Coroners Act 1996
[Section 26(1)]

Western *Australia*

AMENDED RECORD OF INVESTIGATION INTO DEATH

Ref: 45 /17

I, Sarah Helen Linton, Coroner, having investigated the death of ***Lachlan James MITCHELL*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***20 – 21 November 2017*** *find that the identity of the deceased person was* ***Lachlan James MITCHELL*** *and that death occurred on* ***10 November 2015*** *at* ***Princess Margaret Hospital*** *in circumstances* ***consistent with hypoxic brain injury following immersion (drowning)****:*

Counsel Appearing:

Ms F Allen assisting the Coroner.
Mr J Hammond (Hammond Legal) appearing on behalf of Luke Mitchell, Melanie Mitchell and Dennis Hampton (the deceased's family).
Mr P Jarman (Sparke & Helmore) appearing on behalf of Ms Karla Zablah.
Ms D Underwood (State Solicitor's Office) appearing on behalf of the Department of Communities.

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INTRODUCTION

1. Lachlan Mitchell was a happy, active little boy. He was the much loved only child of his parents, Melanie Mitchell[1] and Luke Mitchell.[2]

2. When he was about 18 months old Lachlan began going to day care while his parents were at work. He had started at a mainstream day care centre, but after some problems his parents decided that Lachlan would benefit from a smaller, family day care, environment. They tried a couple of different places before settling on a family day care service run by Ms Karla Zablah from her home.

3. Ms Zablah only cared for younger children and she had child care qualifications, which Mr Mitchell and Mrs Mitchell felt would be ideal to help Lachlan with his development. Lachlan had been diagnosed with global developmental delay when he was younger and, although he had made great improvements, his parents still wanted to make sure that his developmental needs were closely met.

4. Lachlan started attending Ms Zablah's family day care in July 2015. He initially went one day a week and by November 2015 he was attending three days per week. Lachlan seemed to be progressing well and he had a good relationship with Ms Zablah.

5. On 9 November 2015, a few days shy of Lachlan's third birthday, Lachlan's mother dropped him off as usual to Ms Zablah's home at 8.45 am. Less than two hours later Mrs Mitchell received a distressed call from Ms Zablah. She told Mrs Mitchell she had found Lachlan immersed in the swimming pool at her home and he had been taken to hospital by ambulance.

6. Tragically, Lachlan had sustained a hypoxic brain injury from which he could not recover. After a discussion with his parents, Lachlan's life support was turned off at Princess Margaret Hospital on the evening of 10 March 2015 and he died shortly after with his parents by his side.[3]

7. Following Lachlan's death his parents have lobbied strongly for change to the rules surrounding family day care services, in particular surrounding whether pools or water features should be present at the premises of such services. Such changes can't bring Lachlan back, but Mr and Mrs Mitchell hope they will save another family from the suffering that they and their extended family have endured and will continue to endure. As part of this process, Lachlan's parents requested the State Coroner order an inquest be held into the circumstances of Lachlan's death. The matter was approved to inquest on 3 October 2016.

8. I held an inquest at the Perth Coroner's Court on 20 and 21 November 2017. The documentary evidence included a report prepared by the WA Police, incorporating statements from the various witnesses to events, as well as

[1] Formerly Hampton at the time of the death.
[2] Although they have since had another child.
[3] PMH Medical Record.

additional policy material provided by relevant agencies such as the City of Wanneroo, Communicare Inc. and Royal Life Saving WA.

9. At the commencement of the inquest it was emphasised on behalf of Lachlan's family that Lachlan's death was entirely preventable. They drew attention to the concerning statistics on drowning and near-drowning of toddlers in pools in Western Australia since 2012 and, within that context, they indicated their strong belief that pools in day care centres should be banned given the inherent risk they present. This was a focus of oral evidence at the inquest. There was also a general focus on the circumstances that led to a lapse in supervision so that Lachlan could enter the pool unseen.

10. It is not my role to suggest that any person is guilty of any offence arising from Lachlan's death.[4] However, I note at the outset that Ms Zablah was prosecuted under the provisions of the *Education and Care Services National Law (WA) Act 2012* for failing to ensure that Lachlan was adequately supervised. She pleaded guilty and was convicted and fined in the Magistrates Court.[5] Prior to giving her evidence in relation to the events on the day Lachlan died, Ms Zablah sought a certificate under s 47 of the *Coroners Act* on the grounds that her answers might incriminate or tend to incriminate her. I granted her a certificate at the conclusion of her evidence.[6]

11. I am advised that Ms Zablah no longer works in child care education.[7]

MS ZABLAH'S FAMILY DAY CARE SERVICE

12. Karla Zablah qualified as a child care giver in 2001, having completed a Diploma in Children's Services. Prior to January 2015 she had worked at mainstream child care centres, most recently in Merriwa. From January 2015 Ms Zablah began providing child care from her home in Carramar. Ms Zablah and her fiancé rented the house and had moved in a few months before she began working from home.[8]

13. Ms Zablah did not have any children of her own and no children lived permanently at the address.[9]

14. The basis upon which Ms Zablah provided child care from her home was as a family day care educator registered with a family day care service, Communicare, under the 'Family Day Care' National Law. In Western Australia the National Law comes into force through the *Education and Care Services National Law (WA) 2012*. It is administered by the Education and Care Regulatory Unit of the WA Department of Local Government and Communities on behalf of the Director General.[10]

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[4] Section 25(5) *Coroners Act 1996* (WA).
[5] T 20; JO 12947 of 2016, *Dept of Local Govt and Communities v Zablah*, 4.11.2016.
[6] T 28.
[7] T 7.
[8] Exhibit 1, Tab 7. Statement 9.11.2015.
[9] Exhibit 1, Tab 7. Statement 9.11.2015.
[10] Exhibit 1, Tab 12.

15. In 2017 it was estimated there were 1611 individual educators operating a family day care service in WA. This was nearly double the number operating in 2012, which shows the increasing popularity of this form of service.[11]

16. Ms Zablah applied in 2014 to become a family day care educator with Communicare, an approved family day care provider. Communicare staff conducted two interviews with Ms Zablah and assessment visits of her home before she was approved for inclusion as an educator with the service.[12]

17. As part of the application process Ms Zablah had provided a building plan of her residence. The plan does not show a swimming pool, but it was acknowledged there was a fenced in-ground swimming pool on the premises.

