for more than 7 children at a family day care residence or approved family day care venue at any one time.
>
> (2) In determining the number of children who can be educated and cared for by a family day care Educator for the purposes of subregulation (1)—
>
> (a) no more than 4 can be preschool age or under; and

(b) if the children are being educated and cared for at a residence, the Educator's own children and any other children at the residence are to be taken into account if—
(i) those children are under 13 years of age; and
(ii) there is no other adult present and caring for the children.

(3) No more than 7 children can be educated and cared for as part of a family day care Service at a family day care residence or an approved family day care venue at any one time.

(4) Subregulation (3) does not apply to children visiting a family day care residence or an approved family day care venue as part of an excursion.
Note— A visiting family day care Educator must do a risk assessment for the excursion under regulation 100.

(5) Despite subregulations (1) to (4), the Approved Provider of a family day care Service may approve, in writing, a family day care Educator to educate and care for more than 7 children, or more than 4 children who are preschool age or under, at any one time, in exceptional circumstances.

(6) For the purposes of subregulation (5), exceptional circumstances exist if—

(a) all the children being educated and cared for by the family day care Educator are siblings in the same family; or
(b) a child to be educated and cared for is determined to be in need of protection under a child protection law and the family day care Educator is determined to be the best person to educate and care for the child; or
(c) the family day care residence or approved family day care venue is in a rural or remote area and no alternative education and care Service is available.

11.36 The following definitions are relevant to regulation 124:

(a) a "*child over preschool age*" is defined in regulation 4 of the National Regulations to be a child who is enrolled or registered at a school and attends, or will attend school in the year before grade 1 or in grade 1 or a higher grade;

(b) "*children preschool age or under*" is defined in regulation 4 of the National Regulations as a child under the age of 7 years who is not a child over preschool age;

(c) "*family day care residence*" is defined in s. 5 of the National Law to mean a residence at which a family day care Educator educates and cares for children as part of a family day care Service;

(d) "*family day care Service*" is defined in s. 5 of the National Law to mean an education and care Service that:

(i) is delivered through the use of two or more Educators to provide education and care to children; and
(ii) operates from two or more residences; and

(e) a "*residence*" is defined in s. 5 of the National Law to mean the habitable areas of a dwelling.

11.37 Regulation 124 makes clear that a maximum of 7 children (and up to four children under preschool age) can be cared for at a family day care residence. The ratio prescribed is based on the number of children at one residence, not how many Educators are present at one residence.

11.38 Relevantly, section 169(1) of the National Law provides that:

> An Approved Provider of an education and care Service must ensure that, whenever children are being educated and cared for by the Service, the relevant number of Educators educating and caring for the children is no less than the number prescribed for this purpose.

11.39 Further, section 169(5) provides that:

> A family day care Educator must ensure that the number of children being educated and cared for by the family day care Educator at any one time is no more than the number prescribed for this purpose.

11.40 It should be noted that the explanatory memorandum to the *Education and Care Services National Law Bill 2010* indicates that the offences created in Part 6 of the Bill are "*primarily intended to ensure the health, safety and wellbeing of children and the operation of the national approvals system*".

11.41 Evidence gathered by the Inquest establishes that:

(a) family day care Educators most commonly provide care Services from a residential home;

(b) a family day care residence needs to have adequate equipment in order for all children attending on a particular day to have appropriate sleep and rest. In this respect, children sleep on demand, based on their needs, and not necessarily on a schedule;

(c) limiting the number of children cared for in a residence reduces the risk that a residence is overcrowded or that there will be insufficient sleeping facilities;

(d) imposing ratios between children and Educators provides a safeguard against inadequate supervision. Put another way, the ratios limit the number of children which an Educator has to supervise on any one day and assists in ensuring that those children are adequately supervised; and

(e) family day care residences which operate with more children than permitted under the ratios present a risk to the health and safety of those children.

Qualifications of Educators

11.42 Regulation 127 of the National Regulations provides that:

> A family day care Educator must have, or be actively working towards, at least an approved certificate III level education and care qualification.

11.43 It is a core unit of competency in the Certificate III qualification that students know to ensure that sleep and rest practices are consistent with approved standards and a child's individual needs. Ms Rateau gave evidence that as part of her Certificate III studies she was provided with a large amount of information relating to safety sleeping practice for children, including that:

(a) it is important to monitor sleeping babies and keep them within sight or hearing;

(b) to avoid SIDS it is important to keep children on their backs;

(c) children should not have anything in a cot with them, such as pillows or sheets;

(d) children should be kept at the correct temperature so they do not get too hot or distressed;

(e) children should not be put to sleep with a bib on; and

(f) a sleeping baby should be physically checked on every 10 to 15 minutes.

Best practice safe sleeping policies

11.44 The Red Nose publication, *Safe Sleeping - A guide to assist sleeping your baby safely* (**Red Nose Safe Sleeping Guide**), has six key recommendations for safe sleeping and to reduce the risk of sudden unexpected death in infancy:

(1) Sleep baby on the back from birth, not on the tummy or side;
(2) Sleep baby with head and face uncovered;
(3) Keep baby smoke free before birth and after;
(4) Provide a Safe Sleeping environment night and day;
(5) Sleep baby in their own safe sleeping space in the same room as an adult care-giver for the first six to twelve months;
(6) Breastfeed baby.

11.45 Further, the Red Nose Safe Sleeping Guide recommends that a caregiver, when placing a baby to sleep, checks that:

- Bedding is tucked in secure and is not loose. Alternatively place baby in a safe baby sleeping bag
- head coverings are removed before baby is placed for sleep
- there are no doonas, loose bedding or fabric, pillows, lambswool, bumpers or soft toys in the cot

11.46 It is also noted that all new and second-hand cots sold in Australia must meet the current mandatory Australian Standard for Cots (AS/NZS 2172) and bear a label indicting such conformity.

Recommendations in relation to bassinets

11.47 Information provided by Red Nose indicates that there are no Australian standards for bassinets, and that the safest place for a baby to sleep, from birth, is in a safe cot. Further, Red Nose notes that Moses baskets are designed to be carried and sit directly on furniture. As a result, they present similar hazards as baby nests and are not recommended as an infant sleeping environment.

11.48 The Australian Competition and Consumer Commission (**ACCC**) publication, "*Find out more: Keeping baby safe – A guide to infant and nursery products*" (**the ACCC Guide**) notes that "*child safety experts recommend placing babies in a cot from birth*". The ACCC Guide also provides information about what to look for in a bassinet, namely:

- A sturdy bottom
- A wide stable base so the bassinet won't tip over
- A size and style to suit your baby's weight and age
- Sides at least 300mm higher than the top of the mattress base to stop your baby from falling out
- A firm snug fitting mattress – no more than 75mm thick – to prevent suffocation
- If the legs fold, ensure they can be locked and won't collapse when used.
- Short decorative trims and bows that can't strangle your baby – or better still, a bassinet without decorative trims.

11.49 The ACCC Guide also provides the following safety tips:

- Always follow instructions carefully for assembly and use.
- Transfer your baby into a cot as soon as they first show signs of being able to roll.
- Never use pillows, folded quilts, bumpers or toys in a bassinet.

11.50 In 2021, Red Nose published the *Information Statement – Safe Sleep: Bassinets* (**the Bassinet Statement**).

> Sleeping baby in their **own safe sleeping space** in the **same room as an adult caregiver** for the first six to twelve months **is a strategy that has been demonstrated to reduce the risk of Sudden Unexplained Death in Infancy (SUDI)**.
>
> **A baby's own safe sleeping space can be easily created in a cot, which to be safe includes a safe mattress and safe bedding.**
>
> All cots and portable cots sold in Australia must meet the mandatory Australian Standard for Safety (AS/NZS 2172:2003 or AS/NZS 2195: 1999) and must clearly display evidence of this on the cot and its packaging.
>
> Red Nose acknowledges that for a variety of reasons, the use of a household cot or travel cot is not always practical or achievable in order to room share in the very early months following the birth of a baby. These reasons include chosen parenting practices, cultural beliefs, social disadvantage, or simply the impracticality of fitting a cot in the parent/ caregiver's bedroom. Parents may prefer to use a bassinet in the early months in order to successfully room share as they take up less space than a regular standard cot. [original emphasis]

11.51 The Bassinet Statement also recommends the following in relation to bassinets:

- Ensure baby is **placed on their back to sleep, with their feet to the bottom of the bassinet with their head and face uncovered**;
- Remember babies grow fast and bassinets should not be used once baby shows signs of being able to roll or sit up. This occurs around 4 months of age;

- Discontinue wrapping at this time. [original emphasis]

11.52 The Bassinet Statement also notes the following considerations:

- Always remember that a bassinet is for short-term use only and you should cease use when baby shows signs of rolling. Babies must be moved to safe cot at this time – this is usually around 4-6 months of age;
- It is at this time that babies must be moved to a safe cot and wrapping discontinued.
  […]
- Never leave an infant unsupervised in the bassinet/space
- Consider the use of a safe sleeping bag to help prevent an infant overheating or bedding covering baby's face or head;
- Discontinue use of the bassinet once baby is showing signs of being able to roll
  […]

11.53 Further, the Bassinet Statement identifies the following specific considerations for use of Moses baskets and carry cots:

Use:
- Suitable from birth until baby show signs of rolling.
- Designed specifically to be carried and sit directly on furniture.

Risks:
- Consider baby's age and size and manufacturer's instructions when selecting a Moses basket.
- Ensure the basket is placed on a firm surface or stable base.
- Ensure baby is never slept in a Moses basket once they can roll or sit up.
- Be aware of significant tripping and falls risk.
- Ensure no extra mattresses or soft bedding are used in the basket that may create a wedge hazard.

Recommendations in relation to the use of wraps

11.54 The Red Nose *Guidelines for Safe Wrapping of Young Babies* recommends that wrapping be discontinued as soon as a baby starts showing signs that they can begin to roll. Further, the Red Nose Guide provides:

> Discontinue the use of a wrap when baby can roll from back to tummy and to back again. The wrap may prevent an older baby who has turned onto the tummy from returning to the back position.

Kidstart Safe Sleeping Policies

11.55 The Kidstart *Sleep and Rest* policy (**Kidstart Sleep Policy**) dated November 2018 was, according to Ms Shamsin's evidence, in place as at 2019. The Kidstart Sleep Policy provided for the following:

- The Educator must take reasonable steps to ensure that the needs for sleep and rest of children being educated and cared for by the Educator as part of a family day care Service are met, having regard to the ages, development stages and individual needs of the children

- The Educator will consult with parents of children in care as to their sleep/rest requirements and encourage children to sleep in order to meet their development and at the time that best suits their needs
- No child will be made to sleep during rest times; children who do not wish to sleep will rest quietly or be offered alternative activities such as reading or puzzles
- Best practices which reduce the risk of SIDS shall be adopted and maintained by the Educator and staff as recommended by the SIDS Foundation, including not putting children to bed with bottles or drinks
- Sleeping babies and toddlers will be checked every 10-20 minutes during the day, in line with current SIDS guidelines
- The Educator must ensure that the sleep area is well ventilated and monitor the room temperature to ensure maximum comfort for the children
- Cots (new and second-hand) used in family day care will comply with Australian/New Zealand Safety Standard (AS/NZS 2172 Cots for Household Use) and be maintained in a clean and safe condition, taking into consideration the following:
    - Finger traps – there should be no spaces between 5mm and 12mm wide
    - Arm and leg traps – there should be no spaces between 30mm and 50mm
    - Railings – should be no less than 50mm and no more than 95mm wide
    - Head traps and "fall-through" hazards – there should be no spaces 95mm or wider
    - Protrusions – there should be no protrusions that jut out more than 5mm. Clothing can get snagged on knobs, decorative features, wing nuts, side catches, and cause distress or strangulation
    - Never put pillows or an extra mattress or toys in cots, as the child can become trapped and suffocate between these items or can use these items as a foothold to climb out of the cot
- Portable cots will comply with Australian Safety Standard (AS 2195)
- When using portable cots, ensure the sides are fully locked into place and secure:
    - Check mechanisms regularly for wear
    - Use the cot mattress provided. Ill-fitting mattresses may create spaces where a small baby may be trapped
- Stop using the portable cot if the baby can undo latches
- Stop using the portable cot when the child weighs more than 15kg
- Place the portable cot away from potential hazards
- Check that latches are securely locked before use
- Check regularly for:
    - Tears in vinyl and loose fabric
    - Broken locks and tears that could cause the cot to collapse
- Children will be provided with individual beds and bedding
- Children's bedding will be stored individually and maintained in a hygienic manner
- Children shall never be humiliated or shown negativity through voice or actions when soiling or wetting their bed. Nor shall they be forced to wear nappies to bed for the ease of others
- Family and cultural differences shall be taken into consideration and respected regarding sleeping arrangements
- When sleeping at the family day care residence, a child shall be under the supervision of the Educator and have access to the Educator at all times
- The area in which the children sleep shall be in the part of the home which has been assessed and approved for family day care
- KidStart shall provide Educators with up to date information from recognised safety authorities on the selection and use of cots, beds and bedding and safe sleeping practices.

11.56 The Kidstart Sleep Policy is repeated in the Kickstart Educator Handbook (**the Kidstart Handbook**) which was also in force as at 2019.

Sleep practices adopted at the Rhythm and Rhyme Centre

11.57 The following evidence is relevant to Ms Rateau's understanding of safe sleeping:

(a) Ms Rateau gave evidence that she saw and "*browsed through*" the Kidstart Handbook, but could not recall whether she read the section on sleep and rest. However, having been provided with an opportunity to read the Kidstart Handbook in the witness box, Ms Rateau indicated that she knew everything that was set out in it.

(b) Ms Hanuliakova gave evidence that Ms Rateau gave her documents regarding Kidstart and their procedures for childcare minding when she started working for her. This suggests that Ms Rateau kept a copy of the Kidstart Handbook and appreciated its relevance for an Educator registered with Kidstart.

(c) Ms Rateau confirmed that Ms Trad, on behalf Kidstart, provided her with a Red Nose booklet about safe sleeping.

11.58 Notwithstanding the above, Ms Rateau gave evidence that Ms Trad never gave her any additional information regarding the use of portable cots, or any information about bassinets.

Children cared for at the Rhythm and Rhyme Centre

11.59 On 4 March 2019, Ms Rateau was caring for four children at the Rhythm and Rhyme Centre: Jack, two babies aged 10 months old, and a two-year-old toddler. All four children were put down for daytime naps before lunch:

(a) Jack and the two other babies were put down at 9:00am and woke up at various times throughout the morning;

(b) The toddler had his nap at the same time that Jack was put down for his second sleep, at around 12:35pm.

11.60 The following furniture was used to accommodate sleeping children at the Rhythm and Rhyme Centre:

(a) A soft blue mat for the older children (aged two years or older) to sleep on in the Second Bedroom;

(b) four full-sized portable cots located in the Sleeping Room;

(c) two bassinets; and

(d) the bunk beds ordinarily used by Ms Rateau's daughters in the Second Bedroom.

11.61 The evidence establishes that the following sleeping arrangements were utilised at the Rhythm and Rhyme Centre:

(a) All three bedrooms at the Randwick Property were used at various times to put children down to sleep. This practice was adopted to reduce the possibility that the children would wake each other up.

(b) Typically, older children would sleep in the Second Bedroom, whilst younger children would sleep in the portable cots in the Sleeping Room;

(c) Occasionally, a bassinet or portable cot would be moved to the Master Bedroom so that a child could be put down to sleep;

(d) According to Ms Hanuliakova, it was Ms Rateau who made the decisions regarding where a child should be put to sleep and what furniture would be used;

(e) Ms Rateau's usual practice was to put the smaller babies in a bassinet, and the larger babies in a cot. Ms Hanuliakova gave evidence that the bassinets were used for babies who were not yet four months old, and that a baby was transitioned from a bassinet to a cot once they became too big for the bassinet.

11.62 Prior to registering with Kidstart, Ms Rateau was registered with another Approved Provider, Jellybeans. Ms Rateau gave evidence that, whilst with Jellybeans, she was informed that it was appropriate to use portable cots, provided that they complied with the relevant Australian Standard. Further, Ms Rateau gave evidence that she was not provided with any information, either by Jellybeans or Kidstart, regarding the use of bassinets.

11.63 There were two bassinets used in the Rhythm and Rhyme Centre at the relevant time. Ms Hanuliakova gave evidence that by the start of 2018, Ms Rateau already had one bassinet, and purchased a second bassinet to be used for twin babies who were enrolled at the Rhythm and Rhyme Centre. Ms Das gave also evidence that the bassinets were used for the twin babies. Enrolment records indicate that these twins were six months old when they first commenced at the Rhythm and Rhyme Centre. Notwithstanding, Ms Rateau gave evidence that the twins were only occasionally put in the bassinets.

11.64 Ms Hanuliakova described the two bassinets as follows:

> One of the baskets was bigger than the other. One of the baskets was made of metal material and surrounded by cotton. At the bottom of the cot was a mattress. The other basket was smaller and was made of a thin wooden material basket which was surrounded by cotton. At the bottom of this basket was also a mattress. [Ms Rateau] and I would place a fitted bed sheet on all the mattress cots and baskets.

11.65 In an interview with police, Ms Rateau suggested that a baby would be moved to a cot once they reached 10 months old. However, Ms Rateau initially gave evidence that she only placed babies up

to the age of six months in the bassinets. Records from the Commonwealth Department of Education, Skills and Employment (**DESE**) indicate that in the period between 1 July 2018 and 4 March 2019, Ms Rateau only had two children who were under the age of six months, namely aged around five months old, at the time they first attended the Rhythm and Rhyme Centre. This suggests it is unlikely that Ms Rateau only used the bassinets for around one month. Later in her evidence, Ms Rateau conceded that she used the bassinets for Jack and for the twins, each of whom was over the age of six months. Ms Rateau gave evidence that she believed the bassinet was big enough for Jack to sleep in, although she could not provide a basis as to what gave rise to her belief.

11.66 Ms Rateau also gave evidence that she used a bassinet for certain babies because she believed that it would be more comfortable for them. When asked about her understanding as to when a bassinet would be safe to use, Ms Rateau was unable to provide an answer.

