NEW SOUTH WALES STATE CORONER

Name of Deceased: **Jayden Matthew Lynch**

File Number: **0235/10**

Hearing Dates: **15 – 17 September 2010**

Location of Inquest: **Grafton Local Court**

Date of Finding: **15 October 2010**

Coroner: **Magistrate Scott Mitchell, Deputy State Coroner**

Representations:

- **Mr Guterres of the Crown Solicitor's Office, instructed by Ms Murty appeared to assist the Coroner.**
- **Mr Radburn of Counsel appeared for Mr and Mrs Lynch.**
- **Mr Dearn of the Queensland Bar appeared for Kerrie and Jeffrey Pemberton.**
- **Mr Saidi of Counsel appeared for the Department of Human Services, Community Services.**
- **Mr Kettle of Counsel appearEd for *Clarence Childhood Services Association Incorporated* T/as *Clarence Family Day Care***

1. This is an inquest into the death of Jayden Matthew Lynch who was born on 6 December, 2005 and died on 15 December, 2008. Jayden was the son of Ty and Cyndi Lynch of Yamba in northern New South Wales. Mr. Guterres of the Crown Solicitor's Office, instructed by Ms. Murty, appeared to assist the Coroner. Mr. Radburn of Counsel appeared for Mr. and Mrs. Lynch, Mr. Dearn of the Queensland bar appeared for Kerrie and Jeffrey Pemberton, Mr. Saidi of Counsel appeared for the Department of Human Services, Community Services, and Mr. Kettle of Counsel appeared for *Clarence Childhood Services Association Incorporated* T/as *Clarence Family Day Care*. At the commencement of the inquest, for reasons which I gave at that time, I dismissed an application of Mr. McGee of Counsel on behalf of *Workcover* for leave to appear.

2. The inquest took place from 15 to 17 September, 2010 at Grafton and on 15 September, there was a view of the premises at Yamba where Kerrie Pemberton conducted her day care business.

3. An inquest is a special kind of judicial proceeding. It is very ancient in origin. There were coronial inquests before the Norman conquest but nowadays the jurisdiction is governed by the provisions of the *Coroners Act 2009*. The purpose of an inquest is to discover the truth rather than to apportion guilt and blame or liability. Nobody is on trial at an inquest and the primary duty of a coroner is to determine the identity of the deceased and the date and place of death and the cause and manner of death. There is no doubt, in this case, about the *identity* of the deceased and no doubt as to the *date* of death. As to the *place* of death, it is likely that Jayden's death occurred at Yamba but possible that it occurred later, in the ambulance as he travelled to hospital or at Maclean District Hospital, Maclean. The *cause* of death is sometimes, as in the present case, not a matter of controversy and is usually determined by the coroner accepting the findings of the pathologist who conducted the autopsy. So the nub of this particular inquest is the *manner* of Jayden's death – what were the circumstances which surrounded his death and how might it have been avoided. In an appropriate case where there are lessons to be learned from the manner of death, lessons which might save other lives, the coroner is authorised by section 82 to make recommendations. In their letter to the coroner proposing an inquest, Mr. and Mrs. Lynch asked a number of questions and Mrs. Lynch reiterated them when she came to give evidence during the hearing. One of the purposes of the inquest has been to try to answer those questions because they go to the manner of Jayden's death. Another has been to mark the importance of Jayden's life. He was only a little boy but to his parents, quite rightly, he was a real treasure and to the community at large, he was a citizen and a person who should not have died so young and one from whose passing there are lessons to be learned and good to be done.

4. The *formal* documents including the *P79A*, the *Identification Statement,* the *Certificate of Life Extinct,* the *Autopsy Report* and the *Certificate of the Division of Analytical Laboratories* are, jointly, Exhibit 1 in the proceedings.

5. Dr. Kasinathan Nadesan who conducted the autopsy gave evidence at the inquest. His finding as to the cause of death is not in issue but he explained some of the bases on which he formed his opinion. On examination, he found slight congestion of the brain consistent with *asphyxia* and he found a large volume of inhaled stomach contents in the airways and deep in the lungs.

6. The surface areas of the lungs had collapsed which Dr. Nadesan thought indicative of Jayden having been alive at the time when his airways became blocked. The volume of inhaled stomach contents, on the other hand, persuaded him that Jayden had probably been unconscious at the time and, thus, without a cough reflex so that he was unable to clear his airways. Noting his history, Dr. Nadedsan suggested that Jayden's unconsciousness could probably be explained by seizure.

7. Whether that was a *febrile* seizure or an *epileptic* seizure is unknown but, on examination of Jayden's lungs, Dr. Nadesan found symptoms of a pre-existing infection which may have lead to an elevated temperature. On microscopic examination of the lungs, he found signs of lobar pneumonia.