18. The Communicare Safety Policy in place at the time required family day care educators to "prevent child accidents and illnesses related to swimming and wading pools, other water hazards, and water-based activities through close supervision, education and compliance with state regulations."[13] The policy specified that any items around the perimeter of the pool must be situated to prevent a child using them as climbing aids.[14] It also specified that all children near water were to be closely supervised and no child was to be left alone near water.[15]

19. The first venue assessment was conducted at Ms Zablah's home on 26 September 2014 by Ms Joanne Georgiou, a Resource and Referral Officer with Communicare.[16] Ms Georgiou completed a venue assessment form as part of the process. The area inside the pool fence did not form part of the designated areas for the family day care service but the venue assessment form included a section for risk assessment for the swimming pool. It was noted there were two gates to the pool, both fitted with child proof locks.

20. Ms Georgiou recalled that during the assessment she observed a small blue pot plant with a spiky plant in it that was placed beside the swimming pool fence near the undercover outdoor area. She informed Ms Zablah it could be used as a climbing aid. Ms Georgiou said she then watched Ms Zablah move the pot away from the fence to the right distance of 1.2 metres; far enough so that it could not be used to climb the fence. Ms Georgiou made a note of this on the assessment form.[17]

21. Ms Georgiou's evidence at the inquest was that this was her standard practice when assessing an educator's house with a swimming pool. If she saw an object against the fence, she would ask the educator to move it and would wait for it to be moved.[18]

[11] Exhibit 1, Tab 12.
[12] Exhibit 1, Tab 11.
[13] Exhibit 1, Tab 13, NP16.
[14] Exhibit 1, Tab 13, NP16.
[15] Exhibit 1, Tab 13, NP16.
[16] Ms Georgiou has been the Family Day Care Coordinator at Communicare since August 2017 – T 29.
[17] T 35; Exhibit 1, Tab 11 and JG03.
[18] T 31.

22. Ms Zablah acknowledged that she had been asked to move a pot plant near the pool gate by Ms Georgiou.[19] However, Ms Zablah gave evidence at the inquest that she had not moved it, and it remained in position when the later Communicare inspections were conducted by Ms Georgiou, as well as the inspection by the Royal Life Saving Society and City of Wanneroo.[20] I asked Ms Zablah why she didn't move it, as requested, and she responded that she knew she had to do it but never got around to it as she "was so busy all the time."[21]

23. Ms Georgiou conducted a second visit on 20 October 2014 to check that the areas that were not compliant during the first visit had been completed. A second venue assessment form was completed for these specific areas only.[22] The pot near the pool fence was not mentioned or noted again. Ms Georgiou explained at the inquest that she did not note the pot on the second inspection as it had already been moved during the first visit, unlike other rectifications that took time, such as chopping down a poisonous oleander bush. Ms Georgiou gave evidence that she did not see a pot near the fence throughout any of her later visits to Ms Zablah's home.[23]

24. It was put to Ms Georgiou in questioning by counsel on behalf of Lachlan's family that when the pot near the fence was photographed by the investigating police officers it had roots coming through the bottom of it that had grown into the ground. Ms Georgiou conceded that she had not seen that area for a while as it had been over the winter period.[24]

25. Ms Georgiou remained firm that there was no pot in the area the last time she sighted that area, but could not say how long before Lachlan's death that was.[25] It was put to Ms Georgiou the pot could conceivably have been there for four to five months, to which she responded that she did not know.[26]

26. I note that when interviewed by an investigator after Lachlan's death, Ms Zablah made notations on photographs showing the pot plant by the gate and another pot plant, indicating that the pot plants may have been there for 3 months or just a bit less.[27] This is consistent with Ms Georgiou's evidence and suggests that Ms Zablah may have indeed originally moved the plant at Ms Georgiou's request, but then later put a few pot plants back around the pool fence.

27. Ms Zablah was approved and registered to operate as a family day care educator with Communicare sometime in November 2014. Ms Zablah was licensed to care for up to four children at a time,[28] although she did not

[19] Exhibit 1, Tab 7, Statement 22.2.2016 [5].
[20] T 24.
[21] T 25.
[22] Exhibit 1, Tab 11.
[23] T 43, 46.
[24] T 43.
[25] T 43.
[26] T 43.
[27] Exhibit 1, Tab 13, NP120 and NP 121.
[28] Exhibit 1, Tab 7, Statement 9.11.2015.

enrol any children in her care until January 2015. She chose to look after children between 6 months old and 3 years old, rather than older children.[29]

28. The City of Wanneroo had been notified in September 2014 that there was an intention to operate a family day care centre from the home but had advised that no planning approval from the City was required.[30] When the City of Wanneroo contracted the Royal Life Saving Society WA to conduct a safety barrier inspection of the pool at Ms Zablah's home, it was treated in the same way as any ordinary residential property.

29. Ms Tamsyn Young, the Home Pools Coordinator at Royal Life Saving, was previously a home pool barrier inspector and in 2015 Ms Young was authorised by the City of Wanneroo to conduct a pool inspection of the pool at Ms Zablah's home in Carramar. Ms Young was not aware of the intended use of the home as a child care centre, and that did not form part of her inspection. Her inspection was a standard pool safety inspection on behalf of the council.[31] These inspections are required to be completed every four years.

30. Ms Young undertook the first pool barrier inspection on 19 February 2015. During that inspection Ms Young identified a fault in the performance of one of the pool gate's self-closing mechanism. It was the responsibility of the homeowner to rectify the fault, although the information may have been communicated through Ms Zablah as the tenant.[32]

31. On 12 of March 2015 Ms Young returned to the property and confirmed that the gate had been fixed and the gate was self-closing appropriately.[33]

32. Ms Young advised that part of her inspection also required looking for raised moveable objects such as chairs, plant pots and toys on the outside or inside within 30 cm of the barrier. If any such items were seen they would be requested to be removed.[34] Ms Young was asked whether she saw any pot plants up against the pool fence or near the gate that would present a hazard during her inspections and she advised that she did not.[35] Ms Young was shown photographs of the pot plants found in situ next to the pool fence after Lachlan's death and Ms Young gave evidence that those were the type of climbable objects that she was looking for during her inspection and if she had seen them in that position she would have instructed that they be moved or assisted by moving them herself. In particular, in relation to the dragon pot next to the gate, Ms Young's evidence was that she would not have passed the pool if such a plant had been situation against the barrier.[36]

33. Ms Young's evidence also supports the conclusion that Ms Zablah moved the pot plant that was seen during Ms Georgiou's first inspection and then put pot plants back against the pool fence at a later date.

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[29] T 10; Exhibit 1, Tab 11.
[30] Exhibit 1, Tab 14, p.1.
[31] T 98.
[32] T 95 – 96.
[33] T 97.
[34] T 95.
[35] T 97.
[36] T 100 – 102.