Sleep environment

11.67 Ms Hanuliakova gave the following evidence as to how children were put to sleep:

(a) All babies aged 6 to 8 months were wrapped in a cotton sheet before being put to bed;

(b) Where a sleep suit had been provided by a child's parent, it would be used during nap times;

(c) Ms Hanuliakova would usually place babies on their tummy to sleep;

(d) Ms Rateau would "*sometimes place the babies on their tummy's [sic] or sometimes on their sides, however, that was rare as she usually placed the babies on their backs*";

(e) After being put to sleep, Ms Hanuliakova or Ms Rateau would check the babies at least every 15 minutes, particularly the younger babies who were between 6 and 8 months old; and

(f) The door to the Sleeping Room would normally be closed.

11.68 Ms Rateau gave the following additional evidence:

(a) The door to the Sleeping Room would usually be left ajar, but sometimes it would be closed because the room was close to the kitchen;

(b) The window in the Second Bedroom was always open; and

(c) She would check on the sleeping children regularly, including while conducting tours of the Rhythm and Rhyme Centre.

11.69 However, other evidence given during the inquest, suggested that the practices described above were not always adhered to. Relevantly:

(a) Ms Ingram gave evidence that when she toured the Randwick Property on 4 March 2019, which lasted about 45 minutes, she did not see Ms Rateau check on the children who were asleep in the Sleeping Room.

(b) Margot and Joseph gave evidence that when they toured the Rhythm and Rhyme Centre in late 2018, Ms Rateau did not open the door to the Sleeping Room, and did not check on the children asleep in the room whilst they were there.

(c) The police scene examination on 4 March 2019 establishes that the window in the second bedroom was not open that day.

11.70 Notwithstanding the above, Ms Rateau gave evidence that she would "*always*" check on the children whilst they were asleep, and disputed that she did not conduct such checks during the tours conducted with Ms Ingram, and Margot and Joseph. However, it is noted that Ms Rateau described her memory of what occurred on 4 March 2019 as "*sketchy*". Despite this, Ms Rateau agreed as part of her criminal prosecution that she did not check on Jack for a period of 30 to 40 minutes on 4 March 2019.

11.71 Jack had a number of different sleep suits to accommodate changes in temperature. Joseph gave evidence that Jack was usually put in a sleeveless, legless, lightweight sleep suit because he tended to be warmer, rather than cold. On 4 March 2019, Margot provided a sleeveless and legless sleep suit to Ms Rateau. However, Ms Rateau did not use this for Jack when he was put down to sleep at around 12:35pm. Instead, Jack was put to sleep fully clothed and still wearing his dribble bib, and wrapped.

11.72 The evidence indicates that on 4 March 2019 Jack was put to sleep without appropriate care and attention being paid to the instructions given by Margot, and the circumstances of the day. Given the temperature on the day, it is unlikely that it would have been considered appropriate to wrap Jack whilst he was still clothed, instead of placing him in his sleep suit. Further, the window in the Second Bedroom was not open, and the room did not have a fan or air-conditioning.

11.73 **Conclusions in relation to Issue 4:** The Kidstart Sleep Policy in effect as at March 2019 appropriately reflected safe sleeping practices in that it required Educators to implement best practices so as to reduce the risk of SUDI; check on sleeping babies every 10 to 20 minutes during the day; ensure that cots were compliant with the relevant Australian Standards; and ensure that cots were free of any extraneous bedding material.

11.74 However, whilst the Kidstart Sleep Policy was appropriate, it was not meaningfully implemented by Ms Rateau. Rather, by March 2019 a number of practices had developed at the Rhythm and Rhyme Centre which were contrary to the provisions of the Kidstart Sleep Policy, as well as relevant industry guides and recommendations published by Red Nose and the ACCC. Specific aspects of sleeping practices adopted at the Rhythm and Rhyme Centre are discussed below.

11.75 It was inappropriate for Jack to have been placed in a bassinet on 4 March 2019. Jack was seven months old, able to roll from his front to his back to his front again, and was able to sit unaided. The dimensions of the bassinet compared against Jack's height meant that it would have been difficult for him to move, and in particular, for him to roll from his front to his back. Jack's size and best practice meant that he should have been placed in a cot, and not a bassinet, to sleep. Relevantly, the ACCC Guide (which was referred to in the Red Nose Safe Sleeping Guide published prior to Jack's death) expressly stated that babies should be placed in a cot at the first sign of them being able to roll. The Red Nose Safe Sleeping Guide has since been updated to also expressly state that a bassinet should not be used for children who can roll, which typically occurs around the age of four months. Established practice at the Rhythm and Rhyme Centre suggests that the only reason why Jack was placed in a bassinet, when a portable cot was available in the Sleeping Room, was to allow children to be placed to sleep in different rooms to avoid them waking each other.

11.76 Placing Jack to sleep in a prone position would only have been appropriate if Jack was placed in a cot with sufficient room to allow him to roll over, which he was capable of doing by 4 March 2019. Instead, Jack was placed in a bassinet with insufficient space, and which contained extraneous unsafe bedding material, and while still wearing his bib. This was contrary to the Red Nose Safe Sleeping Guide regarding best practices for safe sleeping. Further, Ms Rateau did not place Jack in his sleepsuit which Margot provided on the morning of 4 March 2019, and which would have been appropriate in order to keep Jack cool, given the temperature on the day. Had the sleepsuit been used, it is less likely that there would have been any need for Jack to have been wrapped. Instead, Ms Rateau attempted to wrap Jack whilst he was still fully clothed, and left his dribble bib on, before putting him down to sleep, which suggests that insufficient care and attention was paid to ensure that safe sleeping practices were followed.

11.77 The Second Bedroom where Jack was placed to sleep was not an appropriate or safe sleeping environment. The window to the Second Bedroom was closed, and there was no fan or air-conditioning, meaning that there was inadequate ventilation. Further, the presence of a toddler in the Second Bedroom whilst Jack was sleeping constituted an unsafe sleeping environment.

11.78 The evidence establishes that Jack was not checked with sufficient frequency whilst he slept. He was not checked every 10 to 20 minutes as required by the Kidstart Sleep Policy. Instead, a period of approximately 40 minutes elapsed between when Jack was last observed to be alive, and when he was found to be unresponsive. The evidence suggests that on 4 March 2019 Ms Rateau was occupied with business and personal phone calls, and caring for two other babies, resulting in Jack not being checked on while sleeping for an extended period of time.

Particular legislative and regulatory matters regarding safe sleeping

11.79 Since March 2019, there have been no changes to the National Law concerning safe sleeping practices. Instead, the most recent change to the NQF concerning safe sleeping practices occurred in 2017 following the *Inquest into the death of Indianna Hicks* which was heard at the Coroners Court of Queensland. As a result of this inquest, the National Law was amended to require childcare Services to have a specific policy for sleep and rest for children.

11.80 However, since Jack's death the Department has taken a number of steps to improve monitoring of safe sleeping practices across the childcare sector, including:

(a) Conducting an education campaign, and updating and publishing relevant guidelines, in relation to safe sleeping practices;

(b) Instructing Authorised Officers to place particular focus on safe sleeping environments in their monitoring of Services, with Authorised Officers provided with improved checklists for use when performing such monitoring; and

(c) Conducting training sessions, including some hosted by Red Nose, for Authorised Officers regarding safe sleep.

11.81 Changes to the National Law and National Regulations are made through agreement by all State and Territory Education Ministers. For the National Law to be amended, those changes must then pass through the Victorian Cabinet and Parliament, as it is the host jurisdiction of the National Law. For amendments to the National Regulations, once the changes are agreed, Ministers in each jurisdiction can make those changes.

11.82 On 14 December 2018, the Council of Australian Governments Education Council approved a review of the NQF (**NQF Review**). The NQF Review is a consultative process that involves governments engaging with stakeholders about issues within the terms of reference, which in turn results in governments determining any necessary changes to the National Law (or associated guidance material). The NQF Review is being progressed by a subgroup of the Education Council, including members from ACECQA.

11.83 Following feedback from stakeholders a consultation regulation impact statement (**CRIS**) was developed, agreed and published in February 2021. The CRIS proposes options for changes to the NQF.

11.84 In respect of sleep and rest, the CRIS nominates six (not mutually exclusive) options for change:

(a) no change;

(b) legislative change to require compulsory safe sleep practice training for Educators who care for sleeping children (birth to five years);

(c) further guidance developed to support policies and procedures for sleep and rest, and to provide information to families on safe sleeping practices;

(d) amend the National Regulations to specify the matters that must be included in Services' policies and procedures for sleep and rest;

(e) amend the National Regulations to require a risk assessment to be conducted in relation to sleep and rest, including matters that must be considered within that risk assessment;

(f) legislative change to require that sleeping and resting children in education and care Services are within sight and hearing distance of an Educator at all times.

11.85 Ms Glenda Buckley, the Director of the State-Wide Network in the Early Childhood Education and Care Directorate, gave evidence that the monitoring of safe sleep practices in family day care centres would benefit from the National Law being amended to:

(a) require compulsory training on safe sleep practices;

(b) require Approved Providers and Educators to conduct a risk assessment of sleep environment; and

(c) prohibit bassinets.

11.86 Ms Kerrin Cook, formerly an Authorised Officer for the Department with 15 years' experience, gave evidence that improved monitoring of child care Services would occur if the NQF:

(a) prescribed what constitutes safe sleeping practices;

(b) required Approved Providers to conduct a risk assessment specific to sleep and rest; and

(c) required Educators to have compulsory training on safe sleep practices.

11.87 Ms Alison Wallis gave similar evidence recommending that mandatory safe sleeping training be provided to Educators.

11.88 **Conclusions in relation to Issue 8:** Whilst the Department has undertaken various steps to increase its focus on the monitoring and supervision of sleep and rest, the regulatory system imposed by the NQF does not provide the Department with direct oversight of Educators. As Jack's case demonstrates, although an Approved Provider had in place an appropriate policy in relation to sleep and rest for children in care, the policy was not implemented by the relevant Educator. This suggests that additional and regular training for Educators is required to ensure that safe sleep practices are implemented and followed.

11.89 It was submitted on behalf of the Department that the evidence demonstrates (discussed further below) that Ms Rateau had been fully trained in safe sleep and rest practices, and had available to her all the requisite knowledge and resources to implement such practices on 4 March 2019. Despite this, Ms Rateau failed to put this knowledge and training into practice in relation to Jack. In addition, the Department submitted that under the NQF review, one change under consideration is to require all family day care Educators to hold a Certificate III qualification (rather than be working towards such a qualification) which would effectively result in all Educators being trained in the relevant safe sleep module. Instead, it was submitted by the Department that a recommendation should be made to strengthen safe sleep practices in education and care Services that care for sleeping children.

11.90 It is accepted that the evidence establishes that Ms Rateau had available to her the necessary knowledge and training to implement safe sleeping practices in relation to Jack on 4 March 2019. However, the evidence of Ms Cook and Ms Wallis identifies the practical benefits for improved monitoring of Services if compulsory safe sleep training is required for Educators. Further, the alternative recommendation proposed by the Department does not entirely make clear the way(s) in which safe sleep practices in education and care Services are to be strengthened.

11.91 Therefore, it is considered necessary that a recommendation be made that the National Law and National Regulations be amended to require that Educators who care for sleeping children (from birth to 5 years) undertake compulsory safe sleep practice training and refresher training. Such a recommendation does not limit the ability of a family day care Service to adopt practices that have appropriate regard to the individual needs of a child.

11.92 **Recommendation 1:** I recommend that the NSW Government, in consultation with the governments of other jurisdictions under the National Quality Framework, take steps to amend the National Law so that family day care Educators are required to undertake mandatory safe sleep training.

11.93 However, to give effect to the submissions made on behalf of the Department, it is also desirable to make the following recommendation.

11.94 **Recommendation 2:** I recommend that the NSW Government support the proposal under the National Quality Framework review to require that family day care Educators complete the Certificate III in Early Childhood Education and Care before they can commence as an Educator.

11.95 Whilst Approved Providers are already subject to an obligation to assess family day care residences, there is no mandatory requirement to conduct a risk assessment of a sleeping environment within a family day care centre. It is considered that mandating such an assessment would strengthen the obligations on an Approved Provider to ensure that its Educators are adopting appropriate safe sleeping practices. Therefore it is considered necessary that a recommendation be made that the National Law and National Regulations be amended to require Approved Providers to conduct a risk assessment specific to sleep and rest.

11.96 **Recommendation 3:** I recommend that the NSW Government, in consultation with the governments of other jurisdictions under the National Quality Framework, take steps to amend the regulatory regime in relation to family day care Services so that Approved Providers are required to undertake a risk assessment in respect of an Educator's implementation of sleep and rest policies and procedures.

11.97 The Bassinet Statement recommends that a baby be placed in a cot from birth, whilst also acknowledging that, for families, a cot may not always be practical or achievable in order to have babies sleep in the same room as an adult caregiver "*in the very early months following the birth of a baby*". In such instances parents may prefer to use a bassinet in order to successfully room share. However, whilst such a preference is appropriate in a home environment, it is unlikely that such an arrangement would be appropriate in a family day care setting. This is because it is likely to be non-compliant with relevant safe sleep practices, particularly where such practices need to be adopted to accommodate children across a range of ages. Therefore it is considered necessary that a recommendation be made that the National Law and National Regulations be amended to expressly prohibit the use of bassinets in all early childhood education and care settings.

11.98 **Recommendation 4:** I recommend that the NSW Government, in consultation with the governments of other jurisdictions under the National Quality Framework, take steps to amend the National Law and/or National Regulations to expressly prohibit the use of bassinets in all early childhood education and care settings.

12. Issue 6A – What type of background and qualifications does a person need in order to become an Approved Provider and Approved Service?

Issue 7 – Was the regulatory oversight of Kidstart by the Department in accordance with the National Law, reasonable and in accordance with good practice?

12.1 The following provisions of the National Law are relevant to consideration of these issues:

(a) Section 103 provides that a person/entity must be granted "*Provider approval*" to carry on an education and care Service in NSW. This operates as an "*overall or general approval*" and does not, of itself, permit a person/entity to operate an education and care Service.

(b) Section 12 provides that Provider approval will not be granted unless the Department is satisfied that the applicant (or a person with management and control of the corporate applicant) is fit and proper to provide an education and care Service.

(c) Section 13 set out a number of factors, as at October 2015, to be taken into account in assessing whether an applicant is a fit and proper person. Section 13 set out a list of matters that the regulatory authority must and may have regard to. Section 13 of the current National Law imposes two additional matters that the regulatory authority may have regard to.

(d) Section 14 provides that the Department is authorised to "*ask the person to provide further information*" and to "*undertake inquiries in relation to the person*", in determining whether the person is fit and proper.

12.2 In or around May 2016, the Department determined that it would conduct a risk-based knowledge assessment process to assist in determining whether a person is fit and proper to be an Approved Provider. By asking applicants to answer a series of scenario-based and general questions regarding the National Law and National Regulations, the Department determines whether an applicant can demonstrate how an education and care Service is to operate in accordance with the NQF, and that they have the management capability to operate an education and care Service. Where an applicant's responses do not meet a sufficient standard, the Department will usually not consider that the applicant is a fit and proper person.

12.3 Ms Buckley gave evidence that the Department is of the view that an applicant's knowledge of the National Law and National Regulations is "*an important aspect of ensuring the successful operation of the Service*". Further, whether an applicant has relevant experience or qualifications in childcare Services is relevant to the question of whether the applicant is capable of running a Service, and whether they know and understand the NQF. Notwithstanding, the lack of any such experience or qualifications is not, of itself, sufficient grounds to support a finding of a lack of fitness and propriety. Therefore, the current NQF does not impose any childcare qualification requirement on an Approved Provider.

Provider approval for Kidstart

12.4 The following chronology is relevant to Provider approval for Kidstart:

(a) On 24 May 2013 the Department granted Provider approval to Mr Shamsin pursuant to section 15 of the National Law.

(b) On 4 September 2015 Kidstart Family Day Care Pty Ltd ATF Kidstart Unit Trust applied for Provider approval. Mr Shamsin and Mr Cheema were named as the persons with management and control of the corporate entity. On 23 October 2015 Provider approval was granted. Documentary material (including a criminal history check, Working With Children Check (**WWCC**), and material as to the solvency of Mr Shamsin and Mr Cheema) in support of the application for Provider approval was provided to the Department. This material did not outline the background or experience in childcare of the persons with management and control.

(c) The Department subsequently completed a validation checklist when determining Kidstart's application. The approval for Kidstart ATF Kidstart Unit Trust was granted subject to the condition that it complies with the National Law and National Regulations.

12.5 The evidence establishes the following regarding the qualifications of the persons with management and control of Kidstart:

(a) When Mr Shamsin applied for Provider approval in 2013, he was 28 years old with no experience in childcare. Further, he had not undertaken any studies or qualifications in childcare. Mr Shamsin later obtained a Certificate III in 2014.

(b) According to Ms Shamsin, Mr Cheema did not have any experience in childcare before being involved with Kidstart. Mr Shamsin speculated that Mr Cheema "*would have*" had a Certificate III. However there is no evidence as to whether Mr Cheema did in fact hold such a Certificate and, if he did, when it was obtained.

(c) Ms Shamsin (who subsequently became a director and person with management and control of Kidstart in December 2015) had a Certificate III in early childhood care and education. On 14 August 2014, Ms Shamsin obtained a diploma of early childhood education. Ms Shamsin gave evidence that she gained practical experience in childcare as part of her Certificate III studies by working alongside Educators registered with Kidstart, but acknowledged that she had no experience with any other day care centre.

Relevant provisions of the NQF – Approved Service and Nominated Supervisor

12.6 A Nominated Supervisor has an important role under the NQF, with the individual subject to their own obligations to ensure the safety of children in care. In a family day care context, the Nominated Supervisor is the primary person, together with family day care coordinators, who provides training and support to Educators.

12.7 The following provisions of the National Law and National Regulations are relevant to Nominated Supervisors:

(a) Section 43(2) provides that the person/entity applying for Service approval must either be the operator of the Service, or responsible for the management of the staff members and Nominated Supervisors of that Service.

(b) Section 161 provides that it is an offence for an Approved Provider to operate a Service without at least one Nominated Supervisor for that Service.

(c) Regulation 117C(1) provides for prescribed minimum requirements for a Nominated Supervisor, namely that the person is at least 18 years old; has adequate knowledge and understanding of the provision of education and care to children; and has the ability to effectively supervise and manage an education and care Service.

(d) Regulation 117C(2) relevantly provides that in determining whether to nominate a person as a Nominated Supervisor, an Approved Provider must have regard to the person's compliance with the National Law (or equivalent statutes).