8. Dr. Nadeson's opinion as to the cause of Jayden's death is that there was a pneumonic infection which, by elevating the temperature, may have prompted a seizure. In the course of that seizure and while Jayden was unconscious so that his cough reflex was suppressed, Jayden vomited and inhaled a volume of vomitus into his airways and lungs which he was powerless to expel so that he was asphyxiated. According to Dr. Lennon, vomiting is frequently associated with seizure as is involuntary wetting which appears to have been present in this case.

9. Dr. Nadesan was unable to confirm it but thought that Jayden was probably asleep throughout and Dr. Lennon told the inquest that it is relatively common that children experience seizures in their sleep. Indeed, that seems more often than not to have been so in Jayden's case so that he may never have known that anything was amiss.

10. Nevertheless, both Dr. Nadesan and Dr. Lennon told the inquest that some observable signs of fitting such as jerking or stiffness are likely though not absolutely certain to have been present and available to be seen irrespective of whether Jayden had been asleep at the time.

11. The coronial brief prepared by Detective Senior Constable Grahame Burke, the officer-in-charge, is Exhibit 2. That brief contains statements of various police, *ERISP* transcripts of interviews with Mrs. Lynch and Mr and Mrs. Pemberton, a statement of Dr. Ian David Lennon, Jayden's consultant paediatrician, medical and hospital records, *Clarence Family Day Care*

records produced by and concerning Mrs. Pemberton, various documents published by *National Childcare Accreditation Council*, statements of 15 and 14 December, 2010 of *Clarence Family Day Care* employees Warwick Casson and Janet Kelemec respectively and, very significantly, a letter from Jayden's parents received at the NSW State Coroner's Office on 27 October, 2009.

12. Those who gave evidenced at the inquest included:-
    - The officer-in-charge, Det. Sen. Const. Grahame Burke;
    - Jayden's father, Ty Lynch;
    - Jayden's mother, Cyndi Lynch;
    - Kerrie Pemberton;
    - Jeffrey Pemberton;
    - Dr. Kasinathan Nadesan, forensic pathologist;
    - Dr. Ian David Lennon, consultant paediatrician;
    - Warwick Casson, Child Development Officer of Clarence Family Day Care; and
    - Janet Kelemec, its Scheme Co-ordinator.

13. Even those of us who did not know him, but have read about him and have heard about him know that Jayden was a dear little boy. In their letter, his parents wrote that *" He was a healthy three year old boy. He was a vivacious, funny, intelligent, affectionate child who absolutely loved life. He lit up any room he entered and instantly made people smile. He loved to laugh and receive and give cuddles."*

14. Jayden was conceived after five cycles of IVF treatment and his parents described him as *"our miracle baby."* His father told the inquest that he was *"a gift"* with a beautiful nature, very intelligent and possessing an ability to connect with those about him. He made friends readily with old and young alike. He had a good sense of humour and loved jokes and stories. He loved reading, the *Wiggles* and going out to western New South Wales to visit his grandparents and ride on his grandfather's tractor.

15. Despite a significant health problem about which more will be said, Jayden was not a sickly child. He loved life and his father said that he was *"always positive." "With Jayden,"* his father told the inquest, *"the glass was always 2/3 full."*

16. I have no doubt that everybody associated with this inquest will wish me to extend our heartfelt sympathy to his family and to all those who loved Jayden and still miss him. And everybody will agree, too, that this is a tragedy and that *"Jayden has lost his opportunity to live a full and rewarding life. He should be here today in our arms being loved by his family."*

17. Jayden started at Kerrie Pemberton's day care centre at 30 Wattle Drive, Yamba on 2 May, 2006 and he remained there until the date of his death. At first, he attended on one day per week and, over 2007, his attendances gradually increased until he was attending on five days per week. Then, in August, 2008, he scaled back to four days per week. His parents worked and

still work in their business only a very short drive from the Pemberton house and the evidence shows that Mrs. Lynch was able to be there within a minute or two of being called. Mrs. and Mr. Pemberton, too, were very fond of Jayden and he of them and, of course, Kerrie Pemberton played a very significant part in Jayden's life. As Mr Dearn said in submissions, their lives, too, have been *"shattered"* by his death and I agree that it must have been very difficult for them to participate in and give evidence to this inquest. I am grateful to them and respect their grief at the loss of this dear little boy.

18. I had the opportunity to visit and view the Pemberton's home at 30 Wattle Drive, Yamba where the day care centre was conducted. Exhibit 3 is a plan of the house showing the playroom where the children spent most of their time together with the lounge/dining room and the kitchen, both of which had windows looking into the playroom. In addition, there was a glass sliding door leading from a family room adjacent to the kitchen into the playroom. I noticed, though, that the playroom is not as easily viewed from elsewhere in the house as one might have expected. In the first place, about half of the area of the lounge/dining room window is covered by a cupboard. From the lounge dining room, visibility of the floor area of the playroom, where the children were put down to sleep or rest on little mats or mattresses, is further restricted by furniture placed in the playroom, particularly a large table kept close to the dining room window and, even if one is standing in the lounge/dining room right up against the window, a good deal of the floor area of the playroom is obscured. The kitchen window is above the sink and I found it helpful in seeing the greater part of the floor area to stand as close to the window as possible, leaning over the sink and standing on tip toe. Even in that pose, I was unable to see the point on the playroom floor where Mrs. Lynch says she found Jayden when she arrived to find him dead on 15 December, 2008 and even the point where Mrs. Pemberton says he was lying, further out towards the centre of the room, could be seen through the kitchen window only with difficulty.