34. From January 2015 Ms Georgiou conducted monthly visits at Ms Zablah's home, which were a combination of announced an unannounced visits. The visits would usually take place in the area where the children were located, so sometimes the visits were inside the house and sometimes they were conducted outside the house. Ms Georgiou's last visit was conducted on 22 September 2015. There was no visit in April or October 2015, apparently due to Ms Georgiou being on leave.[37]

35. According to information provided by the Department of Communities, the regulations require only at least one visit to the family day care educator's home annually, after they have been approved, so the fact that two months were missed was not a compliance issue.[38] The regulations also apparently only required an annual inspection of the pool fencing.[39]

36. Ms Georgiou gave evidence that she did not go outside the house to check for hazards during each visit and she did not specifically check the pool area after the initial venue assessment.[40] If the children were outside during the visit she would be outside the house with Ms Zablah and the children. Ms Georgiou did recall that she was outside on some visits.[41]

37. When she did go outside Ms Georgiou did not recall seeing any objects, pot plants or toys that could have been used as a climbing aid into the swimming pool. However, she did not think she would have checked outside after June 2015 according to her monthly visit summaries, although I note the summary for 29 July 2015 suggests she probably did on that occasion. No serious concerns were recorded about the outside area, although there were some prompts to remove a lawnmower from outside on one occasion and to sand some outdoor furniture to avoid splinters.[42]

38. Ms Georgiou indicated that at the time of Lachlan's death there was no specific swimming pool check tick box, although that has changed now. There is now a designated section for "Water features, pools and spas."[43]

39. During Ms Georgiou's visits she discussed with Ms Zablah doing a daily hazard checklist.[44] Ms Zablah had also been given training on supervision as part of Safety and Risk Assessment training, which includes water safety.[45] During the monthly visits Ms Georgiou considered Ms Zablah always displayed appropriate supervision of the children who were present.[46]

40. There were no reportable incidents involving children at Ms Zablah's home prior to the events involving Lachlan.[47]

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[37] T 33.
[38] T 66, 72; Exhibit 1, Tab 12.
[39] T 66.
[40] T 34.
[41] T 35.
[42] Exhibit 1, Tab 11.
[43] T 31 – 32.
[44] Exhibit 1, Tab 11.
[45] Exhibit 1, Tab 11.
[46] Exhibit 1, Tab 11.
[47] Exhibit 1, Tab 7.

LACHLAN'S ENROLMENT WITH MS ZABLAH'S SERVICE

41. Lachlan was born on 12 November 2012. When he was 9 months old he was diagnosed with hypermobility. As a result of his condition he was slower to roll and crawl over and his speech was affected. Lachlan started intensive therapies: attending speech therapy, physiotherapy and occupational therapy. Physically, he had made significant improvement and his speech was also slowly improving.[48]

42. Lachlan had attended mainstream day care from about 18 months of age but he had some immunity issues and was prone to ear infections, so it was recommended that his parents find another care environment where he would be exposed to less children while he built immunity. Lachlan also had some developmental delay, as noted above, so he required more one-on-one attention than a carer could provide in a large day care environment.[49]

43. Lachlan's parents decided a family day care environment met Lachlan's needs. They trialled Lachlan at a couple of different places before settling on Ms Zablah's. It was important to Lachlan's parents that they chose a carer "that understood [Lachlan's] condition and was able to speak to him on a level that was inclusive and didn't make him feel different."[50] Mr and Mrs Mitchell felt Ms Zablah had suitable experience and catered to the right age group of young children to be that person and to help Lachlan with his development.[51]

44. Lachlan loved the water. He had been taking swimming lessons in 2013 but had been forced to stop due to his recurring ear infections.[52] Lachlan's parents had a small inflatable pool at home, which he loved to use, but they always made sure they emptied it after use as Lachlan was very curious. Like many busy toddlers, Lachlan's curiosity and active nature had led him to start pushing things up against furniture so that he could reach things. He was a normal toddler, with the usual small bumps and bruises that come with learning to explore the world. However, he had not come to any major harm or suffered any falls.[53]

45. Knowing Lachlan's curious nature, Mrs Mitchell's evidence was that when they did an induction at Ms Zablah's home "obviously the pool was a major concern."[54] Accordingly, one of the first questions Mrs Mitchell posed to Ms Zablah related to what activities took place outside and the level of supervision. Ms Zablah reassured Mr and Mrs Mitchell that "if she was inside, the kids were inside. If she was outside, the kids were outside."[55]

[48] T 118 – 119; Exhibit 1, Tab 6.
[49] T 118 – 119.
[50] T 120.
[51] T 118.
[52] Exhibit 1, Tab 6 [34] – [35].
[53] Exhibit 1, Tab 6.
[54] T 120.
[55] T 120.

46. Mr and Mrs Mitchell told Ms Zablah that Lachlan was hypermobile and that he was very curious and liked to explore and climb, so that she was aware of this when caring for him.[56]

47. Lachlan began attending Ms Zablah's family day care service in July 2015. He initially went for one day a week and then in mid-October his attendance had increased to three days per week. He was usually dropped off at 8.30 am and collected at 4.30 pm.

48. Lachlan had settled in well and had quickly become the leader as he was one of the older children in the group. Ms Zablah provided a caring, nurturing environment and Lachlan was slowly coming out of his shell.[57] Until the fateful events on 9 November 2015 Lachlan's parents had had no major issues or concerns with Ms Zablah's care of Lachlan.[58]

49. However, there were some issues with the safety of the physical environment. Mrs Mitchell mentioned at the inquest that she had raised a few issues of security with Ms Zablah, in relation to leaving the front door unlocked or unlatched, as she was aware that Lachlan could operate the front door at his own home.[59]

50. Ms Zablah gave evidence that there was a checklist she was required by Communicare to complete each morning, both inside and outside the house. It was designed as a safety check to ensure that potential dangers around the house had been addressed, such as gates being closed, power points covered and poisons locked away. It included a check box specifically relating to the pool gate in the outdoor area. Ms Zablah's evidence was that she would check the gates to the swimming pool were shut each morning.[60]

EVENTS ON 9 NOVEMBER 2015

51. On Monday 9 November 2015 Mrs Mitchel dropped Lachlan off at Ms Zablah's home at 8.45 am. Mrs Mitchell gave Lachlan a kiss and a cuddle while he was playing then said goodbye.[61]

52. There were two other children being cared for that day, a 2 year old girl and an 11 month old baby. Lachlan was the last to be dropped off that day, so all the children were there from 8.45 am.[62]

53. Initially all of the children were inside the house playing with playdough. At about 9.00 am Ms Zablah put the 11 month old to bed but he did not settle. His mother had instructed Ms Zablah to start self-soothing so she left him in the cot to see if he would settle by himself.[63]

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[56] T 20.
[57] T 124.
[58] Exhibit 1, Tab 6 [21].
[59] T 120.
[60] T 11 - 12.
[61] Exhibit 1, Tab 6 [23] – [23].
[62] T 16; Exhibit 1, Tab 7, Statement 9.11.2015.
[63] Exhibit 1, Tab 7, Statement 9.11.2015.