12.8 The National Law does not require the Department to check or confirm the qualifications of Nominated Supervisors. Rather, this responsibility rests with an Approved Provider.

12.9 Prior to 1 October 2017 a Nominated Supervisor was required to obtain a supervisor certificate. The relevant provisions of the National Law in force at the time provided for the following:

(a) The holder of a supervisor certificate may be nominated as the Nominated Supervisor of an education and care Service, and be the responsible person present at the education and care Service premises in the absence of the Approved Provider or the Nominated Supervisor.

(b) A Nominated Supervisor was required to have at least one of the following qualifications: at least three years' experience working as an Educator in an education and care Service or a children's Service or a school or in a Service regulated under a former education and care services law; and approved diploma level education and care qualification; or an approved early childhood teaching qualification.

12.10 At present, there is no prescribed qualification under the current law. Instead, the Approved Provider is responsible for ensuring that the Nominated Supervisor meets the minimum requirements.

12.11 According to ACECQA, the relevant changes to the National Law were made to "*reduce red tape for Approved Providers*". Mr John Mason, the general manager policy and strategic programs with ACECQA, gave evidence as to the following:

(a) the changes occurred because it was considered that the administrative costs of ensuring that a Nominated Supervisor met the prescribed qualifications outweighed the benefits;

(b) the legislative regime prior to October 2017 was costly for Approved Providers and resource intensive for the Department;

(c) Under the current regulatory regime, the judgement as to whether a person is suitable to be employed as a Nominated Supervisor rests with the Approved Provider.

12.12 Section 47 of the National Law sets out a number of matters that the Department must have regard to when determining an application for Service approval for a family day care centre. Section 51 of the National Law provides that every Service approval is granted subject to the following relevant conditions:

(a) The Service is operated in a way that ensures the safety, health and well-being of the children being educated and cared for by the Service; and meets the educational and developmental needs of the children being educated and cared for by the Service; and

(b) The Approved Provider of a family day care Service must ensure that each Educator engaged by or registered with the Service is adequately monitored and supported by a family day care coordinator.

Service approval for Kidstart

12.13 On 4 June 2013, Mr Shamsin applied for Service approval. As part of this application, Mr Shamsin submitted the following material:

(a) An ACECQA application for Service approval form which stated that Mr Shamsin expected 60 Educators and five family day care coordinators to be engaged or registered within six months of the Service commencing operations.

(b) A Nominated Supervisor Consent Form which nominated Ms Zena Al-Achrafe as the Nominated Supervisor, and noted that Ms Al-Achrafe's "*certified supervisor number*" was pending.

(c) A copy of Kidstart's policies and procedures as required by regulation 168 of the National Regulations.

12.14 Mr Shamsin's application was initially incomplete, and the policies and procedures that were submitted were non-compliant with the requirements of the National Regulations. Accordingly, the Department requested that Mr Shamsin complete the application by providing certain material, including a policy that referred to initial training of Educators, and invited Mr Shamsin to amend the non-compliant policies and procedures.

12.15 On 1 July 2013, Mr Shamsin provided the Department with the outstanding and updated material. The Department subsequently completed a new Service approval checklist regarding Mr Shamsin's application which showed:

(a) An initial assessment was completed and indicated that all forms, policies and procedures had been provided, with the check boxes for the "*final assessment*" not completed;

(b) the policies and procedures were assessed against the requirements under the National Law and National Regulations, with no issues of non-compliance being identified.

12.16 According to Mr Shamsin, his wife, Yesria Zreika, was engaged as a family day care coordinator for Kidstart. In 2013, Ms Zreika was 22 years old and had experience as a family day care Educator. Mr Shamsin also gave evidence that Ms Shamsin and Mr Cheema also acted as family day care coordinators, although Ms Shamsin confirmed that she was not a coordinator until after she obtained her diploma in August 2014.

12.17 On 9 September 2013, Mr Shamsin was granted Service approval to operate Kidstart Family Day Care. The approval was subject to certain conditions, namely that the Approved Provider:

(a) Operate in compliance with section 51 of the National Law;

(b) Ensure that no more than 60 family day care Educators were employed or engaged during the first 12 months of operation; and

(c) Employ at least one full-time family day care coordinator for every 15 family day care Educators.

12.18 On 4 September 2015, Mr Shamsin applied to transfer the Service approval for Kidstart Family Day Care to Kidstart Family Day Care Limited. This application was approved by the Department and took effect from 25 October 2015.

Nominated supervisor – Faten Trad

12.19 On 1 September 2014, Ms Trad replaced Ms Al-Achrafe as the Nominated Supervisor for Kidstart. Ms Trad gave the following evidence as to her role:

(a) She was not formally interviewed for the role. Instead, Mr Shamsin and Ms Zreika visited her and explained that they needed someone to conduct safety checks on the Educator residences, in order to ensure that the residences were fit to have children.

(b) She signed a document with Kidstart when she was first employed, which is believed to be the consent to act as Nominated Supervisor form, which bears Ms Trad's name and signature.

(c) She initially dealt with Mr Shamsin and Mr Cheema. However Ms Shamsin confirmed that she subsequently became the primary person at Kidstart who had contact with Ms Trad. Ms Trad explained that Ms Shamsin had been involved in the business since 2014, but at some later point Ms Shamsin "*took over and then she was calling all the shots*".

12.20 On 9 September 2014, Kidstart wrote to the Department (regarding some non-compliance matters) by way of a letter signed by Mr Shamsin and Mr Cheema, stating that Ms Trad had recently been hired as a new Nominated Supervisor. The letter represented that Ms Trad had "*10 years of childcare experience, including 3 years as a Director and 5 years' experience as a Nominated Supervisor*". Mr Shamsin gave evidence that by this letter, Kidstart held itself out to the Department as having taken steps to improve its Service after the Department had identified issues of non-compliance.

12.21 Ms Trad gave the following evidence regarding the contents of the letter:

(a) Whilst she did have about 10 years' experience in childcare, she had not been a director of a childcare centre for three years when she began working for Kidstart. Although Mr Shamsin gave evidence that the description of Ms Trad's experience was based upon information that Ms Trad provided to Kidstart, it is not possible to determine whether Ms Trad inaccurately described her experience to Kidstart.

(b) Between 2014 to about 2018, Ms Trad had a full-time job as the second in charge supervisor for another childcare centre, in addition to her role as Nominated Supervisor for Kidstart. Ms Trad worked around 38 hours per week in this role with another childcare centre, with the precise hours depending upon her shifts. Ms Trad gave evidence that Mr Shamsin, Ms Shamsin and Mr Cheema all knew that she had a full-time job separate to her role with Kidstart, and that she informed the directors of Kidstart of her lack of family day care experience when she was first employed.

Mr Shamsin gave evidence that he was aware that Ms Trad had another senior role at a childcare centre where she was responsible for managing a large number of children. Further, Mr Shamsin accepted that he knew Ms Trad would continue in that role whilst employed by Kidstart. However, Mr Shamsin indicated that he did not know that Ms Trad was employed in a full-time capacity, and did not ask her about this. Instead, Mr Shamsin said that Ms Trad informed him that she had sufficient job flexibility that would allow her to manage both workloads.

Ms Shamsin gave similar evidence that she knew Ms Trad was working in a relatively senior management role at another childcare centre whilst she was Kidstart's Nominated Supervisor. However, Ms Shamsin gave evidence that Ms Trad informed her that she was attempting to transition to a part-time role.

(c) Ms Trad gave evidence that she was stretched very thin in her role as Nominated Supervisor by reason of her other full-time job, although she asserted that she "*would always allocate, you know, room for me to go out, and like I said, do what I needed to do*". Further, Ms Trad indicated that she thought this was sufficient to fulfil her obligations to conduct hazard reduction checklists.

However, the number of Kidstart Educators increased between March 2015 (when Kidstart informed the Department that it had 17 Educators) and the end of 2017 (when Kidstart was nearing its limit of 60 Educators).

(d) Ms Trad gave evidence that she knew that the role of a Nominated Supervisor was to ensure that all children being cared for were adequately supervised. However, Ms Trad asserted that she was employed only to conduct hazard reduction checklists when a new Educator was setting up a residence. Ms Trad understood that this task involved ensuring that a residence was adequate and safe, and that things were in order to have children on the premises.

In contrast, Mr Shamsin gave evidence that Ms Trad's role was not limited to just checking the residences of Educators. Mr Shamsin asserted that the responsibility for ultimate decision-making regarding signing off a house for safety purposes rested with Ms Trad.

(e) Ms Trad gave evidence that it was not part of her role to train Kidstart Educators, and that, in particular, she was not involved in training Ms Rateau. Further, Ms Trad gave evidence that she was concerned that Kidstart were not providing training to its Educators, and that she raised this issue with Ms Shamsin. When it was suggested to Ms Trad that she had given advice, instruction and training to Ms Rateau in respect of a biting child, Ms Trad stated that she did not provide training, just "sort of advice".

12.22 **Conclusion:** When Ms Trad commenced employment with Kidstart, she had a diploma in children's services which she obtained in 2007. Further, Ms Trad had previously applied for a supervisor certificate in 2012, representing that she was familiar with the requirements and obligations pursuant to the NQF. This certificate was later issued by the Department. In addition, while Ms Trad had no experience in a family day care setting when she commenced with Kidstart, her experience in centre-based child care was relevant to her role as Nominated Supervisor for Kidstart. For example, Ms Trad indicated that conducting a safety and hazard check at a family day care residence involves similar considerations to a corresponding check at a centre-based day care. Therefore, the evidence indicates that Ms Trad was appropriately qualified to perform the role of Nominated Supervisor, and was aware of the responsibilities of such a role.

12.23 However, the evidence establishes that Ms Trad's role was more limited, and that she was not, in fact, carrying out the proper duties and responsibilities of a Nominated Supervisor. In essence, Ms Trad's role was limited to conducting house visits (both for new Educators and on an ongoing basis) and providing Educators with documentation. There is no evidence that Ms Trad undertook a broader supervisory role or was involved on a day-to-day basis with the running of Kidstart. This is supported by the fact that it is unlikely that Ms Trad had the time and capacity to perform the role of Nominated Supervisor, given the responsibilities of her other full-time job.

12.24 In this regard, Kidstart knew, or ought to have known, that Ms Trad was not performing the role of Nominated Supervisor adequately. Both Mr Shamsin and Ms Shamsin gave evidence that Ms Trad had a far more expansive and significant role, and corresponding responsibilities, including conducting initial checks of residences, making home visits to Educators and providing on-the-job training to Educators. This was a consistent theme in the evidence of both Mr Shamsin and Ms Shamsin, in the sense that they repeatedly sought to minimise, or deflect, their responsibility. Further, both Mr Shamsin and Ms Shamsin frequently provided non-responsive answers to questions that they were asked.

12.25 **Conclusion in relation to Issue 6A:** The NQF requires that a person must be fit and proper to provide an education and care Service. Determination of fitness and propriety involves a consideration of matters such as a person's compliance with the laws relating to education and childcare, their criminal history and their solvency.

12.26 The Department conducts a conducts a risk-based knowledge assessment to assist with this determination, where an applicant's experience or qualifications in childcare services is relevant to the question of fitness and propriety. However, the absence of such experience or qualifications is not, on its own, determinative.

12.27 In relation to Kidstart, Mr Shamsin and Mr Cheema did not have any experience or qualifications in education and childcare when the first applying for Provider approval, with the available evidence only able to confirm that Mr Shamsin obtained relevant qualifications in 2014. Ms Shasmin held relevant qualifications by the time she became a person with management and control of Kidstart in 2015.

Department monitoring and supervision of Approved Providers and Services under the NQF

12.28 It is important to understand that the current model of early childhood regulation, particularly in the family day care sector, is co-regulatory. The National Law and National Regulations provide that the Department, as regulatory authority, can approve Providers and Services on the basis of stipulated minimal requirements in the legislation. The National Law and National Regulations then require Approved Providers, Nominated Supervisors and Educators to comply with their statutory obligations.

12.29 Pursuant to the NQF, the Department is required to monitor, assess and supervise Approved Providers and Services. The Department monitors Approved Providers both proactively and reactively through Authorised Officers, who have a number of statutory powers, including powers of entry and to obtain information, documents and evidence.

12.30 However, as submitted on behalf of the Department, there is an expectation of compliance as with all co-regulatory systems. The Department places significant reliance on information provided by Approved Providers. In the absence of information to the contrary, the Department does not assume that information provided is incorrect, or that an Approved Provider, approved Service, Nominated Supervisor or Educator will be non-compliant with their statutory obligations.

Proactive monitoring

12.31 The Department's proactive monitoring involves assessment and rating of Services under Part 5 of the National Law, data monitoring and analysis, targeted campaigns on particular issues, and unannounced visits. Ms Buckley gave evidence that the last of these tools is the most effective in respect of keeping children safe. Unannounced visits can occur at both the head office of a Service and at an Educator's residence. Unannounced visits are not conducted on all registered Educators; rather, a team of Department staff are used to visit a sample of Educator residences.

12.32 When issues of non-compliance at a Service or Educator residence are identified, the Department relies on Approved Providers giving accurate information about how such issues have been addressed. The Department can also require an Approved Provider to give evidence as to the steps it has taken to address such issues.

12.33 The Department uses the NQS (prescribed by the National Regulations) to quality rate childcare Services. The purpose of assessment and rating against the NQS is to promote improvement by Services and to provide information to parents and prospective parents. Schedule 1 to the National Regulations establishes seven quality areas against which a Service is assessed with, relevantly, Quality area 3 concerning physical environment. The ACECQA Guide explains that the NQS "*sets a national benchmark for the quality of education and care Services and includes seven quality areas that are important outcomes for children[…]*". Under Part 5 of the National Law, Services are assessed against the NQS and given a rating for each of the seven quality areas, plus an overall rating based on those results.

12.34 Ms Buckley gave evidence that the rating system is often misunderstood. It is not an indicator as to whether a Service is compliant with the National Law, but rather a system "*which measures and encourages the quality of Services*". All Services are expected to be compliant with the National Law at all times. The assessment and rating of Services rate the quality of the Service. As a result, this process is not the Department's primary compliance monitoring tool, even though issues with compliance might be identified as part of the assessment process.

12.35 Approved Providers are required to prepare a quality improvement plan (**QIP**) within three months of obtaining Service approval. This is a self-assessment against the NQS. The National Regulations provide that Approved Providers are required to review and revise their QIP at least annually, and whenever requested to do so by the Department.

12.36 Individual Educators are not assessed and rated under the NQF. The Department assesses the approved Service. Regulation 63 of the National Regulations provides for how this assessment is to be conducted, which includes arranging for a site visit of one or more approved family day care venues or residences. Such quality rating visits generally involve an Authorised Officer visiting the head office of the approved Service, and visiting a sample of one or more Educators in their residences. For family day care Services, a sample of around 10% to 20% of Educators is chosen for assessment as part of this process.

12.37 Following an assessment, the Department must give each Service a rating, with the available ratings being:

(a) Excellent (where a Service promotes exceptional education and care, demonstrates sector leadership and is committed to continually improving);

(b) Exceeding National Quality Standard (where the Service goes beyond the requirements of the NQS in at least four of the seven quality areas, with at least two of these being quality areas 1, 5, 6, or 7);

(c) Meeting National Quality Standard (where all 40 elements that make up the NQS are met);

(d) Working Towards National Quality Standard (where there are one or more areas or elements not met, and identified for improvement); and

(e) Significant Improvement Required (where a Service is assessed as a significant risk to the safety, health and wellbeing of children, and where the regulatory authority will take immediate action).

12.38 The ACECQA Guide explains that:

> A significant risk is more likely to arise when there is non-compliance with the physical environment, children's health and safety, or staffing requirements, but it could arise in other parts of the NQS.

12.39 If one quality area is assessed as Significant Improvement Required, then this is reflected in the overall rating. Ms Buckley explained that if an issue of non-compliance is identified as part of an assessment, the Department would likely take two steps: continue with the assessment process and concurrently require an Approved Provider to remedy the non-compliance. If a major risk to health and safety is identified, immediate action, such as suspending the Service, might occur.

12.40 There is no period prescribed by statute in which Services must be assessed by the Department. The ACECQA Guide explains that:

> To focus resources on Services most in need of Service improvement, the actions of regulatory authorities are responsive and risk-based. Services with a lower quality rating will be re-rated more frequently. Services with higher quality ratings will generally have a longer period of time between assessment and rating visits in recognition of their ability to operate above the NQS.

12.41 Mr Mason gave evidence that the "*best practice regulatory design*" is to allow Authorised Officers the flexibility to attend to Services where the risk is greatest, meaning that "*a lower quality rating*" (such as Working Towards NQS) would be re-rated more frequently than a higher rated Service. For example, a Service which is given a Significant Improvement Required rating would be attended by Authorised Officers for a follow-up visit within three months, and the Service which is given a Working Towards NQS rating would be reassessed within 12 months.

12.42 Ms Wallis gave evidence that if initial visits to Educators revealed that a Significant Improvement Required rating was warranted for the Service, further assessments of Educator residences would be conducted. Such visits might occur as part of the assessment and rating process, or through regular monitoring visits.

12.43 The assessment and rating process is scheduled based upon a Service's compliance history: for example, if a Service has a history of non-compliance, the assessment and rating process will be brought forward. The length of time since a Service has been assessed and rated is a relevant factor when scheduling a reassessment. The longer the period between assessments, the more likely it is that a rating given to a Service could lose its currency. According to the ACECQA Guide, ratings must be displayed at the Service. Relevantly, a family day care Educator is also expected to display the Service rating at the family day care residence. Ratings are also published on the ACECQA website and Child Care Finding website.

12.44 The Department has implemented several initiatives aimed to improve its assessment and rating process, including:

(a) In 2018, the Department introduced real-time Electronic Structure Assessment Methodology, which allows Authorised Officers to collect and record evidence at assessment and rating visits in a structured manner on electronic devices;

(b) In late 2019, the Department promoted the use of self-assessment as part of assessment and rating processes. Ms Buckley gave evidence that this has resulted in a significant uplift in quality, and given Authorised Officers greater capacity to make more unannounced monitoring visits to Services;

(c) In 2020, the Department rolled out a "*family friendly*" star graphic to its rating certificates;

(d) In March 2021, the NSW Government launched a public campaign to raise awareness with families of the quality rating system; and

(e) The Department has updated its parent portal on its website to provide information to families on how to choose a Service and on how to raise concerns about a Service. However, Ms Buckley acknowledged that there remains a "*way to go*" to ensure that parents and prospective parents understand the purpose and role of a rating given to a Service.

