Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 21/14

I, Sarah Helen Linton, Coroner, having investigated the death of ***Daniel Jarvis COOK-HILL*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth****, on* ***3 June 2014****, find that the identity of the deceased person was* ***Daniel Jarvis COOK-HILL*** *and that death occurred on* ***12 October 2008*** *at* ***House 10, Wakathuni Aboriginal Community, via Tom Price*** *as a result of smoke inhalation and burns:*

Counsel Appearing:

Sergeant L Housiaux assisting the Coroner
Ms J O'Meara (State Solicitors Office) appearing on behalf of the Department for Child Protection and Family Services
Mr P Gazia (Aboriginal Legal Service) appearing on behalf of the family of the Master Cook-Hill

TABLE OF CONTENTS

INTRODUCTION

1. Master Cook-Hill died on the morning of 12 October 2008 as a result of smoke inhalation and burns he sustained after he was trapped in a caravan that caught fire.

2. At the time of his death Master Cook-Hill was subject to a protection order (time-limited) made in the Children's Court of Western Australia on 16 October 2007, pursuant to s 28 of the *Children and Community Services Act 2004* (WA). As such, he was a child in the Chief Executive Officer's care.[1]

3. As Master Cook-Hill was a child under the care of the CEO, he was a 'person held in care' as defined in section 3 of the *Coroners Act 1996* (WA).

4. It is a mandatory requirement of 22(1) (a) of the *Coroners Act 1996* (WA) that an inquest be held into the death of a person held in care immediately before that person's death. Accordingly, I held an inquest at the Perth Coroner's Court on 3 June 2014.

5. The inquest focused primarily on the care of Master Cook-Hill in the period leading up to his death as well as the circumstances of his death.

6. The documentary evidence tendered comprised a single volume of materials.[2] Two witnesses gave oral evidence expanding upon that information, namely Detective Sergeant Dave Gorton, who investigated the death, and Ms Cheryl Barnett on behalf of the Department for Child Protection and Family Services (the Department). There were no areas of controversy in the evidence given.

[1] Section 30(b) *Children and Community Services Act 2004* (WA).
[2] Exhibit 1.

BACKGROUND OF THE DECEASED

7. Master Cook-Hill was born on 4 July 2005 to Jasmin Ethel Dora Duxie Cook and Daniel Ross Hill.[3] He was their only child together, although the deceased did have a number of half-siblings as a result of Ms Cook and Mr Hill having children with other partners.[4]

8. The Department had an extensive history of contact with the family for reasons that raised concerns for Master Cook-Hill's safety and care.[5]

9. Following an investigation, on 26 October 2006 the Department substantiated emotional harm for Master Cook-Hill from his parents. This did not precipitate the Department taking any action at that time to remove him from his parents' care.[6]

10. However, on 18 December 2006 a further investigation again substantiated emotional harm for Master Cook-Hill. An assessment of an incident that occurred two days previously, together with a consideration of the cumulated incidents over time, led the Department to bring Master Cook-Hill into provisional care at that time.[7]

11. He was initially placed with a Departmental foster carer, followed by placement in a Family Group Home in Albany.[8]

12. On 22 December 2006 the Department facilitated Master Cook-Hill's placement with his maternal grandmother, Ms Joyce Drummond. Ms Drummond lives at the Wakathuni Community, 27 kilometres south of Tom Price.[9]

---

[3] Exhibit 1, Tab 23 [7].
[4] Exhibit 1, Tab 18, Tab 23 [9].
[5] Exhibit 1, Tab 23 [8], [17], [19] – [20].
[6] Exhibit 1, Tab 23 [21].
[7] Exhibit 1, Tab 22 [5], Tab 23 [25] – [27].
[8] Exhibit 1, Tab 23 [27].
[9] Exhibit 1, Tab 23 [28].

13. On 7 February 2007 Ms Drummond was registered as a Relative Foster Carer.[10]

14. On 30 August 2007 a care plan was completed regarding Master Cook-Hill.[11] The care plan is required to identify the needs of the child and outline the steps or measures to be taken in order to address those needs. It is intended to be an inclusive process, where the views of the child, the child's family and significant others are gathered and documented. [12]

15. On 16 October 2007 a protection order, time-limited for a period of 18 months, was granted for Master Cook-Hill.[13] Master Cook-Hill was to remain in the care of his grandmother, Ms Drummond.