19. So far as the sliding glass door is concerned, it was and remains covered with gauze and, on its lower panels, with sail cloth which reduces its transparency and, if one is crossing the room from the kitchen *en route* to the lavatory or the bedrooms, as both Mr. and Mrs. Pemberton say they occasionally were, their view of the playroom floor would have been further limited by a large cupboard standing in the playroom near the sliding doors and by the bench and the table in the family room beyond which they had to pass to reach their destination. I do not say that that one could not have seen Jayden as he lay sleeping from the lounge/dining room, the kitchen or the family room but it does seem to me that it would have been necessary to make an effort - either to stand near the dining room window, to stand on tip toe at the kitchen window or to pause in the family room, in order to see clearly into all areas of the playroom where children were likely to find themselves. The interior of the playroom was not as easily viewed as one might have thought.

20. Jayden was happy in day care. He and Mrs. Pemberton were obviously fond of each other. His routine there included play time with other children and there were refreshments and a sleep in the afternoons, usually from about

1pm until 3pm.. Mr. and Mrs. Lynch were generally very happy with the care Jayden received from Mrs. Pemberton.

21. Jayden first experienced a seizure on 8 June, 2006. The Maclean District Hospital notes record that he presented *"with a history of screaming attack associated with going very quiet, arching of his body associated with eyes rolling back in his head (according to and witnessed by his mother.) Patient also had very clear red fine rash all over his body."* He was *afebrile* with no obvious respiratory distress on arrival at hospital but there was a recent history of flu like symptoms including a cold and a runny nose.

22. Next day, Jayden was transferred to Lismore Base Hospital where he was admitted for the night. It was here that he first came into contact with Dr. Lennon who has been his paediatrician since that time and who gave evidence at the inquest. It appears that Jayden was hospitalised on eight separate occasions following seizures, most of which occurred during his sleep and were of various durations of between about 20 seconds and, on 25 October, 2006, 8 minutes.

23. Jayden's first known seizure occurred shortly after he was vaccinated which may have prompted some speculation as to the cause of his subsequent difficulties. In fact, Dr. Lennon was able to tell the inquest that no cause for Jayden's epilepsy was ever found despite extensive investigation. Dr. Lennon explained that epilepsy – true epilepsy, is *afebrile* in that it is not prompted by or associated with fever and that, in his opinion, Jayden was a true epileptic. That is not to say, however, that he did not sometimes experience *febrile* convulsions, which are not uncommon phenomenon in children, and where temperature and fever are very definitely factors. In fact, Dr. Lennon's opinion is that some of Jayden's seizures were *febrile* in character and some were a manifestation of true epilepsy. It appears that the outward signs of epileptic convulsion and *febrile* convulsion are similar but the cause and the treatment differ markedly. Indeed, Dr. Lennon explained that some medications, indicated for epilepsy, simply *"do not work"* or, in other instances, are not very effective in relation to *febrile* convulsions. Further, medications used for *febrile* convulsions tend to have undesirable side effects and, although these convulsions are a serious matter, medication is necessarily used extremely sparingly. The undesirable side effects of medication otherwise available to treat *febrile* convulsions may range from a definite risk of fatal liver disease and suppression of breathing to an increase in disinhibited behaviour in the young. Fortunately, *febrile* convulsions rarely continue beyond the fifth year of a child's life so that the most common form of management consists of medication such as *nurophen* designed merely to reduce temperature and this is how Jayden's propensity to *febrile* convulsions was approached. As to true epilepsy, his most important medicines were *Tegratol* and, later, *Trileptac.* *Trileptac* is not effective for *febrile* convulsions but it achieved some limited success in managing Jayden's epilepsy and where it was necessary to dispel a seizure, *diazepam*, was administered rectally.

24. Dr. Lennon went on to describe the nature of seizures or convulsions or fits – the terms are interchangeable. They can be simple or complex, simple when

they affect a single part of the body, usually a single limb, and complex when multiple parts of the body are involved. In the case of complex seizures, there is often some warning which the sufferer can detect and this is known as an aura but warnings are by no means always available and never or almost never in the case of simple convulsions. Sometimes, a complex seizure is accompanied by a scream and more often by a diminished consciousness level which can amount almost to unconsciousness.