54. Ms Zablah took Lachlan outside to play in a garden area that was accessed via the laundry. The little girl did not follow them outside as she has a phobia about flies and did not like to play outside. Instead, the little girl stood at the laundry door and played with a toy while they were in the yard.[64]

55. Lachlan and Ms Zablah were outside in the garden for about five minutes, during which time Ms Zablah could still hear the baby crying inside and becoming increasingly distressed. Ms Zablah decided to go inside to try to settle him. Ms Zablah said at the inquest that the children usually followed her everywhere she went, and she called out to Lachlan and the other child to come with her.[65] The little girl followed her but the evidence suggests Lachlan remained outside.[66]

56. Ms Zablah was unable to settle the baby so she brought him through into the lounge room. The little girl was inside with them but Lachlan was outside, unsupervised. Ms Zablah told police she had not realised that Lachlan had not followed her until that moment. Once she realised, she went outside to check on him.[67]

57. When Ms Zablah spoke to ambulance officers and police on 9 November 2015 she estimated she went back outside to check on Lachlan after only a few minutes, perhaps 5 minutes in total.[68] Ms Zablah later gave another statement to the police suggesting it may have been as long as 7 minutes.[69] She then clarified further that she was not wearing a watch and did not pay immediate attention to the time, so she might be mistaken as to the length of time that elapsed and the times she had given were merely estimates.[70]

58. What is known is that on walking outside Ms Zablah could not initially find Lachlan. There was a pool cover over the pool and she noticed the pool cover had been disturbed a little bit on the side. She then saw Lachlan floating face down on the surface of the swimming pool. Lachlan was floating near the steps of the pool.[71]

59. Ms Zablah went inside the pool gate and ran to Lachlan. She pulled him from the water and laid him next to the pool on the paving and started to perform CPR. She did three compressions to his chest and gave him three breaths. Lachlan started to bring up water almost immediately and vomited. Ms Zablah continued to do chest compressions and intermittently put him on his side to assist in getting the water out of him. She eventually stopped and carried Lachlan inside into the lounge room of the house, where she continued to perform CPR. Lachlan was still bringing up water and vomiting.

60. Ms Zablah couldn't call for help as she couldn't find her mobile telephone. Eventually Ms Zablah stopped doing CPR and ran out of her house to try to

[64] Exhibit 1, Tab 7, Statement 9.11.2015 and Statement 22.2.2016.
[65] T 18.
[66] Exhibit 1, Tab 7, Statement 9.11.2015 and Statement 22.2.2016.
[67] Exhibit 1, Tab 7, Statement 9.11.2015.
[68] Exhibit 1, Tab 7, Statement 9.11.2015 [46] and Tab 10.
[69] Exhibit 1, Tab 7, Statement 22.2.2016 [22].
[70] Exhibit 1, Tab 7, Letter to CIU 22.2.2016.
[71] Exhibit 1, Tab 7, Statement 9.11.2015 [46] and Tab 13, NP11.

get help. She ran to her neighbours' house, banged on the front door and shouted out to them to call for an ambulance. Ms Zablah's neighbours, Mr Keith Morrison and Ms Karen Ballard, were at home and heard Ms Zablah calling for help. Mr Morrison terminated a telephone call, so he knows the time was 9.57 am.[72]

61. Mr Morrison told his wife to call for an ambulance and he followed Ms Zablah, who was hysterical, next door. Upon entering the house Mr Morrison saw Lachlan lying motionless, soaking wet. He told Ms Zablah to take the other children into another room.[73]

62. Mr Morrison had up to date CPR skills through St John Ambulance training and he put them into effect, with extra guidance from a St John Ambulance operator over the telephone. As he performed chest compressions and breaths Mr Morrison noticed that fluid and vomit were still coming out of Lachlan's airways.[74] Ms Ballard waited out the front and guided the ambulance to the house.

63. The first ambulance arrived at 10.04 am and the ambulance officers noted Mr Morrison was performing effective CPR when they arrived. The ambulance officers observed that Lachlan had no apparent injuries but he was unresponsive, grey/white in colour and cold, with a temperature of only 30.5°C. They assisted with resuscitation efforts and urgently transported Lachlan to Joondalup Health Campus.[75]

64. After the ambulance left Mr Morrison helped Ms Zablah find her telephone, which was inside the pool fence. Ms Zablah had taken it out of her pocket and thrown it there when she jumped into the pool to get Lachlan.[76]

65. Mrs Mitchell received a telephone call from Ms Zablah at about 10.30 am. Ms Zablah was hard to understand because she was so distressed, but she managed to explain that an ambulance had been called for Lachlan after he had been found in the pool. She told Mrs Mitchell Lachlan could have been in the pool for up to 5 minutes.[77] Ms Zablah also notified Ms Georgiou at Communicare about what had occurred.[78]

CAUSE OF DEATH

66. Lachlan arrived by ambulance at Joondalup Health Campus at 10.33 am. He was still asystolic on arrival and it was estimated he had been immersed and/or in cardiac arrest for at least 30 minutes by that time. His body temperature was still very low so the doctors began warming him and

[72] Exhibit 1, Tab 7, Statement 9.11.2015 and Tab 8 and Tab 9.
[73] Exhibit 1, Tab 8.
[74] Exhibit 1, Tab 8.
[75] Exhibit 1, Tab 10.
[76] T 18 - 19.
[77] Exhibit 1, Tab 6.
[78] Exhibit 1, Tab 11.

performed aggressive resuscitation, including doses of adrenaline, to try to revive him.[79]

67. Lachlan was transferred to Princess Margaret Hospital in the afternoon. The following day, being 10 November 2015, brain stem testing was completed in the presence of Lachlan's parents on two occasions and brain death was confirmed. At 6.00 pm Lachlan was taken off life support and at 6.15 pm a doctor confirmed he had died.[80]

68. At the request of Lachlan's parents, a full internal post mortem examination was not conducted.

69. An external post mortem examination was performed by the Chief Forensic Pathologist, Dr C. T. Cooke, on 11 November 2015. Dr Cooke noted there were minor, healing scratch injuries to the left elbow, right knee and left shin, but there were no further externally evidence injuries.[81] Dr Cooke described the scratch injuries as "tiny little areas"[82] and the sort of "abrasion you will see on every two or three year old kid."[83]

70. Dr Cooke was asked about whether he would have seen any bruising if Lachlan had climbed and fallen over the pool fence. Dr Cooke's evidence was that if there was significant bruising, he would have seen it in the external examination, but if it was a very subtle bruise it might not appear or just be disguised during an external examination.[84]

71. Dr Cooke reviewed Lachlan's hospital medical files, which indicated a history of hypoxic brain injury following a period of cardiorespiratory impairment due to immersion in water.