16. His mother, Ms Cook, was also living with Ms Drummond at that time and this was acknowledged in the order.[14] Ms Cook consented to the order.[15]

17. Master Cook-Hill's father, Mr Hill, had been advised of the care plan and impending court proceedings and had expressed verbally his desire to maintain contact with his son but he did not actively participate in the proceedings.[16] The order confirmed that contact was to be facilitated by the Department, having regard at all times to Master Cook-Hill's welfare and safety.[17]

18. On 5 March 2008 a visit was completed by a Senior Field Officer of the Department. Master Cook-Hill was seen at the Kids Maya Wakathuni Playgroup. He was observed to be neat and clean and appeared

[10] Exhibit 1, Tab 23 [29].
[11] Exhibit 1, Tab 23 [30].
[12] Exhibit 1, Tab 23.
[13] Exhibit 1, Tab 20.
[14] Exhibit 1, Tab 20 [4].
[15] Exhibit 1, Tab 19.
[16] Exhibit 1, Tab 22 [10] – [30].
[17] Exhibit 1, Tab 20 [3].

to be healthy. There were no concerns raised in relation to his care at that time.[18]

19. On 22 March 2008 Master Cook-Hill's mother died in a motor vehicle accident.[19] He remained in the care of Ms Drummond from this time.

20. On 18 June 2008 Mr Hill spoke to a Senior Field Officer from the Department and confirmed that whilst his aim was to move towards shared care of Master Cook-Hill with Ms Drummond, he was happy for him to remain with Ms Drummond as he knew she was looking after him well.[20]

21. On 27 June 2008 Ms Drummond was formally interviewed by a Senior Field Officer for a Relative Carer Assessment. The Case Notes record that Ms Drummond and Master Cook-Hill had formed a close, secure attachment and he was being raised in a caring, safe and culturally appropriate environment.[21]

22. On 4 and 13 September 2008 Departmental staff apparently completed further home visits to monitor Master Cook-Hill's welfare. It was noted that he regularly attended play group and day care. He was meeting all developmental milestones and developing a sense of culture through his grandmother's teachings and cultural activities. He was understandably missing his mother, given her recent death. No other concerns were reported.[22]

EVENTS OF 12 OCTOBER 2008

23. In October 2008 Master Cook-Hill was living at House 10 in the Wakathuni Community with Ms Drummond and a number of other adults and

[18] Exhibit 1, Tab 23 [32], CB3.
[19] Exhibit 1, Tab 23 [33].
[20] Exhibit 1, Tab 23 [34], CB4.
[21] Exhibit 1, CB7,
[22] Exhibit 1, Tab 23 [35] – [36] – Case notes not provided.

children. The children ranged in age from 2 years to 10 years, with Master Cook-Hill one of the younger children at 3 years of age. There was one younger child, a little girl of 2 years of age named Kyla Chadd.[23]

24. In the back yard of the house was a caravan. The caravan was used to store discarded items of clothing and old bedding. According to Ms Drummond, the children knew that they were not to go inside the caravan.[24]

25. Over the night of 11-12 October 2008 Master Cook-Hill slept on the bed in the loungeroom with his grandmother and Miss Chadd slept with her mother in a bedroom. Miss Chadd got out of bed at about 6.00am to have breakfast with the other children.[25]

26. At about 7.00am Ms Drummond woke up. She noted the house was unusually quiet and that Master Cook-Hill and Miss Chadd had not followed their usual routine of waking her up at about 5.30-6.00 am to get them breakfast.[26]

27. Ms Drummond went into the kitchen. One of the other children walked into the kitchen and Ms Drummond realised something was wrong. She went out the back door and could see that the caravan in the back yard was on fire. About a quarter of the caravan was already engulfed in flames.[27] She guessed that the two youngest children were inside it.[28]

28. Around the same time Miss Chadd's parents were told by one of the children that the caravan was on

[23] Exhibit 1, Tab 8 [1] – [5].
[24] Exhibit 1, Tab 7 [20].
[25] Exhibit 1, Tab 8 [7] – [8], [12] – [13].
[26] Exhibit 1, Tab 7 [5], [21] – [22].
[27] Exhibit 1, Tab 7 [24].
[28] Exhibit 1, Tab 7 [7] – [8].