25. In Jayden's case, it is likely, judging by some of his behaviours, that he could sometimes predict an approaching seizure was approaching but this seems not to have been always the case. Sometimes he was affected in one body part only and sometimes generally. Sometimes he lost consciousness although most of his seizures appear to have taken place while he was asleep. On the other hand, what was likely to have been his longest seizure, a grand mal incident on 25 October, 2006, and another incident while he was in the shower on 30 October, 2008 occurred while he was wide awake.

26. In answer to Mr. Saidi of Counsel, Dr. Lennon stressed the importance of education for those caring for a child prone to seizures, whether febrile or afebrile. In particular, any hint of elevated temperature and any apparent sluggishness or diminished appetite should be watched for and treated as a warning sign. According to Dr. Little, time is of the essence in managing an epileptic seizure and rectal valium (diazepam) is recommended at two, three or five minutes from the first onset, depending on the individual case. Then, if the seizure has not been brought under control within twenty minutes of its first onset, the person caring of the child should seek medical or hospital assistance and, if necessary, call for an ambulance. In the meantime, Dr. Lennon said, the child should be placed in a safe position, the so called recovery position which is lying on his or her side so as to minimise the possibility of choked airways.

27. Of course, timing the progress of a seizure is not always possible, particularly if the seizure occurs while the child is asleep so that the onset of the seizure is not always noticed and, according to Dr. Little, that circumstance merely highlights the need for close supervision of the sleeping child.

28. All in all, it is plain, as Dr. Lennon emphasised, that carers including parents, teachers and childcare professionals need to be properly trained with emphasis on how to detect the warning signs, how to respond to seizures, how and especially when to administer medication and when to seek medical/hospital assistance. It appears that, while timing is not everything, it is of paramount importance in the safe and efficient management children experiencing seizure. The carer must learn how to properly record the time of the onset, the time when medication is to be administered and the time when professional help is to be sought and, in the meantime, how to properly place the child so as to minimise damage during the seizure.

29. Although Dr. Lennon cannot recall preparing a management plan incorporating those principles for Mr. and Mrs. Lynch, it is likely that he did do so and I note his view that the written instructions which Mrs. Lynch gave to

Mrs. Pemberton to assist her in managing Jayden should he suffer a seizure were appropriate and in line with Dr. Lennon's views. These principles were adopted by Jayden's parents and Mrs. Lynch's evidence is that, on the first day when Jayden went to care after diagnosis on 19 July, 2006, she handed to Kerrie Pemberton the written management plan, a photocopy of which is contained at page 110 of the brief, and explained to her the various instructions in detail. Mrs. Pemberton's evidence is that, in July, 2006, Jayden's mother gave her written instructions but that, apart from those written instructions, she was told little about Jayden's medical condition and about what to do in the event of a seizure. She admits that she was told to place the boy on his side in the recovery position while he was in seizure but she says she never knew that sometimes his seizures might be prompted by fever, that sometimes his seizures might take place while he was asleep, that the administration of *nurophen* or *Panadol* was important in preventing temperature or that vomiting might accompany seizure.

30. These are matters which it was most important for his carer to know and I think Mrs. Pemberton is mistaken in suggesting that Jayden's mother did not provide her with proper information about them. It is quite clear that, far from being relaxed about keeping a close watch on Jayden and about his medical needs, Mrs. Lynch was punctilious, not to say obsessive, about those matters. She provided the written note to Mrs. Pemberton setting out various instructions as the latter admits. She provided a thermometer for Jayden's use. She provided the medication and regularly came to Mrs. Pemberton's house to check the *use by* dates of the various medicines and to replace outdated medicines. I believe her when she says she had frequent discussions with Mrs. Pemberton about Jayden's health as it evolved over time and the various requirements as to his management. I have no doubt that she did keep Mrs. Pemberton fully informed in great detail about Jayden's health status and his particular needs including detailed instructions as to how to manage him and what to watch out for including elevated temperature, depressed appetite and listlessness and about the need to watch him closely and constantly.

31. On the morning of 15 December, 2008, Jayden appeared to be his normal, "*buzzy"* self as he prepared for the day until he confided in his father that he was feeling off colour. Mrs. Lynch thought he was not too bad and noted in her statement that *"…he appeared to be OK … and was eating OK… He had no runny nose that morning. I honestly thought that he was toying with us. I didn't think he was genuinely sick."* But his parents took his temperature twice that morning which returned readings of *37.4* and *37.5* and, because Dr. Lennon had said that a temperature of *37.5* was the commencement of *"the danger zone,"* Mrs. Lynch administered some *nurophen* along with his regular medication and then got him ready for the day care centre. She delivered him there a little before 9 o'clock and, according to her statement, told Mrs. Pemberton *"Jayden has told Ty he's S-I-C-K. But, as you can see…he looks fine."* Mrs. Lynch added *"I was going to go to Grafton. I'm not now. I'm at work. I've got nothing major on. If there's any problems, if something develops, give me a ring and I'll come and get him."* Mrs. Pemberton admitted in cross-examination that although, on this occasion, Mrs. Lynch

warned her to *"keep an eye on him,"* she didn't take any special precautions because Jayden seemed his normal self and, in particular, she saw no reason to check his temperature.