72. At the conclusion of the limited investigations performed, Dr Cooke formed the opinion the cause of death was consistent with hypoxic brain injury following immersion (drowning). I accept and adopt the conclusion of Dr Cooke as to the cause of death.

MANNER OF DEATH

73. The evidence supports the conclusion that Lachlan, who like many toddlers had an attraction to water, found a way to enter the swimming pool area while unsupervised and either entered, or fell into, the water. Investigations into exactly how Lachlan entered the pool were inconclusive.

74. Ms Natalie Petrusich is a Senior Investigations Officer in the Education and Care Regulatory Unit, which forms part of the Department of Communities. Ms Petrusich investigated the circumstances of Lachlan's death. As part of the investigation Ms Petrusich visited Ms Zablah's house on 11 November

[79] PMH Medical Record.
[80] PMH Medical Record.
[81] T 90 – 91; Exhibit 1, Tab 4.
[82] T 91.
[83] T 91.
[84] T 92 – 93.

2015. Ms Petrusich observed a large yellow car and a number of pot plants along the pool fence line and could see gardening equipment indicating gardening had been conducted in the area recently. This is consistent with Ms Zablah's account that she and her fiancé had been in the pool area doing some gardening the weekend prior to Lachlan's death.[85]

75. Ms Petrusich' initial thought, on viewing the area, was that Lachlan could have stood on a pot plant situated close to the pool gate to open the gate. She saw the pot plant as an obvious climbing hazard for gaining access to the pool gate. Ms Petrusich was asked as to her impression of how long the relevant pot plant had been there, and she gave evidence it appeared to have been there for "a long time."[86]

76. Mr Jon Pilkington, the Director of the Education and Care Regulatory Unit, accompanied Ms Petrusich to Ms Zablah's home and he lifted the pot off the ground. Mr Pilkington gave evidence that there was a fine root structure that appeared to be working its way into the ground from the pot plant and it was adhered to the ground a little bit because of those roots.[87] Mr Pilkington did not believe Lachlan could have moved the pot himself and he doubted that the pot had been moved "in the recent times."[88]

77. The other obvious alternative was that the gate was not properly secured.[89] Mr Pilkington also checked the pool gate and found it was a normal pool gate that self-closed in the normal way.[90]

78. No further information obtained during the investigation suggested an alternative option, but neither did the investigation confirm how exactly Lachlan had accessed the pool.

79. Conducted at the same time as Ms Petrusich's investigation was a police coronial investigation. Police officers from the Forensic Survey Unit did measurements of the pool gate, fence and surroundings and identified that the pool gate latch was approximately 1.5 metres from the ground and the height from the top of the pot plant next to the gate to the top of the pool gate latch was just approximately 1.2 metres. A measurement taken of Lachlan with his stretched above his head measured approximately 1.1 metres, which shows that it would not have been impossible for Lachlan, standing on top of the pot plant stretching up, to open the pool gate latch.[91] Although there was a white pool gate lock also shown on the latch, it was confirmed by police investigators with Ms Zablah that this lock had not been functional for some time.

80. I am satisfied on the evidence available that Ms Zablah had originally been told by Ms Georgiou to move a pot plant from the perimeter, which was done immediately, and there were no pot plants near the pool fence when a pool inspection was done by a Royal Life Saving Society WA inspector on behalf of

[85] T 64; Exhibit 1, Tab 7, Statement 22.2.2016.
[86] T 68.
[87] T 83.
[88] T 83.
[89] T 65.
[90] T 83.
[91] Exhibit 1, Tab 2, p. 2 and photographs and Tab 13, photographs.

the City of Wanneroo. Sometime after, no more than three months before Lachlan's death, some pot plants were put next to the pool fence in the grassed area at Ms Zablah's home, significantly the large 'dragon' pot next to the pool gate. There is also evidence that Ms Zablah and her fiancé were gardening in and around the pool area in the days prior to Lachlan's death, which indicates that people were going in and out of the gate and it is not impossible that the gate was not properly closed at some stage, although there is evidence that the self-closing mechanism had been found to be functioning properly some months before.

81. I am unable to conclusively determine how Lachlan entered the pool, although I accept the general weight of the evidence is towards Lachlan having climbed a pot plant to either open the gate or climb the fence. This occurred while he was outside in the garden unsupervised.

82. As noted earlier, Ms Zablah believed she was only away from Lachlan for approximately five to seven minutes.[92]. Mrs Mitchell, in her evidence at the inquest, expressed her doubt at this account. She spoke to Ms Zablah on the day and has heard her later account of events and Mrs Mitchell has obviously, and understandably, then given the matter a great deal of thought. In considering Ms Zablah's version of events Mrs Mitchell has also taken into account her own knowledge about young children, particularly Lachlan. Mrs Mitchell believes it would have taken Lachlan some manoeuvring to be able to get over the pool fence given his lack of fine motor skills, which was unlikely to be achieved in a timeframe of five to seven minutes. Mrs Mitchell believes either Ms Zablah left Lachlan unsupervised for a longer period than she now estimates, or if her estimate of time is correct, then it is more likely Lachlan entered the pool area through a gate that wasn't properly latched.[93] As I have indicated above, that is a possibility open on the evidence.

83. Mrs Mitchell also pointed to the fact that Ms Zablah has previously conceded that she was unaware of the time and didn't have access to a clock or watch, so she was not basing her timeframe on an accurate objective measure of time. In discussion, Mrs Mitchell agreed that Ms Zablah's underestimation of time would be most likely attributable to Ms Zablah being mistaken, rather than deliberately lying.[94]

84. Dr Cooke was unable to give any estimate of how long Lachlan was immersed in the swimming pool. However, Dr Cooke gave evidence that it does not take long at all for a toddler to drown. He noted it is well described as a "very quick and very silent occurrence."[95] Based on information from an article published in the Medical Journal of Australia, Dr Cooke indicated that once in the water the child will usually simply hold their breath and calmly sink to the bottom. They will become unconscious within possibly half a minute and significant brain damage will occur within as little as two to four minutes.[96] Therefore, even if on the most favourable version of the

[92] T 18.
[93] T 121.
[94] T 122.
[95] T 91.
[96] T 92.

evidence Ms Zablah was only gone for five to seven minutes that was still long enough for Lachlan to suffer irreversible brain damage if he entered the pool shortly after she left.

85. I am unable to find with certainty how Lachlan entered the pool, or how long it took him to do so, but there is no doubt that direct supervision of Lachlan by Ms Zablah would have prevented him from doing so. Once he entered the pool there was only a very short window of time in which he could have been saved, given how little time it takes a child to drown, which is why prevention by way of supervision and barriers is so important.