fire and that Master Cook-Hill and Miss Chadd were inside it. They ran outside to the caravan.[29]

29. Ms Drummond tried to go through the door of the caravan but was forced back by the heat.[30] Miss Chadd's father grabbed a garden hose and tried to put out the fire. Unfortunately, it was ineffective against the intensity of the fire.[31]

30. Members of the Tom Price volunteer Fire and Rescue Brigade were alerted to the fire at 7.09am and attended at the house at 7.32 am.[32] By the time they arrived the fire had largely self-extinguished but was still smouldering.[33] The remnants of the fire were quickly extinguished with water.

31. The caravan was completely destroyed by the fire. The incident controller of the fire crew, Christopher O'Connell, and another volunteer fire fighter conducted a search of what remained of the caravan. Mr O'Connell lifted a small piece of metal wall that had fallen into the caravan. He observed two small burnt bodies underneath. He replaced the metal and placed a canvas tarpaulin over the bodies.[34]

32. Local police were notified and attended the scene. An examination of the scene was conducted and they took the bodies of the two children away.[35] Officers from the Arson Squad later attended and completed their own examination.[36]

[29] Exhibit 1, Tab 8 [15] – [17].
[30] Exhibit 1, Tab 7 [9].
[31] Exhibit 1, Tab 7 [10] – [12], Tab 8 [17].
[32] Exhibit 1, Tab 3 [5].
[33] Exhibit 1, Tab 7 [14] – [15], Tab 9 [5].
[34] Exhibit 1, Tab 9 [7] – [9].
[35] Exhibit 1, Tabs 10 – 13.
[36] Exhibit 1, Tabs 13 – 14.

CAUSE OF DEATH

33. Master Cook-Hill was identified by way of DNA comparison with his father.[37]

34. On 16 October 2008 Dr J McCreath conducted a post mortem examination. Following the initial examination and further miscroscopic and toxicological investigations, Dr McCreath formed the opinion that the cause of death was smoke inhalation and burns.[38]

35. I accept and adopt Dr McCreath's conclusion as to the cause of death.

ARSON INVESTIGATION

36. Detective Sergeant Gorton, a qualified fire investigator from the Arson Squad,[39] conducted an investigation into the cause and origin of the caravan fire. The examination revealed that the fire had been internal to the caravan and that there were no external sources of ignition.[40]

37. Due to the high level of thermal damage, it was not possible to identify the exact point of origin of the fire. However, the origin of the fire was identified as somewhere in the north-west end of the caravan.[41]

38. Electricity and gas were eliminated as a cause of the fire as the caravan was not connected to either.[42] Further, no evidence of any liquid accelerant or incendiary devices was located.[43]

---

[37] Exhibit 1, Tab 5.
[38] Confidential Report to the Coroner, Dr J McCreath, 16 October 2008 and Supplementary Report.
[39] ts 5 (Gorton, D.S.).
[40] ts 6 (Gorton, D.S.); Exhibit 1, Tab 3, Fire Report, [11].
[41] Exhibit 1, Tab 3, Fire Report, [11].
[42] ts 6 (Gorton, D.S.); Exhibit 1, Tab 3, Fire Report, [12] – [13].
[43] Exhibit 1, Tab 3, Fire Report, [14].

39. Although Det Sgt Gorton concluded that the ignition source and cause of the fire were undetermined,[44] he noted that it appeared a mobile heat source may have been introduced into the caravan, such as a cigarette lighter or matches.[45]

40. He confirmed in oral evidence that there were no suspicious circumstances identified in relation to the fire.[46]

MANNER OF DEATH

41. Early in the morning of Sunday, 12 October 2009, Master Cook-Hill and Ms Chadd awoke before the adults in the household and made their way outside the house unsupervised.

42. While in the backyard they entered the caravan and presumably were playing in there amongst the old clothes and household items.

43. At some stage a fire was ignited, possibly by way of one of the children playing with matches or a cigarette lighter (although that is speculative). What is clear is that once the fire was lit, by whatever means, it took hold and intensified quickly due to the readily combustible materials inside.