Reactive monitoring

12.45 The Department's reactive monitoring involves responding to and investigating complaints. The Department's compliance investigation team is allocated cases to investigate arising out of incidents and complaints that meet the threshold of breaching the NQF.

12.46 Ms Buckley gave evidence of a number of difficulties associated with the monitoring and compliance of family day care Services:

(a) There is no cap or limit in the National Law, or elsewhere, as to the number of family day care Services that may be approved.

(b) The assessment and rating of all Services in NSW represents a significant allocation of time and resources which permit the Department to undertake assessment and rating of approximately 25% of all Services each year.

(c) The Department seeks to identify and cancel Provider Approvals of Services where evidence establishes that the service is non-compliant with the National Law and National Regulations, and are placing children at risk. However, the review system often results in such decisions being overturned by the NSW Civil and Administrative Tribunal because of the very limited grounds in the National Law to cancel Provider or Service Approval.

(d) Authorised Officers, who are tasked with a variety of monitoring and compliance duties, are required to monitor a large number of Services spread across a diverse geographical area.

Department and DESE regulation of childcare Services

12.47 In addition to the Department's monitoring and regulation of childcare Providers, DESE regulates Providers for the purpose of child care subsidy (**CCS**) payments.

12.48 The CCS scheme is a means by which the Australian Government provides financial assistance to Australian families. It is governed by a body of laws referred to as the *Family Assistance Law*. In most cases, CCS payments are paid directly to childcare Providers, with the benefit passed onto families by way of a reduction in childcare fees. The process for a CCS claim generally includes the following:

(a) DESE must assess and approve a Provider (after the Provider has first been approved by the Department) in respect of a family day care Service to ensure that the Provider is fit and proper to receive government payments. In order to maintain their approval under the *Family Assistance Law*, an Approved Provider must comply with all requirements imposed by a law of the state or territory in which the Service is situated, such as the National Law for Services in NSW.

(b) The Approved Provider is required to verify (usually through the use of third party software) the accuracy of fortnightly time sheets submitted by registered Educators for submission to DESE. Ms Melanie Dolph, an investigator employed by DESE, gave evidence that DESE relies upon Approved Providers to monitor its Educators to ensure the accuracy of information submitted in relation to CCS payments.

(c) DESE calculates what CCS payments are to be made based on a child's hours of attendance at a care Service, and applying family income and "*activity test*" criteria.

(d) DESE pays the CCS payments into an Approved Provider's nominated bank account, and sends a payment advice reflecting the fortnightly payments.

(e) An Approved Provider then remunerates its registered Educators in accordance with their private contractual arrangements. Relevantly, Kidstart would pay the CCS payment to an Educator, less an administration fee

(f) An Approved Provider and/or Educator sets the fees payable by a parent, who is also responsible for paying any gap between the fees and the CCS payment for their child.

12.49 As with any federal government subsidy program, the CCS payment system is vulnerable to fraudulent or dishonest activity. This can occur in at least three ways:

(a) A claim can be submitted for a session of care even though a child did not attend that session;

(b) The fee charged by an Approved Provider/Educator to a parent is inflated when reported to DESE. As CCS payments are calculated as a percentage of the fee, the CCS payments will be greater than what the actual fee charged to the parent permits; and

(c) A parent is not charged a gap fee (which disentitles any CCS payment).

12.50 It is the experience of the Department that the introduction of the CCS scheme resulted in an increasing number of for-profit Providers entering the sector, not to provide high quality care, but rather to attempt to defraud the Commonwealth government. Ms Buckley gave evidence that family day care Services are at higher risk of attracting such activity due to the lower cost to establish this type of Service compared to a centre-based Service. As a result, the Department has prioritised the prevention of fraudulent and unscrupulous entrants into the family day care sector. Ms Sharon Dodd-Gilhooly, a family day care coordinator employed by Waverley Council, noted that the effect of privatisation on the early childhood education and care industry "*created more problems that it solved*".

12.51 Further, business profitability is directly proportionate to the number of children attending a session of care. In other words, Approved Providers will have higher administration fees, and Educators will have increased CCS payments and fees for each child in care. For family day care Services, this provides a financial incentive for an Educator to care for more children than permitted under the ratios prescribed by regulation 124 of the National Regulations. While this conduct will not necessarily constitute fraudulent behaviour in contravention of the *Family Assistance Law*, if a family day care Service provides care in such a way that breaches the National Law (such as breaching ratios), an Approved Provider will likely be in breach of a condition for continued approval under the *Family Assistance Law*.

Overlap between the Department and DESE

12.52 Regulation of the childcare sector by the Department and DESE overlap in a number of key respects, including as follows:

(a) There is a flow of information between the Department and DESE, particularly where one regulator obtains information relevant to the regulatory functions of the other regulator;

(b) The Department and DESE collaborate on campaigns, particularly where there is overlap between high-risk Providers from their separate perspectives; and

(c) ACECQA works with DESE on regulatory policy reviews, and DESE is one of the bodies that controls ACECQA by nominating people to its board.

12.53 DESE holds information about parents and their children relevant to CCS payments. This includes when a child entered into care with a particular Service, and the days and times of that child's attendance. DESE uses this information to monitor behaviour, including to check that CCS is being properly administered by Providers. This information, together with information about the number of Educators operating from one residence, is relevant to both child health and safety, as well as the regulation of CCS payments.

12.54 Under the *Family Assistance Law*, the Secretary has discretion to share information held by DESE with a state regulator for the purposes of the National Law. DESE works with other agencies, including the Department, to seek to address suspected non-compliance with the law, collusion,

fraud or criminal activities. Information sharing may occur when DESE forms a reasonable belief that disclosure is necessary for, among other things, administration of the National Law, or upon specific request by the Department.

12.55 A number of initiatives for improved information sharing between the Department and DESE are underway, including a joint monitoring and data sharing project with the aim of improving childcare quality and compliance operations, weekly meetings for planning ongoing joint campaigns and a proposal to expand access to real-time information across the agencies. Ms Buckley gave evidence that it would be helpful to the Department to have a right to access information collected by DESE. Ms Dolph similarly acknowledged that "*anything which makes information sharing easier*" would assist in approving compliance and child care quality.

Kidstart, the Rhythm and Rhyme Centre and CCS

12.56 On 26 October 2015, Kidstart was approved to administer childcare benefits (the precursor to CCS payments). Records held by DESE regarding the session Educators who had worked at the Randwick Property between 2 July 2018 and 1 March 2019 indicate the following:

(a) All the children for whom CCS were claimed during this period were aged between five months old and three years and four months old;

(b) Ms Rateau, Ms Hanuliakova, Ms Das and a woman named Patricia Cass each conducted care sessions at the Randwick Property for which a CCS payment was claimed;

(c) There were multiple occasions where two Educators were providing care from the Randwick Property on the same day;

(d) Up to nine children could be enrolled to attend the Rhythm and Rhyme Centre on any one day (although this data does not indicate if a child was absent for the session); and

(e) There were multiple occasions when Ms Rateau is recorded as the session Provider for more than four children under the age of four.

12.57 Pursuant to a subpoena issued on 18 June 2021, Kidstart produced payment summaries and advice reports for Ms Rateau. These records indicate that:

(a) A "*total fee*" was calculated for each child who attended the Rhythm and Rhyme Centre that week;

(b) Kidstart charged an administration fee for all children;

(c) A CCS payment was made in respect of most children;

(d) The gap which a parent was required to pay was calculated as a difference between the "*total fee*" and the CCS payment for the child; and

(e) The amounts that Kidstart paid to Ms Rateau was calculated as the difference between the total of all CCS payments and the total administration fee for the week.

12.58 Kidstart's subcontract with Ms Rateau provided for Kidstart to charge a fee of $1.45 per hour per child. Ms Hanuliakova also signed a subcontract with Kidstart containing the same regulation (although it is not signed by Kidstart, but was produced by Kidstart pursuant to a subpoena). Notwithstanding, Kidstart was aware that Ms Hanuliakova was operating from the Randwick Property and that she, together with Ms Rateau, would care for up to eight children per session.

12.59 However, the summaries of payments made by Kidstart to Ms Rateau (again, produced on subpoena by Kidstart) indicate that Ms Rateau received the CCS payments for all the children being cared for at the Rhythm and Rhyme Centre, regardless of who Kidstart nominated as the session Educator to DESE.

12.60 Available records indicate discrepancies between the sign in sheets kept by Ms Rateau, Ms Hanuliakova and Ms Cass for children attending the Rhythm and Rhyme Centre, and DESE records of the sessions for which CCS payments were claimed. For example, according to DESE records, on 9 July 2018 Ms Rateau is recorded as session Educator for five children, and Ms Cass is recorded as session Educator for three children. However these records do not correspond with the respective sign in sheets for both Ms Rateau and Ms Cass, which nominate different numbers and names of children.

12.61 Further, Kidstart's payment summary for Ms Rateau for the week of 9 July 2018 indicates that Kidstart charged Ms Rateau an administration fee in respect of all the children who attended the Rhythm and Rhyme Centre that week and all the CCS payments for that week, not just for the children who signed in with Ms Rateau. In other words, the records indicate that Ms Rateau received CCS payments for a number of children that she did not sign in at all that week.

12.62 Kidstart was issued with a subpoena to produce any record relating to fees paid to an Educator operating from the Randwick Property including, without limitation, Ms Hanuliakova and Ms Cass. No payment summaries were produced for Ms Hanuliakova, Ms Cass, or Ms Das.

12.63 The available evidence indicates the following:

(a) Kidstart was aware that more than four children aged four or under were being cared for at the Rhythm and Rhyme Centre;

(b) Kidstart did not check, or checked poorly, the accuracy of information submitted to DESE, in circumstances where the session Educator recorded by DESE did not match the corresponding sign-in records;

(c) Kidstart's payment summaries demonstrate that it operated differently to the procedure set out in its subcontracts with Ms Rateau and Ms Hanuliakova. Ms Rateau was charged the administration fee and received the CCS payments for all children, regardless of who was the session Educator for the purposes of CCS claims.

12.64 **Conclusion:** The financial arrangements between Ms Rateau, Ms Hanuliakova and Ms Das (and Ms Cass, although there is no evidence as to what those arrangements were) are a matter of private contractual arrangement. This arrangement created a financial incentive for Ms Rateau and Kidstart to breach regulation 124 of the National Regulations regarding child ratios. Such a breach places children in the care of the Service at risk. As already noted, having children in excess of the ratio presents a risk to their safety and well-being. Further, it reflects a practice of a Provider prioritising profit over quality of care.

12.65 It was submitted on behalf of the directors of Kidstart that whether the financial structure in operation at Kidstart created an incentive to breach the National Regulations is not a matter relevant to the cause or manner of Jack's death, or consideration of any possible recommendations pursuant to section 82 of the Act.

12.66 Any alleged fraudulent practices in relation to having multiple educators registered at single residences or breaches of statutory child ratios give rise to safety concerns in two respects: first, whether having more than the specified ratio of children at the Rhythm and Rhyme Centre meant that there were insufficient resources and facilities (including cots) available; second, whether registered Educators understood their statutory obligations. It is accepted that such practices did not directly bear upon Jack's death, and that on 4 March 2019 Ms Rateau was the only Educator at the Randwick Property and was in compliance with the statutory ratio. However, consideration of the existence of such practices necessarily informs understanding of whether Kidstart and Ms Rateau gave appropriate consideration to the safety, health and wellbeing of children being cared for, as regards safe sleeping practices.

Department monitoring and supervision of Kidstart

12.67 It is noted that in 2018 there were 2,380 complaints received by the Department and 1,406 compliance actions initiated. Further, in 2019 the Department had available to it 113 Authorised Officers and 11 investigators to conduct its monitoring and compliance roles in relation to the 10,153 Educators registered to operate in that year.

12.68 Prior to Jack's death, the Department did not receive any complaints regarding Kidstart that expressly referred to the Rhythm and Rhyme Centre, and did not visit or inspect the Rhythm and Rhyme Centre. The Department's oversight and supervision of Kidstart may be summarised as follows:

(a) After Service approval was granted for Kidstart on 10 December 2013, the Department visited the Service premises for Kidstart (where a post-approval visit summary was completed) and one Educator residence (where a post-approval checklist was completed which identified that the Educator had only one of the six policies required by the National Regulations – an Authorised Officer later confirmed that the Service had "all additional policies").

(b) Between 11 November 2013 and 5 February 2019 the Department received 10 complaints regarding Educators registered with Kidstart. Ms Buckley gave evidence that the number and type of complaints received by the Department were not unusual, and were similar to the

number and type of complaints received in relation to family day care Services in the for-profit sector. The Department determined that three complaints required no further action, with investigations opened for the remaining complaints. These complaints are described below:

(i) On 19 August 2014 Authorised Officers attended an Educator residence and identified a number of risks relating to child health and safety, including the use of unsafe cots with extraneous bedding material and first aid kits not being available. The following day, Kidstart suspended the Educator from providing care until improvements were made. On 26 August 2014 the Department sent a letter to Mr Shamsin inviting that action be taken in relation to a number of non-compliance matters, and that evidence be provided showing that each matter had been rectified. On 9 September 2014 Mr Shamsin and Mr Cheema wrote to the Department indicating that extraneous bedding material had been removed from all sleeping areas and that Kidstart Educators and staff had been retrained and made aware of Kidstart's policies and procedures. On 21 October 2014 the Department noted that all breaches had been rectified and recommended that a follow-up visit occur within three months.

However, it does not appear that such a follow-up visit occurred. Ms Buckley gave evidence that the follow-up monitoring likely formed part of the assessment and rating of Kidstart, which was due in 2015. As part of this investigation, the Department's Authorised Officers became concerned that fraudulent childcare benefit claims were being made, based on incorrect attendance records. This concern was referred to DESE although it appears that no action was taken. Ms Buckley gave evidence that this investigation represented an instance where the possible concern about fraudulent activity also raised a concern about the safety and well-being of the children in care.

(ii) On 14 June 2017 Authorised Officers attended an Educator residence in response to complaints that eight children were being cared for at the residence, and that there were concerns regarding poor hygiene and safety measures at the residence. Inspection of the residence revealed that there were three Educators operating from the residence, with two Educators in a job share arrangement, and there being two separate residences that were used for separate day care Services. In November 2017 and late December 2017 complaints were made to the Department that the Educator was allegedly seeking employees for the family day care centre. On 15 December 2017 an Authorised Officer rang Ms Trad and was provided with information indicating that two separate residences were being used for separate day care Services. On 25 January 2017, Authorised Officers conducted a further visit to the property, and again confirmed that the property consisted of two self-contained residences with separate sign in sheets. Having regard to this information, and the fact that the Educators were not sharing supervision of children, the Department determined that the Educators were not in breach of the National Law.

(iii) On 20 December 2018, Ms Dodd-Gilhooly made a complaint to the Department regarding Kidstart having a number of Educators operating from a single residence. On the same day, Ms Dodd-Gilhooly sent the same complaint to DESE. On 2 December 2019 Ms Dodd-Gilhooly contacted DESE again to explain her belief that having more than one Educator in a

residence was a concern with respect to CCS payments. On 8 January 2019, a DESE representative asked Ms Dodd-Gilhooly to provide the names of individuals suspected of committing CCS fraud. Later that day, Ms Dodd-Gilhooly provided information identifying Ms Rateau as having a "*team*". On 14 February 2019 an investigation was opened in the Department's National Quality Agenda IT System (**NQAITS**), assigned a medium priority and categorised as relating to a potential risk to the health and safety of children due to the physical environment. It does not appear that any action was taken until the targeted campaign following Jack's death.

12.69 **Conclusion**: It is accepted, as submitted on behalf of the Department, that none of the complaints made about Kidstart prior to March 2019 related to the supervision of Educators provided by Ms Trad, the use of bassinets, the implementation of the Kidstart Sleep Policy or the lack of training of Educators. Further, it is also accepted that there was nothing in the content of the complaints, the responses provided by Kidstart, or the manner in which the Department investigated the complaints which put the Department on notice that there were widespread safety concerns in relation to Educators engaged by Kidstart.

12.70 Notwithstanding, it is evident that in late December 2018, the Department was aware of concerns raised regarding the number of Educators operating at the Rhythm and Rhyme Centre. It took almost six weeks for the complaint to be lodged on 14 February 2019 and a further three weeks before any action was taken, following Jack's death. If this complaint had been triaged more quickly by the Department, it likely would have been put on notice that the Rhythm and Rhyme Centre was operating with more than one Educator from a single residence.

Assessment and rating of Kidstart

12.71 The assessment and rating of Kidstart in 2015 is summarised below:

(a) On 19 March 2015 the Department notified Kidstart that it was to be assessed and rated, and requested Kidstart to submit, among other things, its QIP and Educator list.

(b) On 19 May 2015 Authorised Officers visited the Kidstart Service premises at Bankstown. A total of three visits were made to this premises as part of the assessment and rating process. Two Educator residences in Bankstown and Greenacre were also visited by Authorised Officers.

(c) From these visits, the Authorised Officers observed breaches of the NQF, which needed to be addressed urgently, including absence of appropriate medication and administration forms or plans, and Educators who were not appropriately qualified.

(d) On 1 June 2015 Kidstart was sent a draft assessment and rating report, inviting comments, together with a non-compliance letter which identified a number of breaches of the NQF, and an invitation to rectify the breaches and provide a response by 15 June 2015. The breaches included:

(i) Kidstart failed to ensure the Nominated Supervisor and Educators were aware of NSW child protection law;

(ii) Kidstart failed to ensure all equipment and furnishings were safe, clean and in good repair; and

(iii) Kidstart failed to ensure all Educators were actively working towards a qualification.

(e) On 14 June 2015 Kidstart responded, providing advice and evidence as to the following:

(i) Kidstart had organised a refresher course on NSW child protection law for the Nominated Supervisor, coordinators and Educators;

(ii) Protective features had been put in place regarding unsafe furniture and premises to mitigate the risk of harm to children;

(iii) The two Educators identified without appropriate qualifications did in fact have those qualifications.

(f) On 15 June 2015, Kidstart provided comments in response to the draft report, including a staff evaluation form for Ms Trad which described her as having "*meticulous attention to detail when performing hazard checks and monthly visits*".