32. Also in Mrs. Pemberton's care that day were Kyla, then aged a little under 5 years, Natalia, then 4 years of age, Melody, then about 2 and a half years of age and a baby, Lily, asleep in a cot in a bedroom. Jayden spent the morning playing, doing puzzles and paintings and singing Christmas songs. There was morning tea at 10 o'clock and lunch at noon. Then Jayden and the others helped clean up the lunch table and prepared for a nap by arranging sleeping mats on the floor of the playroom.

33. There is some doubt as to the precise location of Jayden's sleeping mat. Mrs. Pemberton would place it on the floor of the playroom about midway between the children's lunch table and the sliding door and well out from the kitchen windows so that it could easily be seen through those windows. Mrs. Lynch would place it closer into the children's table and closer towards the kitchen windows to that it could not so easily be seen whether through the kitchen windows or the lounge/dining room windows. Although I can't be sure, I think that Mrs. Lynch's recollection is to be preferred because both Mrs. and Mr. Pemberton say that each checked on Jayden while passing through the family room *en route* to the lavatory but I think that, because of the position of the bench and the table in the family room behind which they would have passed and the cupboard standing in the playroom against part of the sliding door, the view of Jayden from the family room would have been greatly limited if he were positioned as Mrs. Pemberton says he was.

34. It was about 1pm when Jayden went down for his afternoon sleep, lying on his mat with a sheet over him. And the other children either slept or sat quietly watching television while Mrs. Pemberton cleared up and then stood in the kitchen, making her lunch which she ate at the dining table or sitting on the settee. A few minutes later she was joined by her husband, Jeffrey Pemberton. Both Mrs. and Mr. Pemberton have made statements which are part of the coronial brief and each was closely cross-examined at the inquest. I think they did their best to answer the questions put to them. But so poor and confused are their recollections of their movements that it is not possible for me to be entirely clear as to the precise steps they took with regard to the supervision of the children from Mrs. Pemberton's withdrawal to the kitchen to prepare her own lunch until the time when she re-entered the playroom to wake the children.

35. It is clear that Mr. Pemberton watched television and may have fallen asleep so that the degree to which he supervised the children was, I think, minimal although, *en route* to the lavatory, he may well have glanced at them or some of them through the sliding doors in the playroom. Mrs. Pemberton ate her lunch, watched a little television and attended to her paper work at the dining table and, from time to time, looked into the playroom to see the children, either through a window which I think she did on one but perhaps on two occasions, or by peering through the sliding door in the family room which I think she did once or perhaps twice. In addition, like her husband, she

glanced into the playroom *en route* to the lavatory. Although the television was playing, she says that she didn't have much interest in it and could have heard any disturbance among the children had one taken place and, no doubt, had she been so alerted, she could have been in the playroom within seconds. Had there been an intruder or had a fire broken out, she would have been on the *scene* and, in that sense, the children were supervised throughout. But the supervision was really not *close supervision* in the sense that Jayden needed it and Mrs. Pemberton, even when she was standing at the sliding door, peering into the room, was not really checking on the *welfare* of the children, much less their *health* but, whatever she thought she was doing, was merely ensuring their presence in the room and the absence of any disturbance. As events so tragically demonstrate, this was inadequate to Jayden's needs.

36. Although Mrs. Pemberton's evidence is that she took no special precautions as to Jayden's supervision on 15 December, I think this was a day when particular care was indicated. Mrs. Pemberton was on notice that, although it may have appeared inconsistent with his boisterous and cheerful affect, Jayden had complained about feeling sick that day and his mother had asked her to *"keep an eye on him."* Furthermore, Mrs. Pemberton had seen one of Jayden's convulsions for herself. On 13 August, 2007, while he was playing on a tricycle, Jayden suffered a seizure and fell to the ground. On that occasion Mrs. Pemberton scooped him up and carried him inside. He was shaking and his eyes were rolling and she laid him on a mat in what she had been taught was the *recovery* position. Mrs. Pemberton told the inquest that she had been frightened and that, over the following months, she and Mrs. Lynch had frequently discussed Jayden's epilepsy and she also related the incident to her supervisor, Warwick Casson.

37. The children were due to get up at 3pm but, for some reason, Mrs. Pemberton was running late and it was 3.15 when she entered the playroom to wake them. The two older children were already awake – perhaps they had not slept - and she called *"time to wake up, Jayden,"* noticing that half of his face was in the pillow. She bent down to rouse him and saw that his lips were blue and his face very white. She saw that he had wet the bed, felt that he was clammy and noticed that he was not breathing.