44. The only way to exit the caravan was by way of the door, which was adjacent to the north-west corner where the fire started.[47] The children did not leave through the door once the fire started, possibly because they panicked or because the fire was already blocking their path. Instead, they retreated to the eastern end of the caravan, away from the fire.[48]

[44] Exhibit 1, Tab 3, Fire Report, [18].
[45] ts 6 - 8 (Gorton, D.S.); Exhibit 1, Tab 3, Fire Report, [11].
[46] ts 8 (Gorton, D.S.).
[47] ts 6 (Gorton, D.S.).
[48] ts 7 (Gorton, D.S.).

45. The adult members of the household were alerted to the fire by other children and did their best to try put out the fire and rescue the children inside the caravan, but unfortunately the severity of the fire was already too great.

46. It appears that Master Cook-Hill and Miss Chadd took refuge under a bed, which partially protected them from the fire. However, they were still exposed to the smoke from the fire. Master Cook-Hill most likely succumbed to smoke inhalation first, before the fire reached him. He died as a result of the smoke inhalation, as well as burns he received in the fire.

47. I find that death occurred by way of accident.

QUALITY OF SUPERVISION, TREATMENT AND CARE

48. Pursuant to s 25(3) of the *Coroners Act*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

49. As noted above, Master Cook-Hill was a child in the care of the CEO of the Department at the time of his death.[49] His Departmental case workers were responsible for exercising the role of guardian and accepting responsibility on the CEO's behalf.[50] Accordingly, my focus is on the quality of the care provided by the Department and its staff to Master Cook-Hill.

50. Ms Cheryl Barnett has a long history of employment with the Department and is currently the Executive Director of Metropolitan Services for the

[49] ts 9 (Barnett, C.J).
[50] Exhibit 1, Tab 23 [54].

Department.[51] Ms Barnett completed a comprehensive review of the file of Master Cook-Hill and provided materials to this Court as well as giving oral evidence.

51. Consistent with the Department's philosophy of consulting with family in determining care arrangements and prioritising a family option (a relative carer) where possible, Master Cook-Hill was placed with his maternal grandmother, Ms Drummond.[52] Both his mother and father were accepting of this choice.

52. Departmental case workers are guided by the Department's *Case Practice Manual* and *Field Worker Guidelines*, which were in place at the time of Master Cook-Hill's death.[53] It appears that his case workers appropriately followed those guidelines in managing his care, although there were some delays in completing required assessments, apparently largely due to the availability of Ms Drummond.[54]

53. At the time of Master Cook-Hill's death the Department was in its first year of a five year Reform Agenda following the Ford Report.[55] Since 2008 the Department has increased its staffing resources, including specifically in the Pilbara.[56]

54. An increase in the budget and staffing levels in the Pilbara is certainly a positive step. However, there is nothing in the materials to suggest that any resourcing issues in 2008 impacted upon the Department's care and supervision of Master Cook-Hill to his detriment.

55. The Department's records for Master Cook-Hill reveal that Departmental officers maintained regular contact

[51] ts 8 (Barnett, C.J).
[52] ts 10 (Barnett, C.J).
[53] Exhibit 1, Tab 23 [55].
[54] Exhibit 1, Tab 23 [49] – [50], [57], [78].
[55] Exhibit 1, Tab 23 [41] – [43].
[56] Exhibit 1, Tab 23 [76] – [77].

with Ms Drummond and they were able to confirm that he was doing well in her care and there were no concerns about the level of care he was receiving.[57]

56. I accept that Master Cook-Hill was placed by the Department into a loving, nurturing and culturally appropriate environment and that, by all accounts, he was well cared for and thriving at the time of his death.

CONCLUSION

57. Master Cook-Hill was a 3 year old boy who had been placed into the care of the Department under a time-limited protection order.

58. At the time of his death he was living with his grandmother and was healthy and happy.

59. Sadly, on 12 October 2008 he and another child became trapped in a caravan that caught on fire and Master Cook-Hill died as a result of the effects of the smoke and fire.

60. The tragic events that occurred on 12 October 2008 do not have any connection with the reasons why Master Cook-Hill was taken into care by the Department and there is no action that the Department could have taken that might have prevented his death.

S H Linton
Coroner
11 June 2014

[57] ts 11 (Barnett, C.J.); Exhibit 1, Tab 23 [78].