86. Based upon all of the available evidence, I find that the manner of death was by way of accident.

COMMENTS

87. Under s 25(2) of the *Coroners Act* I may comment on any matter connected with Lachlan's death, including issues related to public health or safety.

88. A primary focus of the inquest was on the inherent risk presented by a swimming pool at a family day care centre, particularly for young children. When asked, most of the witnesses expressed a personal view that swimming pools should not be permitted in such environments.

89. Evidence was given that this was the only known incident involving the drowning of a child in a pool at a family day care centre in Western Australia in fifty years.[97] However, there have been similar events in at least one other state of Australia.

90. I was provided with a copy of a relevant coronial finding of Tasmanian Coroner Ian Matterson following an inquest held on 5 November 1999.[98] That case also involved the tragic drowning of a young child at a family day care in a swimming pool while the child was unsupervised for a period. It was the second such case in the local area in a decade. Coroner Matterson observed that swimming "is an integral part of growing up"[99] in Australia but there needs to be protections in place for children too young to understand water safety, which includes appropriate pool fencing. In that case, the pool gate was not, and had never been self-closing and did not meet the relevant Australian Standard, despite various inspections by a council inspector and personnel from the child care service. The lapse of direct supervision was also a significant factor in the death.[100]

91. In his finding Coroner Matterson expressed his belief that "child care facilities that cater for children under five years ought not to have pools (or for that matter, a spa or Jacuzzi) installed."[101] With that in mind, his Honour outlined his preferred recommendation was effectively for consideration to be

[97] T 79.
[98] Inquest into the death of Chloe Jessica Kealy held 5 November 1999.
[99] Inquest into the death of Chloe Jessica Kealy held 5 November 1999.
[100] Inquest into the death of Chloe Jessica Kealy held 5 November 1999.
[101] Inquest into the death of Chloe Jessica Kealy held 5 November 1999.

given to amending the relevant legislation to exclude homes with a swimming pool, spa or jacuzzi from operating as family day care homes where children under the age of five are admitted to care. However, Coroner Matterson also acknowledged that some existing family day care centres were already operating with such equipment and if it was considered a blanket ban would impose hardship upon those operators, then his recommendation should apply to any future home that is to be licensed for that purpose.[102]

92. I was informed at the inquest that Coroner Matterson's recommendation was followed and the relevant legislation in Tasmania prohibits swimming pools at family day care centres.[103] Tasmania is currently the only jurisdiction in Australia to make that prohibition, although it was suggested at the inquest that at least one local council in Australia may have implemented their own requirements in that regard.[104]

93. Mr Jon Pilkington is the Director of the Education and Care Regulatory Unit under the Department of Communities. Mr Pilkington advised that following the tragic incident involving Lachlan he issued a condition on all Western Australian family day care approvals requiring that where there is a swimming pool, spa or other water feature at the residence of an educator, then whenever a child is outside near that body of water then the educator must be physically in proximity and directly supervising the child. Failure to comply with this condition carries a maximum penalty of $50,000.[105]

94. Mr Pilkington was also aware at the time of Lachlan's death that the then Minister for Education expressed a personal view that pools should be banned at family day care centres and there were calls from the public to similar effect. With that in mind, Mr Pilkington called together the various approved family day care providers, as industry stakeholders, to discuss the issue and consider possible changes that could be made in the days after Lachlan's death.[106]

95. Mr Pilkington advised that some of the approved family day care providers made it clear at that time that if they did not allow swimming pools it would possibly preclude family day care placements in some areas and would certainly reduce the ability to provide that service in some areas.[107] Mr Pilkington explained that in their enquiries the Department had identified 12 family day care services with a pool that did not have another family day care within 5 kilometres that did not have a pool and 4 of those 12 did not have any other care option available within 5 kilometres.[108] This would have an impact on parents and children using the service and requiring child care in the area.[109] It was not clear whether those cases were in a regional or

[102] Inquest into the death of Chloe Jessica Kealy held 5 November 1999.
[103] T 77; Education and Care Services National Regulations 2012 (Cth) Chapter 7, Part 7.7, Division 3, Reg 345.
[104] T 80.
[105] T 75; Exhibit 1, Tab 12.
[106] Exhibit 1, Tab 12.
[107] T 78.
[108][108] T 85.
[109] T 84.

metropolitan area, which could also dramatically affect the distance a family might be required to travel beyond the 5 kilometres.[110]

96. Mr Pilkington also noted that there would be an impact upon those educators' income,[111] some of whom may have been deriving income from providing this service for many years without incident.

97. Mr Pilkington gave evidence that after the meeting the Department gave consideration to the various options that might be implemented. They came up with three main ways that changes could be made. The first would be to ban pools or water hazards at day care centres completely, although he noted that there is an issue surrounding the definition of what is a pool or water hazard that would need to be addressed. The second option is to permit current educators to continue but not to approve any new educators who have a pool or water hazard on their premises. The third option is to increase the level of restriction or requirements for premises that have a pool or water hazard. In that regard, Mr Pilkington gave the example of increased pool fence heights.[112]

98. Mr Pilkington indicated that the Department ultimately decided that the best course was to see whether any recommendations came out of this inquest and then consider the best changes to be made. Mr Pilkington also indicated that the Department is open to considering any recommendations that might be made.[113]

99. In the meantime, some of the family day care service providers have taken their own steps to minimise the risk. Mr Pilkington also advised that there are 41 providers who manage the family day care educators. He is aware that three of these providers (including Communicare, who were involved in this case) have of their own accord adopted the position that they will no longer accept educators who have a pool as a result of Lachlan's death. However, that is a small percentage and leaves the majority still potentially open to taking on new educators with a water hazard on their premises.

100. Mr Pilkington provided some up to date information on family day care services at the inquest and confirmed that of 1470 individual family day care educators operating in September 2017. Of those, 247 operating family day educators had a pool or other water feature at their home, and that narrowed down to 218 with a pool or spa on the premises. This is in the vicinity of 15 to 16% of all family day care educators in WA.[114] This information has been obtained through the Education and Care Regulatory Unit by requesting a register from each provider of which educators have a pool or water feature.[115]

101. Ms Melissa Perry is the current CEO of Communicare and she also held that position at the time of Lachlan's death. Ms Perry advised that Communicare

[110] T 86.
[111] T 84.
[112] T 84.
[113] T 79.
[114] T 76.
[115] Exhibit 1, Tab 12.

has updated its Water Safety Policy since Lachlan's death and they no longer take on educators who have swimming pools, spas or water features at their homes. Further, if an existing educator moves to new premises that have such a pool, spa or water feature, their membership is terminated. Communicare's decision to decline to take on any new educators with a pool or other water feature was made because of Lachlan's death.[116] However, already enrolled educators who have swimming pools or the like at their current premises have been allowed to remain operating with Communicare.