38. Mrs. Pemberton called to her husband to phone Mrs. Lynch which he did and, grabbing the telephone from Mr. Pemberton who was panicking, she called *000*. Not surprisingly given the ghastly events, Mrs. Pemberton is not entirely clear whether she commenced *CPR* before or immediately after taking the phone and, almost immediately, Mrs. Lynch arrived and took over *CPR*. An ambulance arrived three minutes after Mrs. Lynch, at 3.24pm and Jayden was described as *"cyanosed, pulseless, apnoeic and asystolic".* Ambulance officers attempted *CPR* and Jayden was treated with adrenaline and atropine but without result and he was transported to Maclean District Hospital and pronounced dead at 4.15pm. It is not certain whether death took place at Yamba or *en route* to hospital or at Maclean.

39. The conduct of Mrs. Pemberton's day care operations were governed by legislation. Under the *Children and Young Persons (Care and Protection) Act 1998* and the *NSW Children's Services Regulation 2004*, a licence was granted by the Director-General of the Department of Human Services (Community Services) to *Clarence Childhood Services Association Incorporated* trading as *Clarence Family Day Care* to provide professional and supervised care for children in the homes of registered carers. *Clarence Childhood Services Association* is one of many similar volunteer organisations of which the *NSW Family Day Care Association* is the peak body. According to Janet Kelemec, the principal executive officer of *Clarence Childhood Services Association Incorporated*, *Clarence Family Day Care* provides for approximately 1,000 children throughout the Clarence Valley area. The child care system of which *Clarence Family Day Care* and, ultimately, Mrs. Pemberton's operation are part is, as Mr. Saidi described it, *"self-regulating"* in the sense that, once the Director-General has granted a licence, her relationship is with the *licensee* and the *authorised supervisor* who that *licensee* appoints – in this case, *Clarence Family Day Care* as *licensee* and Ms. Kelemec as *authorised supervisor.* The *licensee* then appoints *family day care carers* who, like Ms. Pemberton, may be *primary carers* or may be *relief carers* but who have no direct relationship with the Department. *Primary carers* like Mrs. Pemberton have a relationship, not with the Department but with the *licensee*.

40. *Primary carers* and *relief carers* must be registered with the *licensee* and that registration is renewable annually and they must comply with certain other criteria. For instance, a *primary carer* must hold a current First Aid certificate which Mrs. Pemberton told the inquest is renewable every three years after a two day refresher course. Further, a *primary carer* will be required to undertake training prescribed by the *licencee* from two to four times per year and Mrs. Pemberton has been trained in such topics as *safety in the home, risk of harm behaviours* and *failure to thrive*.

41. The *primary carer*, who is defined in the Regulation as *"a natural person who is directly involved, at his or her home, in educating, supervising or caring for children for a family day care children's service,"* was required to accept the supervision and directions of the *licensee* and some of these directions related to the keeping of records, the provision of information to the *licencee* and willingness to allow regular fortnightly and sometimes *ad hoc* inspections and audits by the *licensee*. In return, the *primary carer* was entitled to expect information, advice and support from the *licensee* and, specifically, from its executive, the *authorised supervisor*. As at 15 December, 2008, Ms. Kemelec was the *authorised supervisor* and Warwick Casson, who filed a statement and gave evidence, was her agent in his dealings with Ms. Pemberton.

42. The system is complex but it is beyond my task as coroner to look into its rationale or its origin. I imagine that one of its principle virtues is that it allows for a degree of self-regulation in what is, after all, an important service rendered in large part by dedicated private citizens who government is keen to encourage. And the success of the system over time and on a state-wide basis suggests the wisdom of its design. The Department sets the tone and

philosophy of child day care and insists on minimum standards, allowing *licensees* with their personal dedication and local knowledge to implement child care arrangements in their own local areas.

43. But the system depends on *licensees*, through their *authorised supervisors*, enforcing standards, providing proper support and acting with a degree of rigour to ensure that standards remain high and here, I think, both Mrs. Pemberton and, more importantly, Jayden may have been let down.

44. In this case, the conduit between the *licensee* and the *authorised supervisor* on the one hand and the *primary carer* on the other, was Warwick Casson. Mr. Casson was and remains an employee of *Clarence Family Day Care* working to Ms. Kemelec and it was his job to deal with Mrs. Pemberton, ensuring her compliance with her obligations, providing her with appropriate support and information and keeping his employer and Ms. Kemelec informed of what was happening at Mrs. Pemberton's service. If, on his fortnightly inspections, Mr. Casson discovered any default on Mrs. Pemberton's part or any failure to comply with her various responsibilities, it was his job to correct her and to inform Ms. Kemelec. If Mrs. Pemberton provided him with any information which Ms. Kemelec and *Clarence Family Day Care* needed to know, such as up to date information regarding Jayden's epilepsy, it was his job to tell them and to ensure that the information could be recorded in the records of the *licensee*. If there appeared to be irregularities in Mrs. Pemberton's operation, such as caring for and supervising four children in one room and, simultaneously, a baby in another room, the facts should have been advised by him to the *licensee* and Ms. Kemelec and he should have advised Mrs. Pemberton of her obligations in that regard.