(g) On 15 July 2015 Kidstart was provided with the Department's final assessment and rating report (**A&R Report**) which noted that all quality areas, except Quality area 5 (being relationships with children), were rated as Working Towards NQS. Quality area 5 was given a Meeting NQS rating.

12.72 The A&R Report recorded the following:

(a) Each child's comfort is provided for and there are appropriate opportunities to meet each child's need for sleep, rest and relaxation […] Mats and linen are provided for children to use for sleep or rest in a designated sleep room;

(b) The Service is working towards ensuring that every reasonable precaution is taken to protect children from harm and any hazard likely to cause injury. This does not pose an unacceptable risk to the safety, health or wellbeing of any child or children being educated and cared for by the Service;

(c) Although co-ordinators conduct safety checks on Educator premises every four weeks, they have failed to identify risks and take action to ensure the safety of children. For example, book units that have glass panels accessible to children;

(d) […] Educator-to-child ratios and qualification requirements are maintained at all times [noting that Kidstart had two diploma qualified co-ordinators];

(e) The Induction of Educators, co-ordinators and staff members is comprehensive;

(f) There are currently no performance evaluations undertaken in relation to Educators.

12.73 As requested, Kidstart prepared its QIP dated March 2015 for submission to the Department. Mr Shamsin was involved in the production of this document. The QIP identified Mr Shamsin as the Approved Provider and primary contact for the Service, with Ms Trad as the Nominated Supervisor.

12.74 The QIP noted the following:

(a) As part of Kidstart's Service statement of philosophy, it was noted:

> Our Service actively collaborates with staff, Educators and parents to continuously improve our Service and practices. We are committed to ongoing professional growth and developing the best practices within our Service. Our Educators are provided with regular training as well as individual support sessions to ensure they are always confident in their practices and deliver quality care […]

(b) In its list of "*strengths*" for Quality area 2, Kidstart noted that, "*all Educators have an appropriate area for sleep time*".

(c) No reference was made to safe sleeping furniture and areas.

12.75 The Department's Service summary report includes an entry for 8 April 2016 which indicated "*Assessment and Rating Due Activity*". Notwithstanding, Kidstart was not reassessed in the period between May 2015 and Jack's death in March 2019. Ms Buckley gave evidence that she would expect Kidstart to have been reassessed in 2019 or 2020 in the usual course of events.

12.76 Mr Mason gave evidence that a period of four years without reassessment was unusual and longer than average. Mr Mason also agreed that if the Department had received information suggesting that an Approved Provider was not compliant with the National Law (as occurred in the case of Kidstart), this ought to have escalated an assessment of the Service.

12.77 **Conclusion:** Kidstart ought to have been reassessed and re-rated earlier than 2019 or 2020. In accordance with best practice, this should have occurred in 2016. It is accepted that assessment and rating is not the primary compliance tool used by the Department. However, a rating of Working Towards NQS indicated that there were shortcomings in the quality of the Service provided by Kidstart. This ought to have triggered an earlier reassessment. Further, to the extent that the NQF requires a quality assessment to be conducted for education and care Services, that assessment and rating should occur in a way that produces meaningful information to parents, including by providing up-to-date information.

Referral from DESE

12.78 On 24 November 2017 a DESE representative sent an email to the Department disclosing information regarding apparent breaches of the National Regulations by Kidstart with respect to Educator to child ratios. The email attached two spreadsheets which identified 13 Educators whose CCS information indicated they were apparently in breach of regulation 124 of the National Regulations regarding child ratios.

12.79 Ms Buckley gave evidence that an email of this kind of should have prompted the Department to visit Kidstart, however no visits occurred due to resourcing and competing priorities. It was accepted however that as a matter of best practice, the Department ought to have followed up this information.

Department response following Jack's death

12.80 On 5 March 2019, the Department commenced an investigation into Jack's death.

12.81 On 7 March 2019, the Department conducted a targeted compliance campaign, visiting the addresses of 23 Educators said to be registered as family day care Educators with Kidstart. This campaign revealed the following:

(a) six Educator residences which were non-compliant under the NQF, including that:

(i) an Educator had not received any training from Kidstart in relation to child protection;

(ii) an Educator's first aid kit was not easily recognisable or accessible to adults;

(iii) a number of Educators had not conducted emergency evacuations every three months and failed to post the emergency evacuation display in a prominent position near an exit;

(iv) Kidstart had failed to ensure that the Educators had current approved first aid qualifications (this concerned two Educators (in addition to Ms Rateau), whose CPR qualifications had lapsed in April 2017 and November 2018 respectively);

(v) an Educator's residence had multiple potential hazards accessible by the children, including an ability for children to access the back electrical cords at the rear of an audio-visual unit, which faced into the back of the play/sleep room;

(vi) Kidstart had failed to ensure that the furniture and equipment used by an Educator was safe, clean and in good repair;

(vii) Kidstart failed to ensure that all adults at an Educator's premises had a current WWCC;

(viii) an Educator was unable to find and provide the Service's policies and procedures required to be kept under regulation 168 of the National Regulations;

(ix) Educators were unable to provide enrolment records for children in care;

(x) Kidstart failed to ensure that the information contained in Educator registers was accurate; and

(xi) an Educator failed to provide safe and accessible toilet and washing facilities;

(b) several residences nominated as Educator residences where no one was home or no children were being cared for at the time;

(c) several residences where the occupants had never heard of Kidstart and had never cared for children; and

(d) several "residences" which were in fact unoccupied shop fronts or the addresses for other family day care Services.

12.82 The consequences of this investigation and campaign resulted in the following:

(a) On 8 March 2019, Ms Rateau was prohibited from providing education and care Services under the National Law, pursuant to section 187 of the National Law;

(b) On 8 March 2019, Kidstart's Provider approval was suspended;

(c) On 28 June 2019, a Notice of Decision to Cancel Provider approval, effective from 8 June 2019, was served on Kidstart by the Commonwealth Government;

(d) On 30 September 2019, the Department issued Notices to Show Cause to Cancel Provider and Service approval to Kidstart, and Notice to Show Cause to Ms Trad and Ms Shamsin. No response to those notices was received; and

(e) Effective 14 October 2019, Kidstart's Provider approval and Service approval were cancelled by the Department and Prohibition Notices were issued to both Ms Shamsin and Ms Trad.

12.83 The Department prosecuted each of Ms Rateau, Ms Trad and Kidstart for offences under the National Law. Ms Rateau and Kidstart each pleaded guilty. Ms Trad defended the charges but was found guilty.

12.84 Since Jack's death, the Department has implemented several initiatives aimed to improve its monitoring and supervision of family day care Services. These initiatives include:

(a) a campaign to educate the sector on safe sleep practices, including by reviewing and republishing guideline documents/pamphlets;

(b) checklists for Authorised Officers when carrying out monitoring of Services now require that the Authorised Officer confirm Provider and Service compliance with respect to sleep and rest and supervision and safe environments for children including safe sleeping environments;

(c) training of Authorised Officers focused on safe sleep policies, environments and practices in family day care Services, including through face-to-face training sessions with presentations by Red Nose; and

(d) webinars on the safe sleeping practices available to Authorised Officers and the sector more broadly as part of their ongoing training.

12.85 The Department has also introduced two new specialist teams since Jack's death:

(a) A family day care specialist team (**Specialist Team**) established in March 2019, whose members monitor family day care Services and take a risk-based approach when selecting Services to visit by considering the compliance history of the Service, including the responses to any current or previous compliance actions and whether these have been resolved or require further action, and referrals from other managers and hub coordinators based on the seriousness of the risk to children's health, safety and well-being.

For high to very high risk rated family day care Services (with systemic non-compliance), the Department will conduct full unannounced visits to the Service premises plus all Educator residences on the one day.

For Services with unknown levels of compliance, many campaigns are conducted with Authorised Officers attending the Service premises plus some Educator residences as a sampling exercise to determine the level of compliance or non-compliance.

(b) A Compliance Team proactively targets high-risk Services by looking at risk ratings that are generated against each Service in NQAITS, together with information from previous visits and any incidents or complaints lodged against a Service. The compliance team predominately operates through unannounced monitoring visits, and prioritises visits based on the longest time since the last visit, and schedules ongoing monitoring visits for Services where breaches have been identified. Such visits are generally no longer than three months since the last visit.

12.86 Further, in January 2020, the Department's triage and scheduling functions were amalgamated under a single State-wide Operations Manager. This means that all reports, complaints and incidents are assessed and immediately distributed based on the risk profile of a report/complaint, guiding the priorities of Authorised Officers.

12.87 The Department's evidence as to the regularity of monitoring visits to family day care Services and Educator residences is that:

(a) In 2020, the Department visited 84.36% of all Services across NSW;

(b) Only 200 of the 5812 current childcare Services in NSW have not been visited since 2019; and

(c) While Educator residences are checked by the Department, it is not possible to visit every Educator every year on existing resources.

12.88 **Conclusion in relation to Issue 7:** The evidence establishes that the Department complied with its statutory obligations in respect of Kidstart, including by: assessing and approving Kidstart as an Approved Provider and Service; investigating complaints made in respect of Educators registered with Kidstart; conducting an assessment and rating of Kidstart under Part 5 of the National Law; undertaking an investigation and targeted campaign following Jack's death; and suspending and then cancelling Kidstart's Provider approval. Although the Department complied with its obligations under the NQF, there were a number of omissions which did not reflect best practice.

12.89 First, following a complaint made in August 2014, the Department recommended internally that a monitoring visit occur within three months, which did not in fact occur. Although the Kidstart Service was assessed and rated from March to May 2015, the residence of the relevant Educator was not visited as part of that assessment.

12.90 Second, Kidstart was rated the second lowest rating in 2015 and not reassessed before March 2019. Although the NQF does not prescribe a time within which a Service must be assessed, given the rating it received, Kidstart should have been reassessed earlier than March 2019. In reaching this conclusion, it is accepted, having regard to the evidence of Ms Buckley, that the assessment and rating process is not considered the Department's most effective tool in identifying poor practice and non-compliance. Rather, as already noted above, the use of unannounced visits is considered to be the Department's most effective tool in this regard.

12.91 Third, in November 2017 the Department was put on notice by DESE that Kidstart appeared to have 13 Educators operating in breach of the National Regulations for child ratios. This warranted an investigation and the Department ought to have taken compliance action through visits, or reassessing Kidstart. However no action was taken.

12.92 Fourth, an investigation into the complaint made in December 2018 was not opened until 14 February 2019, with no substantive action was taken until after Jack's death. It is accepted, as submitted on behalf of the Department, that the complaint was not sent by Ms Dodd-Gilhooly to the Department until 5 February 2019. In response, the Department undertook enquiries on 12 February 2019 and created an investigation two days later. This investigation was closed on 15 March 2019 due to the suspension of the whole Kidstart Service following Jack's death.

13. Issue 6 – Was the supervision of the Rhythm and Rhyme Centre by Kidstart in accordance with the National Law, reasonable, and in accordance with good practice?

13.1 At the outset, it should be noted that the following was submitted on behalf of the directors of Kidstart:

> Although a wide ranging enquiry into Kidstart's compliance with the National Law and Regulations might be tempting, many of the matters addressed by [Counsel Assisting] are remote from the manner and cause of Jack's death.

13.2 It was further submitted on behalf of the directors of Kidstart that a number of matters considered by the inquest:

> […] Do not bear upon the cause [sic] manner of death, nor are they incidental to any recommendation, and go beyond what are the proper limits of the inquest or are otherwise unsupported by sufficient evidence […]

13.3 It should be remembered that in advance of the inquest, as a matter of procedural fairness, the list of issues which the inquest proposed to examine was distributed to the parties considered to have sufficient interest. On behalf of the directors of Kidstart no application was made prior to, or during, the inquest seeking any amendment to the issues list. Further, it should be remembered that the issue of supervision of the Rhythm and Rhyme Centre by Kidstart (and the regulatory oversight of Kidstart by the Department) are issues that involve consideration of the implementation of safe sleeping practices at the Rhythm and Rhyme Centre as at 4 March 2019, which is directly relevant to the manner of Jack's death.

13.4 As noted above, a co-regulatory system exists under the NQF in relation to the supervision and monitoring of Approved Providers and Educators. Whilst the Department monitors Approved Providers, it performs no similar function in relation to Educators, who are instead monitored by Approved Providers. Consequently, if an Approved Provider does not comply with its obligations under the NQF, or does not provide effective supervision, monitoring and training of its Educators, it is likely that a family day care Educator is able to operate unregulated.

13.5 Under the NQF, Approved Providers are required to supervise, train and support the Educators registered with their Service. Among other things, the NQF provides for the following:

(a) An Approved Provider is required to ensure that an Educator holds all relevant qualifications, including an approved Certificate III level education and care qualification (or be at least working towards a qualification), a current approved first aid qualification, and that an Educator has adequate knowledge and understanding of the provision of education and care to children.

(b) An Approved Provider must employ or engage the prescribed minimum number of qualified persons as family day care coordinators, whose role includes supporting, monitoring and training the Educators registered with the Service. A family day care coordinator must have an approved diploma level of education and care qualification. Further, at all times that a family

day care Educator is caring for children as part of the Service, an Approved Provider must ensure that one of the following persons is available to provide support to the Educator (including by being able to be contacted by phone to provide advice and assistance): the Approved Provider (or a person with management and control of the Service), a Nominated Supervisor of the Service, or a person in day-to-day charge of the Service.

(c) An Approved Provider must have in place policies which outline how Educators will be supervised, supported, monitored and trained. An Approved Provider must take reasonable steps to ensure that Nominated Supervisors, staff members and Educators engaged by or registered with the Service follow the policies required to be established.

(d) An Approved Provider must conduct an assessment, including a risk assessment of a family day care residence, at least annually, and before care is provided to children, to ensure the health, safety and well-being of children cared for by the Service are protected.

(e) An Approved Provider must keep a register in respect of each Educator, family day care coordinator and Educator assistant engaged by or registered with the Service. This register must include information prescribed by regulation 153 of the National Regulations, which relevantly includes the address of the residence where an Educator operates a family day care business, evidence of the Educator's relevant qualifications and evidence of training completed by the Educator (including first aid training). Such information is required to be held on a register until the end of three years after the date on which the Educator, coordinator or Educator assistant ceases to be employed or engaged by or registered with the Service. The Department can request that an Approved Provider provide a copy of its registers within 24 hours. The following matters are relevant to such registers:

- Information kept on a register is useful for the Department's monitoring of education and care Services;

- If a register is not kept by an Approved Provider, or information contained within it is inaccurate, then the Department has limited visibility or oversight of the Service's Educators;

- The Department's monitoring and oversight of Services and Educators would be improved if such registers were held by the Department and not just the Approved Provider; and

- If the registers specified the number of children in the care of an Educator, this would enhance Department oversight of Educators.

13.6 ACECQA publishes information about approved Services to give families and prospective families access to information about education and care Services. The ACECQA website does not allow for prospective families to search for individual family day care Educators, noting that it is the Service and not the Educator who was assessed and rated under Part 5 of the National Law. Mr Mason gave evidence acknowledging that a parent would be interested in information about an Educator, as well as a Service, and that it "*could be worth considering*" including information about an Educator on the ACECQA maintained website. However, in order to do so, ACECQA would need current

information about the Educators, which could be obtained if Approved Providers were required to submit their registers to the Department as a matter of course.

13.7 As part of the application for Service approval, Mr Shamsin submitted policies to the Department (**Kidstart Policy**), which were drafted by Mr Shamsin and Mr Cheema. These policies largely remained the same up to 4 March 2019, with only minor updates made between 2013 and 2019.

13.8 The Kidstart Policy represented the following, in relation to the selection and registration of Educators:

> Kid Start FAMILY DAY CARE [sic] will ensure that the education and care Service premises and all equipment and furniture used in providing the education and care Service are safe, clean and in good repair.
>
> KidStart Family Day Care will go through a detailed selection process to select Educators who will provide the best possible care for children.
>
> Kid start Family Day Care will assess if the Educator meets the standards in the "fit and proper" requirements and will proceed.

13.9 Mr Shamsin gave evidence that the directors of Kidstart were responsible for checking an applicant's references and qualifications, with Ms Trad giving evidence to the same effect. Ms Trad initially said that in her role as Nominated Supervisor, she was not involved in the process of an Educator becoming registered with Kidstart. However, later in her evidence, Ms Trad acknowledged that it was part of her role to form a view as to whether a new Educator should be registered with Kidstart or not.

13.10 The Kidstart Policy also provided for the following in relation to the monitoring and supervision of Educators registered with Kidstart:

> Educators are visited by a coordinator on a monthly basis after commencement of work.
>
> Visits may be unannounced or at a scheduled time.
>
> Unannounced visits are made to Educators premise [sic] at least once every four weeks.
>
> Educators are visited at different times on different days to ensure all children in care are observed and their care monitored.
>
> Information gathered on home visit is documented and used to provide feedback to Educators and also to provide feedback to families regarding their children's experience in family day care.
>
> […] inspection of the [Educator] venue to be performed on a regular and ongoing basis (preferably a monthly basis).

13.11 The Kidstart Policy expressly stated that visits to Educators' premises will occur on an ongoing basis, preferably monthly, and unannounced visits occurring at least every four weeks. However, Mr Shamsin gave evidence that an Educator would be visited monthly during the initial phase

when an Educator is registering with Kidstart, and not after they had commenced working as an Educator. However, a plain reading of the Kidstart Policy indicates that no distinction is drawn between newly register Educators and other Educators in relation to the nature and frequency of visits for the purposes of monitoring and supervision.

13.12 Further, other contemporaneous documents, which Mr Shamsin assisted in preparing, also referred to Kidstart's commitment to visiting Educators monthly:

(a) The QIP prepared as part of Kidstart's 2015 assessment and rating includes the following statements:

> Child safety is a high priority in our Service with coordinators performing monthly house visits to ensure a safe environment is maintained.
>
> The Service ensures Educators maintain a safe environment by […] checking the emergency equipment (fire extinguisher, fire blanket, etc) at monthly visits.

(b) On 15 June 2015, Kidstart sent a response to the Department's draft report which contained a staff evaluation form for Ms Trad, which described her as having "*meticulous attention to detail when performing hazard checks and monthly visits*".

13.13 In relation to induction training, the Kidstart Policy provided that, prior to starting, Educators and Educator's assistants will be provided with initial training by Kidstart staff holding a Certificate IV in training in relation to the following topics: introduction to family day care, policies and procedures, child development workbooks, risk mitigation strategy and business planning.