102. Ms Perry explained that the reason they have been allowed to continue as family day care educators, despite Communicare bringing a policy to refuse any new educator who has a pool, was because most of them had been educators with Communicare for an exceptionally long period of time and it would have caused hardship to those educators to make a sudden decision to terminate them. Therefore, in consultation with the board, a decision was made not to accept new educators with a pool but to await the outcome of the inquest to make a decision about the remaining already in their system.[117] At the time of the inquest Communicare managed approximately 40 family day care educators. Of those, seven still have a pool at their home.[118]

103. Ms Perry also advised that following Lachlan's death all Communicare educators who had a pool or spa were visited and their pool and/or spa environment was assessed within three days of the incident at Ms Zablah's home.[119] Further, to manage those premises in the future, Communicare has introduced a new policy of inspection where a site visit is conducted every month during which the Communicare staff member will walk around the pool to make sure that the gates are properly functioning, there are no loose panels on the fence and nothing is sited up against the fence. There is a Home Pool Safety Checklist[120] that is completed on each occasion. Communicare is also considering taking photographs of the visits at the seven remaining premises that have a pool.[121]

104. Further, the staff member doing the inspection must remind the educator of the need for supervision prompted by the checklist, which refers to adult supervision, in combination with pool fencing, as the most effective method of preventing a child from drowning. It specifies that when playing near pool fences all children must be within arms' reach of an adult.[122] There is an expectation that the children will always be within sight and/or hearing of the educator, and all in the same location; that is, all outside or all inside.[123] This is set out in the Child Safety policy.[124]

105. In addition, the Australian Children's Education and Care Quality Authority has released updated guidance material aimed specifically at the family care

[116] T 41.
[117] T 54.
[118] T 51.
[119] Exhibit 1, Tab 16.
[120] Exhibit 1, Tab 16C.
[121] T 56.
[122] T 36, 48, 53 - 55.
[123] T 49.
[124] Exhibit 1, Tab 13, NP86.

sector informing them of their roles and responsibilities under the National Law, which was developed partly in response to Lachlan's death. [125]

106. Ms Perry indicated that Communicare is always open to making sure they mitigate the risk and keep children safe, and as part of that Communicare is willing to support a total ban on pools at any form of child day care centre, if that is the outcome of the inquest.[126]

107. Mr Peter Leaversuch is the CEO of the Royal Life Saving Society in Western Australia and has been working continuously with the society in various positions for more than 20 years. Mr Leaversuch confirmed that Royal Life Saving WA is contracted by the City of Wanneroo to carry out pool safety barrier inspections, as well as for a number of other local governments. In the financial year leading up to the inquest Royal Life Saving WA had conducted 7000 pool inspections, with an individual inspector completed approximately 6 to 8 inspections on any working day.[127] According to Mr Leaversuch, approximately 70% of pools inspected will comply on the first visit, another 20% will be compliant by the second visit after some rectification has been completed and the remaining 10% will be referred back to the relevant local government to take action against the homeowner.[128]

108. Mr Leaversuch agreed that the statistics are concerning in that they represent a falling back in safety standards over the four year period between inspections, given so many properties fail. However, to decrease the inspection period to a shorter period than four years would represent a logistical challenge given there are approximately 150,000 pools in the State.[129] Mr Leaversuch indicated his preference is to empower the homeowner to prioritise and maintain safety themselves. As Mr Leaversuch put it, 'we are trying to win the hearts and minds of homeowners …that this is important and it's reasonable."[130] However, in the absence of that being achieved he accepted the alternative might be to consider increasing the frequency of inspections.[131]

109. This is within the context that, depending upon when the pool was installed, different safety requirements apply, although the inspectors encourage homeowners of older properties to voluntarily increase safety barriers.[132]

110. Mr Leaversuch agreed in his evidence that he would recommend changes to the way inspectors inspect a pool barrier where the property is used to conduct a family day care business, although until now that has not been a major focus as it is not information routinely provided by the council to inspectors. Mr Leaversuch agreed that such information would be important to assist the inspectors in considering the context and assess the risk.[133]

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[125] Exhibit 1, Tab 12.
[126] T 56 – 57, 63.
[127] T 105.
[128] T 105 – 106.
[129] T 115.
[130] T 116.
[131] T 115.
[132] T 106 – 107.
[133] T 108.

111. Mr Leaversuch was asked whether in his opinion he considered it appropriate to have a swimming pool on a family day care premises and he indicated he believed it was appropriate, as there are ways to use pools safely, but he also emphasised that constant supervision is something that he would want to see strengthened in such circumstances. The emphasis is on "learning to live with water"[134] and the Royal Life Saving WA message is "keep watch," which has four key components: always supervise, fence the gate, teach the kids to swim and learn resuscitation. These same principles would apply to a child care setting.[135]

112. Nevertheless, although he was not familiar with how family day care centres operate, Mr Leaversuch accepted that it would be a challenge to provide the appropriate level of supervision "and feel you're under control."[136]

113. In terms of pool fencing, Mr Leaversuch emphasised that it is designed to impede access and act as a deterrent but it is not a foolproof solution and cannot replace supervision. So although Mr Leaversuch conceded a higher fence might provide a greater deterrent, he noted the greatest risk is often from the gate failing or being left open to provide access, or climbable objects being left near the fence.[137]

114. Mr Leaversuch noted that Western Australia is the only state that has been requiring councils to conduct checks on pool safety barriers every four years, so our current regulations are unique in that regard and we are leading the way for other states.[138]

115. Mr Leaversuch provided some statistics and information on child drownings in Australia and noted that the most at risk group is toddlers under five and in a home setting. Lachlan's death fell into both categories. Mr Leaversuch noted that supervision is always the number one factor in these cases, followed by fencing. Mr Leaversuch also provided the frightening statistic that "for every drowning, there's about 10 hospitalisations,"[139] so there are a lot of near misses surrounding every tragic death. The greatest proportion of these events, representing over half of the incidents, occur in a swimming pool. Boys are also over-represented, making up approximately two thirds of the victims.

116. The Ombudsman for Western Australia, recently completed a major investigation into ways to prevent or reduce deaths of children by drowning in Western Australia. The report is available at www.ombudsman.wa.gov.au/drowningsreport. The investigation looked at fatal and non-fatal drowning incidents involving children in Western Australia from 1 July 2009 to 30 June 2015 and found, similarly to the statistics provided by Mr Leaversuch that most of the incidents involved children under 5 years and 54% of those deaths and 66% of the non-fatal

[134] T 114.
[135] T 107 - 108.
[136] T 113.
[137] T 109.
[138] T 110 – 111/
[139] T 113.

incidents occurred in a swimming pool. The Ombudsman's investigation also found that a lack of supervision and an inadequate or faulty pool barrier or climbable object near the permanent barrier were major factors in the incidents.[140]

117. In the final report the Ombudsman made 25 recommendations to the Department of Mines, Industry Regulation and Safety and the Building Commissioner, which were primarily focussed on swimming pool barriers.