45. But, apart from providing Mrs. Pemberton with a copy of the *licensee's* policy book and a copy of the *Regulation*, it seems to me that very little of this took place and Mr. Casson seems to have approached his task with very little rigour. Perhaps it was not surprising that Mrs. Pemberton's supervision of Jayden, when he was put down for a sleep on 15 December, 2008, was so aimless and unfocused when one considers that Mr. Casson, her supervisor and mentor, was unable to tell me what he thought constituted supervision of children. He gave the appearance that all that was required to ensure the *"constant supervision"* for which the *National Childcare Accreditation Council* guidelines call was to conduct a series of *body counts* and I was unable to detect any understanding of what the carer was supposed to be checking for. He admitted that he never told *primary carers* how often they should enter a room in which a child was sleeping in order to provide proper supervision. Indeed, he did not seem to understand that the purpose of supervision, in the context which applied to Jayden from 1pm on 15 December, 2008 onwards, had something to do with ensuring that the child was well, was not about to have or was not having a seizure and was not in difficulty and needing assistance. Mr. Casson was unable to tell me what, in practical terms, those guidelines meant when they spoke of sleeping children being *"monitored regularly"* and what he thought of the mode and frequency of monitoring being provided by Mrs. Pemberton for Jayden as he slept. He described the

guidelines as *"only guidelines which were not binding"* and he seemed oblivious to the corresponding, and binding, requirements of the *Regulation*.

46. Mr. Casson was questioned regarding his attitude to Mrs. Pemberton attending to her *paper work* while ostensibly supervising the children. He accepted that there was a legislative prohibition against this but told Mr. Saidi of Counsel that *"some paper work in my view would have been accepted as part and parcel of running a child care service."* As a child development officer, it had not been his practice, he told the inquest, to tell carers that they were not to attend to their paper work while supervising children.

47. Mr. Dearn of Counsel accepted that, on a number of bases, Mrs. Pemberton's supervision of Jayden on 15 December, 2008 was not adequate but he submitted that, at the time, she had believed that it was and that it had been accepted as such by Warwick Casson on behalf of *Clarence Family Day Care*.

48. Mr. Casson was made aware by Mrs. Pemberton that Jayden had suffered a seizure and he made a note of that on 28 August, 2007 but it is not clear that Ms. Kemelec or *Clarence Family Day Care* were ever advised and, certainly, neither they nor Mr. Casson took any steps in response to that information. Mr. Casson was unable to recall advising or telling Mrs. Pemberton to consult with the parents and he certainly felt no need to discuss the matter with them. Nor did the information prompt him to take any particular steps to ensure that Mrs. Pemberton was properly equipped to take charge of the situation.

49. His explanation for such a relaxed attitude was that he *"had no reason to think that Jayden was epileptic."* Instead, he had formed the view, he told me, based on his own personal experience and on some *Google* research, that Jayden had merely suffered a *febrile* convulsion. I have some difficulties with that evidence. In the first place, there was no reason for Mr. Casson to conclude that Jayden's seizure was not true epilepsy and nothing in his *Google* research could reasonably have prompted that view. And secondly, it is ridiculous to speak of a <u>*mere*</u> *febrile* convulsion as though *febrile* convulsions in young children are not extremely dangerous and do not sometimes lead to death.

50. Apart from the comfortable view that it had been a *mere febrile* convulsion and nothing to worry about, the other explanation of Mr. Casson's inaction is that, because Mrs. Pemberton was happy with the way in which she had handled Jayden's August, 2007 convulsion, he saw no reason to provide her with any additional training or instruction. That was surely a matter for his employer but, to the extent that he had any influence in the matter, one would have hoped Mr. Casson would have exercised it in favour of Jayden and that appears not to have been the case.

51. In relation to Mrs. Pemberton's records and *paper work,* Mr. Casson told the inquest that he had never sighted any of it and that he had never asked to see any of it. Seemingly, his view was that it was sufficient discharge of his obligations in that regard that he ask Mrs. Pemberton if her paperwork was up

to date and he was prepared to accept her word that it was. It follows that Mrs. Pemberton's records were never provided to Ms. Kemelec or recorded in the files of *Clarence Family Day Care* and, consequently, full details of Jayden's medical condition were notified to neither. For that reason, there never was an opportunity for Ms. Kemelec, the *authorised supervisor*, on behalf of the *licensee* to formulate a proper *management plan.* Dr. Lennon, who knew nothing of Jayden being at day care, and Jayden's *GP* could have been consulted and could have had useful input into such a management plan. More precise and more rigorous provisions could have been made for Jayden's supervision at day care. Mrs. Pemberton and Jayden's parents, too, could have been given more detailed information and training as to his proper care at day care but, instead, Mrs. Pemberton, the parents and Jayden were essentially *on their own*.