13.14 In relation to ongoing training of Educators, the Kidstart Policy provided that the Service will engage staff that hold a Certificate IV in training and assessment who can deliver short courses of relevance to Educators in association with registered training organisations, and that Kidstart will provide regular in-house training and continuous education to its Educators.

Registration of Ms Rateau

13.15 The Kidstart Policy included the following representation:

> KidStart Family Day Care will go through a detailed selection process to select Educators who will provide the best possible care for children.

13.16 On 15 September 2016 Ms Rateau applied to be registered as Educator with Kidstart. As part of the application process, Ms Rateau would have been required to provide evidence of her qualifications in order to arrange for Ms Trad to meet with her. According to Ms Trad, a director of Kidstart had "*final say*" on whether an Educator could be registered with Kidstart. Ms Trad gave evidence that the directors of Kidstart decided to approve Ms Rateau as an Educator, despite having never met her.

13.17 Ms Rateau was approved as an Educator on 15 September 2016, and signed a subcontract dated the same day with Ms Trad, on behalf of Kidstart. This subcontract provided that:

(a) Ms Rateau was required to comply with Kidstart's policies and procedures, including those outlined in the Kidstart Handbook, and comply with the National Law and National Regulations;

(b) Ms Rateau was required to ensure that all statutory requirements were complied with;

(c) Kidstart was responsible for ensuring all necessary instructions were provided to Ms Rateau to carry out the Services; and

(d) Kidstart was to authorise staff/personnel to be available to instruct and assist Ms Rateau as required to perform the Services.

13.18 Ms Rateau understood when signing the subcontract that she had an obligation to comply with Kidstart's policies contained in the Kidstart Handbook. However, Kidstart did not provide these policies to Ms Rateau before she signed the subcontract; instead, they were provided after Ms Rateau moved to the Randwick Property in December 2017.

Registration of other staff operating from the Randwick Property

13.19 On 22 December 2017, Ms Hanuliakova registered as an Educator with Kidstart. She recalls signing a document with a Kidstart logo in the presence of a woman from Kidstart. However, Ms Hanuliakova could not recall if Ms Trad or any representative from Kidstart explained the contents of the document that she signed. Notwithstanding, Ms Hanuliakova understood that signing these documents was necessary in order to work for Ms Rateau.

13.20 According to Ms Trad, she understood that Ms Rateau wanted to open up a "*second room*" at the Randwick Property and needed a second Educator in order to do so. Ms Hanuliakova registered with Kidstart on the same day that Ms Trad conducted her initial inspection of the Randwick Property.

13.21 Ms Hanuliakova explained her understanding of the working arrangement with Ms Rateau in this way:

> When she's Educator as well, I'm the Educator, so that's mean we altogether we can have eight kids. Because I was register as an Educator assistant, and that's mean I can have like a – it's not like I'm responsible for only my four certain kids and I'm looking just my four certain kids. We are just altogether is like childcare centre […] So, we were two, so she can have, like, ratio eight kids. But it's not like…like only I was looking my certain four kids. It, it doesn't work like this. We work altogether.

13.22 Ms Hanuliakova gave evidence that she understood Ms Rateau to be her boss. Ms Hanuliakova also understood that four of the children were legally her responsibility, but also believed that she was just employed to assist Ms Rateau. Notwithstanding, Ms Rateau accepted that she never told

Ms Hanuliakova that she had statutory obligations as an Educator, or provided her with any training in relation to her role as an Educator.

13.23 Ms Rateau paid Ms Hanuliakova a salary of $200 per day, which was paid by Ms Rateau and not Kidstart. Ms Rateau explained that Ms Hanuliakova completed her own timesheets and later had her own sign in sheet for "Harmony", the electronic application used to record timesheets for the purposes of CCS payments. Notwithstanding, Ms Hanuliakova did not understand that she would be registered with DESE so that parents could obtain CCS payments, and she did not receive any payments from Kidstart.

13.24 Ms Das completed an assistant registration form on Kidstart letterhead dated 8 August 2018. This form identified the Randwick Property and listed Ms Rateau as her employer and Ms Hanuliakova as her colleague, with both named as referees. According to a document produced by Kidstart, Ms Das was registered with Kidstart on 10 August 2018 and operated from 7:30am to 5:00pm at the Randwick Property.

13.25 Ms Cass submitted an application to be registered as an Educator with Kidstart which appears to be dated 11 May 2018. She had an approved diploma level education and care qualification. According to an Educator register, Ms Cass was registered with Kidstart to work from the Randwick Property between 4 June 2018 and 7 September 2018. DESE records indicate that Ms Cass conducted sessions of care at the Randwick Property from 18 June 2018 to 3 September 2018.

13.26 DESE records indicate that Amy Robinson was an enrolment Educator for a single child who was enrolled for care at the Randwick Property. Given that this child is the twin sister of another child, who also commenced being cared for at the Rhythm and Rhyme Centre on the same day, it is unlikely that two different Educators enrolled each child. Despite a subpoena being issued to Kidstart for production of the Educator register and payment summaries for Ms Robinson (among others), no such documents were produced. Ms Robinson also did not appear on the session Educator datasets, suggesting that she did not provide any care from the Randwick Property. This is consistent with Ms Rateau's evidence that she had no recollection of working with Ms Robinson. Ms Robinson's name was included in the list of Educators who appeared to operate in breach of child ratios provided as part of the DESE Referral. Following Jack's death, the Department conducted a visit to Amy's residence as part of its targeted campaign. This visit identified a number of issues of non-compliance, including:

(a) It took Ms Robinson several minutes to locate the first aid kit;

(b) Emergency evacuation drills had not occurred every three months as required by the National Regulations;

(c) Ms Robinson's CPR qualification expired on 24 April 2017, some two years before the visit was conducted on 7 March 2019;

(d) A number of harms and hazards were identified, including "*potentially hazardous placement of beds and play equipment*"; and

(e) Ms Robinson was unable to produce a record of her own current WWCC.

13.27 **Conclusion:** The evidence establishes that the monitoring and supervision by Kidstart of Educators at the Rhythm and Rhyme Centre was inappropriate and deficient in a number of respects. Ms Rateau was approved as an Educator without first meeting any of the directors of Kidstart, and was not provided with relevant policies and procedures so that she understood her obligations with respect to the care of children prior to signing her subcontract.

13.28 Further, the available documentary material appears to be inconsistent with the understanding of Educators, such as Ms Hanuliakova, as to their responsibilities and statutory obligations. It is a clear safety issue that Ms Hanuliakova was unaware that she had been registered as an Educator (in circumstances where she believed she was simply assisting Ms Rateau) and accordingly unaware of the statutory responsibilities of that role. It is equally concerning that Kidstart, Ms Trad and Ms Rateau allowed Ms Hanuliakova to operate under this misunderstanding. In addition, the issues of non-compliance identified by the Department regarding care provided by Ms Robinson also demonstrates an absence of appropriate monitoring and supervision by Kidstart.

Number of children cared for at the Randwick Property

13.29 During 2018, up to eight children were being cared for at the Rhythm and Rhyme Centre. Ms Trad gave evidence that she could not remember if this many children were cared for at the Rhythm and Rhyme Centre, but that the only time Ms Rateau "*would have*" had that many children was when she had the "*second room*" and a second Educator. The evidence establishes that Ms Trad also knew that more than eight children were being cared for at the Rhythm and Rhyme Centre throughout 2018.

13.30 Ms Rateau gave evidence that if Kidstart had told her she was not allowed to have a second Educator operate from the Randwick Property she would not have done so. However, Ms Rateau conceded that she did not confirm with the Department herself whether or not she was allowed to have eight children at the Rhythm and Rhyme Centre, provided that there were two Educators present.

13.31 Ms Trad and Ms Shamsin gave evidence to the effect that up to eight children were allowed to be cared for at the Randwick Property, provided there were two Educators at the residence. Ms Trad originally acknowledged that, as Kidstart's Nominated Supervisor, she was aware that only four children under preschool age could be cared for at the Randwick Property. However, Ms Trad also asserted that she could not recall the ratio of children permitted, that she knew there were eight children when both Educators were there, and that she did not know that Ms Rateau was not permitted to operate from another room on the premises.

13.32 Ms Shamsin gave evidence that the Department had provided information to Kidstart to the effect that two Educators could work out of the same residence in South Coogee. Ms Shamsin acknowledged that it was her understanding that in order for more than one Educator to operate from a single property, there had to be separate facilities (toilet, kitchen and sleeping areas) for the two separate day cares.

13.33 However, the Randwick Property did not have the necessary facilities for more than one Educator to operate from that premises. Only four portable cots were set up in the main house, the property only had one bathroom, and the garage (which had been converted into a playroom) had no toilet, sink or food preparation area. Further, Ms Hanuliakova gave evidence that she and Ms Rateau shared the care for all children attending the Randwick Property.

13.34 The Randwick Property contained a converted garage which had been renovated into a playroom to be used as part of the education and care Service. Following this renovation, Kidstart gave approval for a second family day care centre to operate from the Randwick Property. Ms Rateau recalled that this approval was given around the beginning of 2018.

13.35 Mr Cheema gave evidence on behalf of the Kidstart that no approval was sought from Ms Rateau to convert the garage. However, contemporaneous emails indicate that on 30 November 2017 an email was sent from a Kidstart email address to Ms Rateau. Ms Shamsin conceded that it was likely she sent the email, which noted the following:

> Just following up on our conversation regarding opening up a second room in your house. Is the plan still to do this?
>
> I'm not sure if you are aware but we have a limit on the amount of Educators we can have in our scheme – 60 Educators. We are nearing that amount so we just want to see if your plan is still to do this so that we can keep a position available for the Educator you place in this room.

13.36 On 5 December 2017, Kidstart followed up with Ms Rateau regarding documentation for the second Educator. On 22 December 2017, Ms Hanuliakova registered as an Educator with Kidstart to operate from the Randwick Property. Therefore, the evidence indicates that Ms Rateau did seek approval for a second Educator, and that Kidstart granted that approval.

13.37 The evidence also indicates the following in relation to the renovation of the garage into a playroom:

(a) Ms Ingram recalls seeing the garage during her tour and thought it looked like "*it was set up for an arts and crafts room for children*";

(b) Ms Hanuliakova recalls taking children into the converted garage to play, paint and draw, particularly on rainy days;

(c) Joseph recall seeing the garage set up like a playroom when he and Margot toured the Rhythm and Rhyme Centre;

(d) The converted garage did not have a sleeping area. Ms Trad initially gave evidence that she knew there were no cots or bedding in the garage, but later revised her evidence to indicate that she could not recall.

13.38 There are significant discrepancies between the evidence of Ms Shamsin and Ms Trad regarding the Randwick Property. On the one hand, Ms Shamsin gave evidence that:

(a) Ms Trad had assessed the property and deemed that it was suitable for two Educators to operate from;

(b) Ms Trad had told her that there was an outside toilet on the Randwick Property which satisfied the requirements for multiple Educators to operate from the property; and

(c) a second Educator only operated from the Randwick Property for about a month.

13.39 In contrast, Ms Trad gave the following evidence:

(a) She agreed that the Randwick Property was a single residence; and

(b) She conceded that the Randwick Property remained a single residence following the garage conversion, as the garage did not have bathroom or cooking facilities.

13.40 The evidence establishes that Kidstart, through Ms Trad and Ms Shamsin, could not have reasonably believed that more than one Educator was permitted to operate from the Randwick Property. The contemporaneous records of Ms Trad's discussions with the Department negate any suggestion that Kidstart could have reasonably believed that this arrangement had been sanctioned by the Department.

13.41 **Conclusion:** It is evident that having two Educators operate from a single residence makes the family day care business more profitable, as well as increasing the fees earned by the Approved Provider. Ms Rateau gave evidence that she was directly told that one other Educator connected with Kidstart had a similar arrangement where multiple Educators were operating from one premises, and that she heard rumours that "*quite a few Educators*" had this arrangement.

13.42 Whilst Ms Shamsin denied that Kidstart had a business model involving multiple Educators operating from one residence, she confirmed that there were about three households that operated this way. The available evidence indicates that Kidstart had a practice of permitting multiple Educators to operate from one residence. The practice of doing so establishes that Kidstart prioritised the profitability of its family day care Service over compliance with the NQF. Therefore, Kidstart failed to take reasonable steps to ensure the safety, health and well-being of children in the care of its Service.

Home visits conducted by Kidstart

13.43 Kidstart conducted seven inspections of the Randwick Property during the period that Ms Rateau operated from it. Although the Kidstart Policy indicated that Educators would be visited by a coordinator on a monthly basis, and that unannounced visits would be made to Educators at least every four weeks, the evidence establishes that, in practice, the following occurred:

(a) Ms Trad was the only person employed by Kidstart who conducted hazard reduction checks. Relevantly, Ms Trad was the only person to conduct checks of Ms Rateau's residence.

(b) Ms Trad would also conduct regular visits to check the ongoing safety of a residence.

(c) Kidstart would send Ms Trad a list of Educators to visit each week, or each month.

(d) Ms Trad told Ms Shamsin in about 2017 that there were too many Educators for her to be visiting on her own. Ms Trad gave evidence that Ms Shamsin asked what she was struggling with, and that "*all [Ms Trad] need[s] to do is go out and make sure the place is in order*".

Visits to the Rhythm and Rhyme Centre

13.44 On 22 December 2017, Ms Trad conducted an initial inspection of the Randwick Property, and completed a hazard reduction checklist (**First Hazard Reduction Checklist**). Mr Shamsin gave evidence that either he, Mr Cheema or one of the coordinators would likely have checked the checklists. Mr Shamsin also asserted that they each had qualifications to do so because they held a Certificate III and/or a diploma in childcare.

13.45 Ms Shamsin gave evidence that Kidstart would review the hazard reduction checklists and consult with Ms Trad regarding items that needed resolution. Ms Shamsin also indicated that Kidstart would remind Educators that they could not commence working if an outstanding item had not been signed off by Ms Trad. Notwithstanding this, Ms Shamsin also gave evidence that Ms Trad's completion of the hazard reduction checklists could not be cross checked unless a person from Kidstart physically visited an Educator residence. However, it was Ms Trad's sole responsibility to visit the residences.

13.46 Ms Trad completed a further six home visit checklists for the Rhythm and Rhyme Centre between March 2018 and March 2019. The Home Visitor Log for each visit indicates the following:

(a) 29 March 2018, which states she attended for 1 hour, 10 minutes;

(b) 24 May 2018, which states she attended for 1 hour, 10 minutes;

(c) 24 July 2018, which states she attended for 1 hour, 1 minute;

(d) 18 September 2018, which states she attended for 48 minutes;

(e) 27 November 2018, which states she attended for 1 hour, 14 minutes. On this occasion, it was noted that Ms Rateau's First Aid, Asthma and Anaphylaxis Certificates were displayed (notwithstanding that Ms Rateau's CPR certification had expired at this time); and

(f) 24 January 2019, which states she attended for 57 minutes. On this occasion, it was again noted that Ms Rateau's First Aid, Asthma and Anaphylaxis Certificates were displayed (notwithstanding that Ms Rateau's CPR certification had expired at this time). Ms Trad also completed a second hazard reduction checklist (**Second Hazard Reduction Checklist**) on this occasion.

13.47 The home visit checklists completed by Ms Trad describe her as a "*coordinator*". However, Ms Trad gave evidence that she was never a family day care coordinator and that she attended visits at the Randwick Property in her capacity as Nominated Supervisor. There is no evidence that another coordinator accompanied Ms Trad on her visits to the Randwick Property.

13.48 The evidence establishes the following in relation to Ms Trad's visits to the Randwick Property:

(a) The contemporaneous documents and Ms Trad's evidence confirm that visits were conducted at the Randwick Property every two or three months. Ms Trad would also occasionally attend the Randwick Property to see Ms Rateau and drop off documents. The frequency of these visits contravened the Kidstart Policy, which required, among other things, an unannounced visit to Educators every four weeks.

(b) Ms Shamsin, in her evidence, denied any such breach. She asserted that there was a distinction between a visit and a safety check. According to Ms Shamsin, Ms Trad conducted a safety check once every two months, but also visited Ms Rateau by dropping in to see her for about 10 minutes, once per month. This evidence is inconsistent with other evidence, namely Kidstart's QIP which stated that an Educator's emergency equipment will be checked during monthly visits, and Kidstart's representation to the Department that Ms Trad paid "*meticulous attention to detail*" when performing monthly visits. Both of these matters would not in any way amount to a 10 minute drop in to an Educator. Further, Ms Shamsin and Kidstart could not have reasonably believed that Ms Trad had capacity to conduct adequate monthly checks on Educators in circumstances where she was employed elsewhere in a full-time senior role.

(c) The documented records of the home visit checklists indicate that Ms Trad was present at the Randwick Property for, on average, an hour each visit. Examination of individual checklists reveals that on occasion (for example on 29 March 2018) Ms Trad recorded a number of children signed in with Ms Rateau, but did not record any children signed in with Ms Hanuliakova. Further, some items were incorrectly marked as complete on all six checklists. For example, on each checklist Ms Trad marked the sign in on the visitors log as being complete. However, the visitors log itself shows that Ms Trad herself did not sign in on 24 November 2018 or 24 January 2019 (the last two home visit checklists). Relevantly, Ms Trad marked the first aid certificate item on the checklist as complete after 17 October 2018 in circumstances where she did not check that Ms Rateau had in fact renewed her CPR qualification. Ms Trad accepted that by marking this item as complete, she did not undertake a thorough check when visiting Ms Rateau.

13.49 Ms Rateau gave evidence that Ms Trad's visits were perfunctory and short, lasting between 10 to 15 minutes at most. According to Ms Rateau, the only time that Ms Trad stayed longer was during the initial inspection in December 2017. Although Ms Rateau gave evidence that Ms Trad was conducting visits to "*make sure that everything was okay*", Ms Rateau also indicated that Ms Trad would "*chat*" with her. This usually amounted to talking about work, the children, and personal matters. Ms Rateau noted that Ms Trad did not go through the Randwick Property and inspect the different rooms during her visits.

13.50 Ms Hanuliakova gave evidence that a woman from Kidstart visited the Randwick Property approximately once per month, and stayed for around 30 minutes. During this time, the woman would walk around the house and speak to Ms Rateau, checking the facilities around the house.

13.51 Ms Trad denied that she never stayed longer than 10 to 15 minutes at the Randwick Property. Ms Trad gave evidence that she spent a "*fair bit of time with [Ms Rateau]*", including sitting down and helping her on several occasions. Ms Trad also gave evidence that most of the time Ms Rateau did not accompany her as she walked through the house.