118. Some information was also obtained for the inquest from the National Coronial Information System, which shows that from 2012 to 2017 there were 49 drowning fatalities involving children less than 5 years old across Australia. Western Australia represented 22.4% of those fatalities, with only Queensland recording a greater percentage. The more populous states such as New South Wales and Victoria recorded a significantly smaller number, particularly given their greater population base.[141]

119. Mr Leaversuch commented that supervision is the key as "we know with every record that we review, there was a lack of supervision or they were unaware that the child had entered that area."[142]

120. I am advised that Mrs Mitchell currently works with Royal Life Saving WA as a parent ambassador to increase community engagement in strategies to prevent childhood drowning.

121. Mrs Mitchell gave evidence at the conclusion of the inquest. In her evidence, Mrs Mitchell urged this State to be a leader in ensuring that there is supervision, accountability and enforcement at family day care services as Lachlan's death was due to more than just a pool being present on the day. However, Mrs Mitchell also suggested that there should be state-wide pool regulations, rather than local government specific. Mrs Mitchell acknowledged that it might be logistically difficult to implement some of these changes, she emphasised that the safety and wellbeing of children needs to be put first and foremost before everything else.

122. The evidence before me demonstrates that children five years old and under are particularly at risk of drowning in a swimming pool. While pool barriers are important as a deterrent, the statistics show that they cannot replace supervision.

123. The Ombudsman has given detailed consideration to ways in which to strengthen pool barrier protection in Western Australia through the current system and made a large number of detailed recommendations in that regard, so I do not propose to make any further recommendations of my own in that regard.

124. My focus is upon supervision, and particularly at a family day care, where one educator is required to supervise a number of children, who may be all

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[140]. Ombudsman (WA), *Investigation into ways to prevent or reduce deaths of children by drowning*, (November 2017), pp. 14 – 16.
[141] Coronial Report CR17-03 Drowning Fatalities of Children 5 Years or Under in Australia, 2012 – 2017, NCIS.
[142] T 113.

close in age and relatively unfamiliar with the physical environment. In those circumstances, having a swimming pool on the premises where there are children under five years of age creates an unacceptable level of risk. Accordingly, I am satisfied that the proper approach is for family day educators who choose to enrol children under the age of five years to be prohibited from having a swimming pool or other large fixed water hazard on their premises.

RECOMMENDATION 1

I recommend that the Honourable Minister for Child Protection and Community Services give consideration to amending the relevant legislation in Western Australia to exclude homes with a swimming pool, outdoor spa or jacuzzi from being used to operate a family day care service where children under the age of five are admitted to care, which should come into effect immediately given the high level of risk of drowning.

125. There also remains a potential risk for children over the age of five years, but I accept that there needs to be some transition to allow educators who have been operating for many years from their homes that have a swimming pool, without incident, to continue to earn an income from that occupation. In those cases, I consider the approach adopted by Communicare following Lachlan's death to be an appropriate one, involving an increased level of inspection of the premises with specific attention paid to the pool safety barriers and any climbable hazards, as well as reinforcement of the need for direct supervision.

RECOMMENDATION 2

I recommend that the Honourable Minister for Child Protection and Community Services give consideration to amending the relevant legislation in Western Australia to exclude new family day care educators from being approved to operate a family day care service from a home with a swimming pool, outdoor spa or jacuzzi.

RECOMMENDATION 3

I recommend that the Honourable Minister for Child Protection and Community Services give consideration to amending the relevant legislation in Western Australia to require that where an existing family day care educator operates a family day care service from a home with a swimming pool, outdoor spa or Jacuzzi (which will only be for children over the age of 5 years) the approved provider must physically inspect the property monthly to ensure that the safety barrier to the water hazard is functioning effectively and there are no climbable hazards in proximity to the fencing. The need for direct supervision in proximity to the water hazard must also be reiterated to the educator during each inspection.

126. A submission was also made on behalf of Lachlan's family that where a pool is allowed to be present, it should be fitted with a child proof and weight bearing cover. There was no evidence before me as to whether such a thing is currently available in Western Australia, although a brief search of the internet indicated that such a product is likely to be available. It does seem to me to be a sensible and practical option, although I am unaware of the cost of installation and how safe it really is. It certainly does not replace a pool safety barrier. In the circumstances, I make the observation that it may well be a wise option for an approved provider to require any family day care educator with a pool continuing to operate with their service to install such a feature, but I do not make a specific recommendation in that regard.

127. Another issue that was raised at the inquest was that of alternate means of communication in an emergency situation. It arose from the evidence that Ms Zablah could not initially find her mobile telephone and did not have a landline, so she eventually had to leave Lachlan while she went to the neighbour's house to get help and ask them to ring for an ambulance.

128. Ms Zablah agreed in questioning that it would have been better to have had a landline for emergency situations, rather than just a mobile telephone.[143]

129. Ms Georgiou gave evidence that it is not a requirement of Communicare that a family day care service has a landline. It is only a requirement that they have a means of communicating with the service, so a mobile telephone will suffice.[144]

130. Ms Perry, as the CEO of Communicare, gave evidence that it was not an issue that had been considered by Communicare but having heard it raised at the inquest it was "definitely something we will take back and consider thinking about an alternative if there's only one landline or one mobile

[143] T 21.
[144] T 37.

phone."[145] Ms Perry agreed that having an alternative form of communication in an emergency is important, and accepted that mobile telephones in particular are prone to being misplaced.[146]

RECOMMENDATION 4

I recommend that the Honourable Minister for Child Protection and Community Services give consideration to requiring all family day care educators to have a fixed landline installed at their premises so that it is available to contact emergency services in the case of an emergency.

131. A submission was made in relation to recommending that a 'Damages Award' be included in the relevant legislation. I do not see that as falling within the ambit of public health or safety, and I note there is a civil legal process in this State, so I do not propose to make any recommendation in that regard.

CONCLUSION

132. Lachlan's death was tragic and entirely preventable. Lachlan's family want to ensure that no other family suffers such a loss when their child is meant to be safely being cared for at family day care. They hope that lessons can be learnt from this inquest into Lachlan's death. I have made a number of recommendations that hopefully will lead to changes being made that will put into effect the message that Mr and Mrs Mitchell and their extended family have been promoting as part of Lachlan's legacy.

S H Linton
Coroner
30 May 2018

[145] T 55.
[146] T 61.