13.52 Ms Shamsin gave evidence that Kidstart used compliance software for Ms Trad to complete her home visit checklists. According to Ms Shamsin, she was able to see which residences Ms Trad visited, and the logged time spent at each house. Ms Shamsin referred to an example of a day when Ms Trad visited two Educators in the Eastern suburbs. By noting the logged time at each residence, and the distance between the residences, Ms Shamsin indicated that she formed the view that Ms Trad was spending sufficient time at each residence.

13.53 Ms Trad also referred to completing the home visit checklists using an app on her phone. However, Ms Trad was unable to recall the name of the app or describe its functionality. Ultimately, the evidence of Ms Shamsin and Ms Trad in this regard does not assist in determining whether Ms Trad spent sufficient time at the Randwick Property so as to conduct an effective visit.

13.54 There is no prescribed time required for a home visit under the NQF and it is self-evident that different coordinators may perform such a task differently. Ms Dodd-Gilhooly gave evidence that a home visit to a family day care Service should take between 60 to 90 minutes.

13.55 **Conclusion:** The evidence indicates that Ms Trad was likely present at the Randwick Property for more than 10 or 15 minutes on the occasions that she conducted home visits. After checking in which children had signed in with Ms Rateau, and discussing matters relating to the family day care Service and of a personal nature, it is likely that this took more than 10 or 15 minutes. However, it is evident that when she conducted a home visit, Ms Trad completed the Home Visitor Log to represent that she was at the Randwick Property for longer than she actually was.

13.56 Regardless of the time Ms Trad spent at the Randwick Property, it is also evident that Ms Trad did not conduct a thorough or adequate safety check. This is evident from Ms Trad's failure to note Ms Rateau's lapsed CPR certificate, her failure to record the children in the care of a second Educator, and her incorrect marking of the visitor log sign in as being complete, when she herself did not sign in during the November 2018 and January 2019 visits.

13.57 Instead of performing any meaningful supervision and training of Educators, including Ms Rateau, the home visits conducted by Ms Trad were inadequately brief, and involved discussions of a largely personal nature. Indeed, Ms Rateau gave evidence that on occasion Ms Trad left her car on the street, still running, entered the Randwick Property to sign the visitors log, say a quick hello, and then departed. There is little evidence that the visits conducted by Ms Trad complied with her statutory obligations or fulfilled her responsibilities as Nominated Supervisor in relation to the Rhythm and Rhyme Centre Educators.

Inspection of the sleep facilities at the Rhythm and Rhyme Centre

13.58 When completing the hazard reduction checklists, Ms Trad used a colour coding system to indicate the level of risk for each item: red indicated that there was a hazard, amber indicated that an issue was being worked on, and green indicated that something was "*good to go*", with no changes required.

13.59 On 22 December 2017, Ms Trad completed the First Hazard Reduction Checklist which contained the following check:

> Do cots comply with AS/NSZ 2172? Does bedding conform to state and territory legislation?

13.60 In response, Ms Trad marked the item as green and wrote in the comments:

> - 4 portable cots
> bassinet

13.61 Ms Trad gave evidence that she wrote the above comment because she saw four portable cots and a bassinet at the Randwick Property on that day. Ms Trad gave evidence that her understanding as a Nominated Supervisor was that bassinets were not safe for babies older than three months. Further, Ms Trad indicated that Ms Rateau did not have any babies in her care younger than three months at any time while Ms Trad was supervising her.

13.62 Ms Rateau acknowledged that she did own a bassinet at the time that Ms Trad completed the First Hazard Reduction Checklist, and that it was being used at the Randwick Property. When asked why she considered that it was safe for Ms Rateau to use a bassinet, Ms Trad indicated the following:

> Well she didn't have children young enough to use a bassinet, so I mean, you know, being there, I don't see a problem with it, and sometimes the kids would use it, you know, for putting dolls to sleep or something, but I can't like, I mean, it was there, I didn't know she was using a bassinet.

13.63 However, later in her evidence, Ms Trad indicated that she did not know what Ms Rateau was using the bassinet for, that she knew that Ms Rateau did not have babies young enough to be using the bassinet, but that Ms Rateau might have enrolled a younger baby, at which point a bassinet would have been suitable. It was suggested to Ms Trad that by including the bassinet on the First Hazard Reduction Checklist she was acknowledging that it would be used as a form of bedding for a child. However, Ms Trad asserted that she did not know why Ms Rateau had the bassinet but speculated that perhaps it would be used by her for a younger child. Ms Trad specifically denied that the bassinet presented an obvious risk, noting: "*It doesn't say anywhere in the regulation that she can't have a bassinet on premises*". Ms Trad gave evidence that it would have been "*simply different*" if she had known Ms Rateau was going to be using the bassinet for sleeping.

13.64 Given that the relevant question in the First Hazard Reduction Checklist directed attention towards compliance with the relevant Australian Standard, and whether bedding at the premises conforms to applicable legislation, it is improbable that Ms Trad would have made a note of the bassinet if she considered that it was only being used as a toy. Further, if Ms Trad considered that the bassinet was not being used for bedding, but could be for a child younger than three months old, this

should have been noted on the First Hazard Reduction Checklist, or Ms Trad should have spoken with Ms Rateau about it.

13.65 Significantly, if Ms Trad visited the Randwick property on 24 January 2019 as she claimed (but failed to sign in), she failed to notice that Jack had been enrolled with the Rhythm and Rhyme Centre on 15 January 2019, and was due to commence care with Ms Rateau on 3 March 2019. If Ms Trad had noticed these details it could have and should have prompted a discussion with Ms Rateau regarding sleeping arrangements, and risks associated with the potential use of the bassinet.

13.66 In addition:

(a) Ms Rateau could not recall ever having a conversation with Ms Trad about the bassinet, during the initial, or any subsequent, visit to the Randwick Property;

(b) Ms Trad gave evidence that she never spoke to Ms Rateau about the bassinet, but would have done so if she had known that Ms Rateau was going to be using it; and

(c) Ms Shamsin acknowledged that she never spoke to Ms Rateau about the bassinet, even though the First Hazard Reduction Checklist identified it as among the bedding to be used, despite having opportunities to raise it with her.

13.67 Ms Shamsin gave evidence that she reviewed the First Hazard Reduction Checklist and called Ms Trad to discuss the sleep arrangements that had been marked as green and, in particular, the Red Nose Australia guidelines about when a bassinet could be safely used. According to Ms Shamsin, Ms Trad told her that the bassinet would only be used for play, and not as bedding. Ms Shamsin indicated that she wanted it to be made clear to Ms Rateau that the bassinet was not to be used for bedding unless in accordance with Red Nose guidelines (that is, a bassinet is not to be used for children older than six months, and not to be used at all once a child can roll, regardless of age). Ms Shamsin gave evidence that she was under the assumption that Ms Trad would speak to Ms Rateau about these matters.

13.68 Ms Shamsin agreed that, as a person with management and control the family day care, she was responsible for ensuring that Ms Rateau was given a direction not to use a bassinet for babies that could roll. However, Ms Shamsin said that this responsibility was satisfied by giving a direction to Ms Trad to speak with Ms Rateau. Ms Shamsin acknowledged that at no point did she follow up with Ms Trad to confirm that this conversation had in fact occurred, despite knowing at the time that the bassinet was a hazard to children who are able to roll. Further, Ms Shamsin was of the view that she was not obliged to ensure that the conversation did occur.

13.69 Counsel for the directors of Kidstart did not put to Ms Trad in cross-examination that she had been given such a direction by Ms Shamsin. Following the conclusion of the oral evidence in the inquest, Ms Trad prepared a statutory declaration in which she stated that she could not recall discussing the First Hazard Reduction Checklist with Ms Shamsin at any time, or being instructed by Ms Shamsin to have a conversation with Ms Rateau about the bassinet.

13.70 Ms Shamsin's evidence that she instructed Ms Trad to speak to Ms Rateau about the use of bassinets, is inconsistent with her other evidence as to the extent to which she relied upon, and deferred to, Ms Trad in relation to decision-making regarding safety issues. Ms Shamsin's evidence is also not consistent with other evidence regarding her minimal level of involvement in relation to the Randwick Property. If Ms Shamsin had truly been concerned by the presence of a bassinet at the Randwick Property, it is most likely that she would have made enquiries to confirm that Ms Rateau was only using it for children who could not roll and no other circumstances. Ms Shamsin could have confirmed this by speaking to either Ms Trad or Ms Rateau. However, Ms Shamsin conceded that she did not speak to either (after the initial purported discussion with Ms Trad).

13.71 Even if Ms Shamsin did give Ms Trad such a direction, they both failed to take reasonable precautions to ensure that the children in Ms Rateau's care were safe from harm and hazards, in breach of their obligations under the NQF and section 167 of the National Law in particular. There is no dispute that Ms Trad did not discuss safe or appropriate use of the bassinet with Ms Rateau, regardless of whether or not she was directed to do so by Ms Shamsin. Further, it was not reasonable or adequate for Ms Shamsin to have not followed up with either Ms Trad or Ms Rateau about the bassinet, in circumstances where she knew that Ms Trad did not consider the bassinet to be a risk, and where she knew that the ages of children in Ms Rateau's care were consistently six months and above.

13.72 Ms Trad gave evidence that she would sometimes be at the Randwick Property when Ms Rateau was putting children to sleep, but never physically went into the room with her when this occurred. Ms Trad also acknowledged that during her visits she never saw Ms Rateau physically check on a sleeping child.

13.73 Ms Trad also gave evidence that she could not recall if she saw the bassinet at the Randwick Property during her home visits throughout 2018 and early 2019. In the Second Hazard Reduction Checklist Ms Trad marked as green the question regarding whether cots comply with the relevant Australian Standard and whether bedding conforms to state and territory legislation.

13.74 Ms Hanuliakova gave evidence that when Ms Trad conducted her visits, the bassinets were visible in the bedrooms. Further, Ms Hanuliakova denied that the bassinets were ever hidden or put away so that Ms Trad could not see them. Therefore, Ms Trad did see, or ought to have seen, the bassinets in use during her visits, if she was conducting proper checks regarding the bedding used at the Rhythm and Rhyme Centre.

13.75 Ms Trad agreed that having eight children in a residence with a bedroom containing four portable cots created a risk of overcrowding in relation to sleeping arrangements throughout the day, and an increased risk of unsafe sleeping practices. However, Ms Trad sought to explain that Ms Rateau had a "*rotation of sleep*" so that not all children were sleeping at the same time.

13.76 Ms Shamsin initially denied that there was a real risk of unsafe sleeping practices in such circumstances. However, she subsequently accepted that such a risk may arise, depending on the ages of the children and when they were put to sleep. Ms Shamsin conceded that in such

circumstances, an Educator may use unsafe sleep practices if the children did not fall asleep on rotation.

13.77 Ms Rateau gave evidence that during the 22 December 2017 inspection she told Ms Trad that both the Sleeping Room and the Second Bedroom would be used to put children down to sleep, and that Ms Trad approved such sleeping arrangements. In contrast, Ms Trad gave evidence that it was her understanding that children would only be put to sleep in the dedicated Sleeping Room. This evidence was contradicted by Ms Shamsin, who indicated that Ms Trad told her that the beds in the Second Bedroom were also available for use.

Location of bassinet on 4 March 2019

13.78 One additional matter which arose for consideration during the inquest concerned the location of the bassinet during the tour that Ms Rateau conducted with Ms Ingram. During the tour, Ms Rateau and Ms Ingram walked past the Second Bedroom which had its door open. Ms Ingram gave evidence that she had no recollection of seeing a bassinet or Moses basket in the Second Bedroom, or anywhere in the house, during the tour, and that she would have remembered seeing one due to her concerns about safety. Ms Ingram also gave evidence that if she had seen a bassinet or Moses basket she would have made an enquiry with Ms Rateau regarding it, as she did not use one for her own child.

13.79 During her interview with police Ms Rateau indicated that the bassinet was in the same position in the Second Bedroom as when Jack had been placed down for his second nap. Police scene photos taken on 4 March 2019 show that the bassinet was placed in the middle of the Second Bedroom and visible from the doorway to the room. Ms Rateau denied in evidence that she hid the bassinet from view during Ms Ingram's tour.

13.80 It was submitted on behalf of Ms Rateau that in her evidence Ms Ingram did not express certainty (as opposed to indicating an absence of recollection) in not seeing a bassinet in the Second Bedroom touring her tour. In addition, it was submitted that Ms Ingram may have "*processed*" the bassinet as a toy, and not noticed it within the Second Bedroom, and that (from the scene photos taken of the Second Bedroom) it is not apparent where the bassinet could have been hidden. However, it is noted that these matters were not put to Ms Ingram in evidence, and that there was no evidence as to the capacity for a bassinet to be hidden in the Second Bedroom, or elsewhere in the Randwick Property.

13.81 It was also submitted on behalf of Ms Rateau that because Ms Rateau did not consider putting babies to sleep in bassinets to be unsafe, there would have been no reason for her to hide the bassinet during Ms Ingram's tour. It is noted that a statement of agreed facts was prepared as part of Ms Rateau's criminal prosecution. These facts stipulated that Ms Rateau placed Jack to sleep in "*an unsuitable bassinet instead of a cot*" on 4 March 2019. Ms Rateau gave evidence that (with the assistance of her legal representatives) she was involved in the finalisation of these facts, and agreed with their content when pleading guilty to the criminal charges. It was submitted on behalf of Ms Rateau that Ms Rateau's acceptance of these facts was only after the event and for the purposes of sentence proceedings. However, it is clear from the criminal proceedings that by pleading guilty Ms Rateau accepted a failure on her part to ensure adequate supervision of Jack on

4 March 2019. An understanding of the unsuitability of the use of the bassinet on the part of Ms Rateau is clearly a matter relevant to the issue of adequate supervision.

13.82 Further, and in support of the above, the evidence demonstrates that prior to 4 March 2019, Ms Rateau did not inform parents considering enrolling their children at the Rhythm and Rhyme Centre that a bassinet was used to place babies in for naps. Instead, the evidence established that Ms Rateau's typical practice was to indicate that the Sleeping Room was the primary location where children would be put to sleep, with "*older children*" only occasionally put to sleep in the Second Bedroom.

13.83 **Conclusion:** In her role as the Nominated Supervisor, Ms Trad failed to properly assess the Randwick Property in relation to safe sleeping practices. Ms Trad's evidence that she considered the bassinet that she saw at the Randwick Property to be a toy or to be used by children for play is entirely inconsistent with her making a note of it on a hazard reduction checklist. Further, Ms Trad gave evidence that she considered no action was required by her regarding the bassinet because she was aware that there were no children in Ms Rateau's care who were young enough to use it. This represented a significant lack of awareness as to the safety risk which the bassinet posed. That is, it might be inappropriately used for children who were too old/big, or capable of rolling, to sleep in it.

13.84 Further, the inadequacy of Ms Trad's supervision and inspection of the sleeping facilities at the Randwick Property meant that there was a missed opportunity to identify a potential risk in relation to the use of a bassinet before Jack commenced enrolment with the Rhythm and Rhyme Centre. Had this opportunity been taken, it should have led to a meaningful discussion between Ms Trad and Ms Rateau about what safe sleeping practices should be implemented.

13.85 Further, Ms Trad knew, or ought to have known, that the Second Bedroom was being used by Ms Rateau to put children down to sleep. In her role as Nominated Supervisor, Ms Trad ought to have discussed Ms Rateau's bedding choices with her, given the risk of unsafe sleeping practices. In relation to having more children than cots at the Randwick Property, Ms Rateau gave evidence that Ms Trad never asked her about the sleeping arrangements or safety precautions at the Rhythm and Rhyme Centre, and never gave her information or a direction about the use of portable cots, as compared to permanent cots. Having regard to these matters, Kidstart's supervision of the sleep practices adopted by Ms Rateau was inadequate.

13.86 It is accepted that Ms Hanuliakova gave evidence that the bassinets were never hidden or put away during Ms Trad's visits. However, given that Ms Hanuliakova was not present on 4 March 2019 this does not discount the possibility that the bassinet was hidden during Ms Ingram's tour. It is accepted that Ms Rateau was a vulnerable witness and that she had certain difficulties answering specific questions relating to the events of 4 March 2019. In particular, Ms Rateau was unable to directly answer questions regarding whether as at 4 March 2019 she considered it to be unsafe to put Jack to sleep in a bassinet. Instead, Ms Rateau gave evidence that she would not have done so if she felt that Jack was unsafe.

13.87 The evidence establishes, at the least, that Ms Rateau considered it to be unsuitable to use a bassinet to put Jack to sleep on 4 March 2019. Whether this recognition of unsuitability related to the rotational sleeping practices in use at the Rhythm and Rhyme Centre and the use of the Second Bedroom to put children to sleep, or the use of a bassinet for a child of Jack's age, size and stage of development, or both, is not entirely clear. Notwithstanding, both issues themselves are relevant to safe sleeping practices. Given the unchallenged evidence of Ms Ingram, and the evidence which establishes that Ms Rateau did not inform prospective parents of the use of the bassinet at the Rhythm and Rhyme Centre, it is most likely that Ms Rateau did hide the bassinet during Ms Ingram's tour on 4 March 2019, and did so because she was aware of its unsuitability.

Training provided by Kidstart

13.88 The Kidstart Policy represented that Kidstart would provide the following training to its Educators:

(a) induction training by Kidstart staff who held a certificate IV in training, covering:

(i) The key principles for family day care, including how many children can be cared for;

(ii) Kidstart's policies and procedures "*to ensure adherence by Educators*";

(iii) Child development workbooks, which were a template for the learning objectives of a child;

(iv) Risk mitigation strategies and business planning; and

(b) ongoing training via appropriately qualified external trainers, and regular in-house training

13.89 As part of its criminal prosecution, Kidstart admitted that it had failed to:

(a) properly train and monitor Ms Rateau to ensure that she had full knowledge and understanding of policies, procedures and guidelines; and

(b) Provide "*refresher training*" on Kidstart policies and best practice procedures relating to protecting children from harm and hazards, specifically relating to sleep practices and procedures prior to 4 March 2019.

13.90 As to induction training:

(a) Ms Rateau gave evidence that Kidstart did not provide her with any type of induction or introductory process;

(b) Ms Trad denied that Ms Rateau was not provided with any induction prior to beginning with Kidstart. Rather, Ms Trad gave evidence that she performed an induction that took around an hour, and which involved speaking with Ms Rateau about her goals, how to grow and improve her business, what is required to take children on excursions, and went through the Educator "folder" (without being able to recall what documentation was included in the folder);

(c) Mr Shamsin gave evidence that Ms Trad completed an initial induction checklist on behalf of Kidstart; and

(d) Ms Shamsin gave evidence that the induction process involved Ms Trad giving the Educator a start-up pack and familiarising the Educator with Kidstart's policies and procedures. However, Ms Shamsin conceded that she did not contact Ms Rateau to confirm whether she had been properly inducted.

13.91 Although there is evidence that Ms Rateau spoke with Ms Trad which she first began with Kidstart, and that Ms Rateau received the Kidstart Handbook, there is no evidence of any extensive initial training occurring in relation to Ms Rateau.

13.92 Ms Dodd-Gilhooly gave evidence that the induction of new Educators with the Waverley Family Day Care involves a six to eight week program, comprising of some components of Certificate III studies and supervising the Educator in a play session with children. For comparison purposes against this type of program, it is apparent that Kidstart did not provide a thorough induction and training for its new Educators.

13.93 In relation to ongoing training, Ms Rateau gave evidence that Kidstart did not provide her with any such training while she was registered with them. Further, Ms Rateau indicated that Ms Trad did not provide any face-to-face training during any of the home visits that she conducted. Although Ms Trad denied that it was any part of her role to provide training to Educators (a position which differed from the evidence given by Mr Shamsin and Ms Shamsin), Ms Trad's evidence indicates that she was not in fact providing any ongoing training to Educators.

13.94 Ms Hanuliakova gave evidence that Kidstart did not provide her with any training about their policies relating to safety for children, and that she never met with a representative of Kidstart on her own. Ms Hanuliakova also indicated that she received no training to "*like really teach you to do the job*", and that no one from Kidstart explained to her what her responsibilities as an Educator were.

13.95 There is some evidence that Kidstart provided training to Educators through other persons:

(a) Ms Shamsin gave evidence that Kidstart employed a person named Simi Santosh for about 10 months in 2017 to provide educational training programs to Educators at their residences;

(b) Between March 2017 and January 2019 Kidstart sent 12 emails to registered Educators (including Ms Rateau and, occasionally, Ms Hanuliakova) providing reading material, updates from ACECQA and instructions regarding electronic submissions of timesheets.

13.96 Notwithstanding the above, Ms Rateau's evidence is that she only ever spoke with Ms Trad or Ms Shamsin from Kidstart.

13.97 **Conclusion:** The evidence establishes that Kidstart did not provided regular or comprehensive ongoing training to its Educators. An education training program conducted over approximately 10 months, and periodic emails enclosing information or reading material could not be said to constitute comprehensive or ongoing training.

13.98 In relation to training regarding safe sleep practices, Ms Rateau accepted that Kidstart gave her a Red Nose booklet about safe sleeping policies (which Ms Rateau had seen before when she had her own children, but which she did not reread when Ms Trad gave her this copy) and that Ms Trad gave her a "*bunch of booklets and things*".

13.99 Ms Trad gave evidence that she provided Ms Rateau with a packet of information about safe sleeping, but conceded that she did not take Ms Rateau through the documents or provide an explanation of them. In this regard, Ms Dodd-Gilhooly gave evidence that she did not consider it sufficient to provide an Educator with a policy and assume that the Educator would familiarise themselves with, and adopt, that policy.

13.100 Ms Hanuliakova gave evidence that she never received any training from Ms Trad regarding sleep and rest. Further, Ms Hanuliakova said that she could not recall if she had seen the Kidstart Handbook. When shown the relevant sleep and rest section within the Kidstart Handbook, Ms Hanuliakova indicated that she had not seen it before.

13.101 **Conclusion:** Kidstart did not supervise the Rhythm and Rhyme Centre in accordance with the NQF. What supervision was provided was not reasonable, adequate or in accordance with good practice for the following reasons.

13.102 First, Ms Rateau and the other Educators at Kidstart did not receive adequate training regarding the Kidstart Policy or the Red Nose guidelines for safe sleep practices. Kidstart has admitted that it did not properly train Ms Rateau and that it did not provide her with refresher training on safe sleep practices, in breach of the NQF.

13.103 Second, Ms Trad did not conduct adequate safety checks of the residence, as demonstrated by her failure to note that Ms Rateau's CPR certificate had lapsed, and her failure to record the children in the care of a second Educator. This indicates that Kidstart failed to ensure the health, safety and well-being of children cared for at the Rhythm and Rhyme Centre were protected, in contravention of regulation 116 of the National Regulations. If Ms Trad had properly inspected the sleeping environment at the Randwick Property, she ought to have realised that Ms Rateau was not implementing Kidstart's Sleep Policy and was instead utilising unsafe sleeping practices.

13.104 Third, the evidence establishes that Ms Shamsin did not give Ms Trad a direction to speak with Ms Rateau about the use of bassinets. However, even if such a direction were given, Ms Shamsin did not act reasonably by failing to ensure that any such direction had been complied with. Ultimately, Kidstart's failure to adequately supervise sleep facilities at the Rhythm and Rhyme Centre was a factor in Jack's death. If Kidstart had given Ms Rateau a direction to stop using the bassinet, or to only use it for children under six months who could not roll, then it is likely that Jack would not have been put in a bassinet on 4 March 2019. As noted above, the expert evidence established that the size of the bassinet that Jack was placed in on this day was a significant stressor and likely contributed to his oxygen levels decreasing.

13.105 Fourth, throughout 2018, the Rhythm and Rhyme Centre operated in breach of regulation 124 of the National Regulations by having up to eight children under preschool age in attendance on a particular day. During this period Ms Trad visited the Randwick Property at least five times and observed Ms Rateau and Ms Hanuliakova caring for the eight children altogether, whilst not in separate rooms or a separate day care. In this regard, Kidstart not only failed to supervise Ms Rateau, but actively encouraged this practice by approving Ms Rateau's use of the garage and the opening up of a "*second room*". Ms Shamsin's evidence establishes that she knew that Ms Rateau was going to have a second Educator at the Randwick Property, and operate with more than the permitted number of children at the residence. Ms Trad, as Kidstart's representative, ought to have known that the arrangements at the Rhythm and Rhyme Centre contravened the National Law. In 2014, according to contemporaneous documents, Ms Trad spoke with the Department about another residence which properly had two self-contained residences, with separate entrances, sign in sheets and bathroom facilities.

13.106 As Ms Rateau was operating within relevant child ratios on 4 March 2019, it cannot be said that this failure directly contributed to Jack's death. However, given that this failure represented an ongoing breach of the NQF, which was known and permitted by Kidstart, this demonstrates Kidstart's history of inadequate supervision of the Rhythm and Rhyme Centre. Further, the continued breach of mandated ratios at the Rhythm and Rhyme Centre likely contributed to unsafe sleeping practices being adopted (namely, the use of the bassinet in the Second Bedroom, and the use of beds in the Second Bedroom concurrently with a bassinet being used in the same room).

13.107 Fifth, despite both the Approved Provider and Nominated Supervisor being aware that Ms Rateau's CPR qualification had lapsed, no attempt was made to prevent her from caring for children. It is also evident that Ms Rateau was not the only Educator who Kidstart permitted to operate with a lapsed CPR accreditation. In this regard, Kidstart did not adequately supervise it Educators, thereby placing children at risk.

14. Issue 9 – Should any changes to the regulatory regime governing oversight of Approved Providers of family day care centres be recommended?

14.1 The evidence has identified two deficiencies with the co-regulatory regime which governs oversight of Approved Providers.

14.2 First, the NQF does not require an Approved Provider to have relevant qualifications and/or experience in education and childcare. This is in circumstances where the Approved Provider is responsible for ensuring that: its Nominated Supervisor has adequate knowledge and understanding of the provision of education and care to children; appropriate policies and procedures exist for the operation of family day care centres; and Educators are supervised and trained accordingly.

14.3 Further, it is the Approved Provider and Nominated Supervisor who are subject to obligations under the NQF and subject to corresponding offence provisions of the National Law if such obligations are not met. In addition, the National Law requires that Educators are to have access to an Approved Provider, Nominated Supervisor or a person in day-to-day charge of the Service. Unless one of these identified persons has adequate knowledge of education and care matters then only minimal practical support can be provided to Educators.

14.4 Therefore, the absence of a requirement under the NQF for an Approved Provider to have relevant qualifications and/or experience in education and childcare would appear to undermine the overall objectives of the NQF, including in relation to ensuring the safety and well-being of children being cared for. Accordingly, it is necessary to make the following recommendation.

14.5 In submissions, the Department noted its support for a recommendation which seeks to enable regulatory authorities to assess an Approved Provider's knowledge of the NQF as part of the fitness and propriety requirements. However, it was submitted on behalf of the Department that qualifications are already currently assessed as part of the Provider approvals process, together with management capability and experience, and that it is preferable to have a risk-based approach to assessment that considers a range of factors rather than restricting requirements to specific qualifications and experience. Further, it was submitted that school specific teaching experience does not necessarily translate to competency in early childhood education settings. However, these matters are not mutually exclusive and the recommendation proposed below does not seek to limit the factors to be considered as part of a risk-based approach to assessment to only qualifications and experience. Rather, it seeks to ensure that relevant education and experience of an applicant for Provider approval complements that applicant's knowledge of the NQF as part of the fitness and propriety requirements.

14.6 **Recommendation 5:** I recommend that the NSW Government, in consultation with the governments of other jurisdictions under the National Quality Framework, take steps to amend the National Law and/or National Regulations to require that an applicant for Provider approval (or the persons with management and control of an applicant) must: (a) have an approved diploma level education and care qualification or an approved early childhood teaching qualification; (b) have at least three years' experience in an education and care Service or children's Service or a school or in a Service regulated under a former education and care services law; and (c) undertake a risk-based knowledge assessment administered by the Department to demonstrate an applicant has a sufficient standard of knowledge of how an education and care Service is to operate in compliance with the National Quality Framework.

14.7 Second, the Department has minimal oversight of family day care Educators, being the persons who actually provide day-to-day care. The large number of family day care Educators in NSW makes direct oversight by the Department impracticable due to resource limitations. It appears that such oversight might be enhanced if:

(a) Approved Providers are required to submit their Educator and family day care coordinator registers to the Department via the NQAITS and submit real-time updated versions. This would give the Department immediate access to information about Educators, permitting spot checks, unannounced visits to Educators (not just Services) and reducing delayed access to information;

(b) Educator registers should be required to indicate where more than one Educator is operating from a single address and which Educator is operating from what part of the property; and

(c) the Department should have a right of access to information held by DESE, where that information is relevant to children's health, safety and wellbeing.

14.8 Having regard to the above it is necessary to make the following recommendations. It should be noted that the original recommendation proposed by Counsel Assisting regarding section 269 of the National Law contemplated provision of all information contained within a family day care register. However, it was submitted on behalf of the Department that it does not require all such information, and provision of it would have "*unintended consequences*". By way of example, the submissions on behalf of the Department referred to the imposition of a requirement on the Department to directly regulate over 8,000 family day care Educators, with limited funding and resources to do so. In addition, the Department submitted that an additional consequence would be the undermining of the current co-regulatory system so as to lessen or relax the level of oversight by Approved Providers and Nominated Supervisors. These submissions are accepted, and the proposed recommendation has been amended accordingly.

14.9 **Recommendation 6:** I recommend that the NSW Government continue to work with the Commonwealth Government and other jurisdictions through the National Quality Framework review to enable a contemporaneous family day care register to capture requirements referred to in section 269 of the National Law, specifically those parts of regulation 153 of the National Regulations that relate to: (a) names and dates of birth of children attending the Service; (b) names and contact phone numbers of educators, coordinators and educator assistants; (c) days and hours of care and number of children attending per session; (d) relevant dates (for example, residence assessment date, educator commencement/end dates); (e) educators operating above ratio (and the applicable approved provider approved exceptional circumstance); and (f) Provider Digital Access numbers for family day care Educators and Coordinators.

14.10 **Recommendation 7**: I recommend that the NSW Department of Education and the Department of Education, Skills and Employment (DESE) develop and implement an information sharing protocol which may require legislative amendment, such that it provides the NSW Regulatory Authority with access to relevant information held by DESE with respect to Approved Providers and family day care Educators.

14.11 It was submitted on behalf of the Department that the NQF review is considering a number of changes to the family day care register requirements "*to enable all regulatory authorities to have real-time access to relevant [family day care] level data that could enable risk-based proactive approaches to regulation*". It is accepted that a recommendation framed in the above terms would provide support for the strengthening of these arrangements.

14.12 In their submissions, Jack's parents raised for consideration whether the penalties which applied in relation to the Department's prosecutions of Kidstart, Ms Trad and Ms Rateau were significant enough as a matter of general deterrence. In making such a submission, Jack's parents acknowledged appropriately that this issue was not one which was specifically considered by the inquest.

14.13 In submissions in reply, the Department noted that any amendment to the penalties available for breaches of the National Law and National Regulations would need to be approved by the regulatory authorities for all States and Territories. Further, it was submitted that Department is unable to unilaterally amend these penalties and any such amendment will be subject to the process of legislative change, which may take some time. However, the Department acknowledged the importance of the issue raised by Jack's parents and indicated that it "*will commit to investigating and exploring with other States and Territories whether the penalties contained within the National Law and Regulations should be reviewed*".

15. Findings pursuant to section 81 of the *Coroners Act 2009*

15.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Kate Richardson SC and Ms Kate Boyd, Counsel Assisting, and their instructing solicitors, Ms Caitlin Healey-Nash and Ms Amber Richards of the Crown Solicitor's Office. The Assisting Team has provided tremendous assistance during the conduct of the coronial investigation and throughout the course of the inquest. I am also extremely grateful for the sensitivity and empathy that they have shown throughout the course of this distressing matter.

15.2 I also thank Detective Senior Constable Lucy Vasey for conducting a comprehensive investigation and providing support to Jack's parents throughout the coronial process.

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

Identity

The person who died was Jack Loh.

Date of death

Jack died on 4 March 2019.

Place of death

Jack died at The Sydney Children's Hospital, Randwick NSW 2031.

Cause of death

The cause of Jack's death was unrecognised pulmonary hypertension in a setting of unsafe sleeping conditions, which occurred when Jack was placed down to sleep by an educator at a family day care centre.

Manner of death

Whilst cardiac investigations prior to 4 March 2019 likely would have identified Jack's underlying pulmonary hypertension, there was no clear indication from Jack's two previous presentations to hospital, or from his general medical history, for such investigations to be performed. It is most likely that placing Jack to sleep on 4 March 2019 fully clothed and loosely wrapped; in a bassinet that was inappropriate and unsafe for his age, size and stage of development, and that contained extraneous bedding material; in a room which was poorly ventilated and not temperature appropriate; and in circumstances where Jack was not regularly checked on, were all contributory factors to Jack's death.

16. Epilogue

16.1 There is no doubt that Jack's parents miss him every single day. That enormous loss is likely even more deeply felt at the time of year when these findings are being delivered, a matter of days before Christmas, when many family members will take enormous joy from simply being in the company of one another. It is truly heartbreaking to know that Jack's parents have forever been denied what many take for granted. However, there is equally no doubt that the joy that Jack brought to his parents and others, and the brightness of his life, will not diminish.

16.2 On behalf of the Coroners Court of New South Wales and the Assisting Team, I offer my deepest sympathies, and most sincere and respectful condolences to Margot and Joseph, and to Jack's extended family and loved ones for their most painful and devastating loss.

16.3 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
22 December 2021
Coroners Court of New South Wales

Inquest into the death of Jack Loh

Appendix A

Recommendations made pursuant to section 82, *Coroners Act 2009*

Recommendation 1:

I recommend that the NSW Government, in consultation with the governments of other jurisdictions under the National Quality Framework, take steps to amend the *Children (Education and Care Services) National Law (NSW*) (**National Law**) so that family day care Educators are required to undertake mandatory safe sleep training.

Recommendation 2:

I recommend that the NSW Government support the proposal under the National Quality Framework review to require that family day care Educators complete the Certificate III in Early Childhood Education and Care before they can commence as an Educator.

Recommendation 3:

I recommend that the NSW Government, in consultation with the governments of other jurisdictions under the National Quality Framework, take steps to amend the regulatory regime in relation to family day care Services so that Approved Providers are required to undertake a risk assessment in respect of an Educator's implementation of sleep and rest policies and procedures.

Recommendation 4:

I recommend that the NSW Government, in consultation with the governments of other jurisdictions under the National Quality Framework, take steps to amend the National Law and/or *Education and Care Services National Regulations (NSW)* (**National Regulations**) to expressly prohibit the use of bassinets in all early childhood education and care settings.

Recommendation 5:

I recommend that the NSW Government, in consultation with the governments of other jurisdictions under the National Quality Framework, take steps to amend the National Law and/or National Regulations to require that an applicant for Provider approval (or the persons with management and control of an applicant) must:

(a) have an approved diploma level education and care qualification or an approved early childhood teaching qualification;

(b) have at least three years' experience in an education and care Service or children's Service or a school or in a Service regulated under a former education and care services law; and

(c) undertake a risk-based knowledge assessment administered by the Department to demonstrate an applicant has a sufficient standard of knowledge of how an education and care Service is to operate in compliance with the National Quality Framework.

Recommendation 6:

I recommend that the NSW Government continue to work with the Commonwealth Government and other jurisdictions through the National Quality Framework review to enable a contemporaneous family day care register to capture requirements referred to in section 269 of the National Law, specifically those parts of regulation 153 of the National Regulations that relate to:

(a) names and dates of birth of children attending the Service;

(b) names and contact phone numbers of educators, coordinators and educator assistants;

(c) days and hours of care and number of children attending per session;

(d) relevant dates (for example, residence assessment date, educator commencement/end dates);

(e) educators operating above ratio (and the applicable approved provider approved exceptional circumstance); and

(f) Provider Digital Access numbers for family day care Educators and Coordinators.

Recommendation 7:

I recommend that the NSW Department of Education and the Department of Education, Skills and Employment (**DESE**) develop and implement an information sharing protocol which may require legislative amendment, such that it provides the NSW Regulatory Authority with access to relevant information held by DESE with respect to Approved Providers and family day care Educators.

Magistrate Derek Lee
Deputy State Coroner
Coroners Court of New South Wales
22 December 2021