52. Of course, one would have thought that the *licensee* and the *authorised supervisor* might have required higher standards of rigour from Mr. Casson and might have noticed that very little information had been provided to them regarding Mrs. Pemberton's day care operations and her young clients. Perhaps they thought that all that was required of them was that they provide Mrs. Pemberton with copies of their various policies and guidelines. Perhaps they thought that Mr. Casson was rigorously enforcing their standards. But that was not so. They had the responsibility of ensuring the safety of the children in their charge. By not ensuring that their policies were sufficiently clear and comprehensive, by their failure to ensure that Mr. Casson performed his role adequately and by effectively leaving Mrs. Pemberton to her own devices, they failed Jayden with disastrous results.

53. Mr. Casson's evidence is that there have been significant changes in the practices adopted by *Clarence Family Day Care* following Jayden's death. His statement of 15 September, 2010 annexes revised and updated policies of *Clarence Family Day Care* regarding *Accidents, Emergencies and Emergency Medical Treatment, Allergies and Anaphylaxis, Asthma, Medication, Safe Sleeping Practices/Selection and Use of Cots* and *Supervision and General Safety Practices.* A new and, I am assured, improved policy book is now provided to *primary carers* and some of the changes do seem to represent a degree of improvement. For instance, prior to Jayden's death there was little guidance provided by the *licensee* regarding the a safe sleeping policy. Mr. Casson told the inquest that *"We had not focussed on it."* But now, the *licensee* prescribes that babies being put down for sleep should be placed on their backs and that there should be no accessible toys, bibs or bottles. But, significantly, there is still little guidance as to the frequency with which sleeping children should be checked and as to what the carer should be checking other than to say they should be *constantly monitored*. The *"body count"* mentality may still be prevalent among *primary carers* in the Clarence Valley district and elsewhere..

54. As Mr. Saidi of Counsel for the Department submitted, what is important in the proper administration of day care services and what was apparently missing in Jayden's case were *procedures* which would ensure that an informed and efficient plan for Jayden's management in day care could be developed and

enforced. Those with the responsibility for ensuring a proper standard of care, namely the *licensee* and the *authorised supervisor,* were apparently deprived of the knowledge that there were flaws in Mrs. Pemberton's operation and that, as things stood, that operation was inadequate to Jayden's needs because proper procedures were not in place and vital information did not make its way to them and because they appear not to have monitored their own agent. They missed the opportunity to seek input from the parents and from Jayden's treating paediatrician and his general medical practitioner whose professional experience and close knowledge of Jayden's medical condition might very usefully have informed an appropriate management plan. And, in the meantime, the systems which were in place were allowed to degenerate, so carelessly and thoughtlessly were they monitored and enforced.

55. I respectfully agree with Counsel that, even today, the policies and guidelines of *Clarence Family Day Care* are short on procedures which will ensure an adequate standard of care for children, particularly sick children or children with a challenge. . In large part it was lack of a proper procedure which led to failure regarding Jayden and, no matter how good the individual policies may be, there will be further failures unless *Clarence Family Day Care* and other *licensees* develop and adhere to proper procedures. Only by adherence to proper procedures will the individual needs of children like Jayden be identified and proper management plans devised, monitored and enforced.

56. During the course of the inquest, the various legal representatives, aided by Jayden's parents and several senior officers of the Department of Human Services, Community Services, conferred and devised and agreed upon three detailed recommendations which they submitted should be made pursuant to section 82 of the *Coroners Act 2009*. The recommendations are directed to the Minister for Human Services, Community Services. They recognise the independence of the various *licensees*, the providers of family day care in this state, and they support the principle of self-regulation. But importantly they urge the Department to continue and redouble its efforts to provide education, information and encouragement to *licensees* and *authorised supervisors* to put in place and to strengthen procedures aimed at ensuring that proper standards are applied by *primary carers* in their direct, day to day care of children and to remind those *licensees* and *authorised supervisors* that theirs is the responsibility for ensuring, by the preparation of informed and appropriate management plans and by rigorous interventions by their staff, that standards are enforced and maintained and the liability if they are not.

57. The proposed recommendations are aimed at the development of procedures in order to facilitate and ensure compliance with the terms of the *Children's Services Regulation 2004* and, in particular with:-

- the prohibition on *primary carers* performing other duties while supervising children;
- the duty of *primary carers* to make, keep up to date and provide to *licensees* for their retention detailed written records regarding the

health status and requirements of each child. (In that regard, epilepsy is specifically mentioned);

- the duty of ensuring as a condition of licence that written records are retained;
- the duty of ensuring that proper regard is paid to the health status and needs of a child when he or she is enrolled in day care; and
- the duty of ensuring effective supervision of children, awake or asleep.

58. It can be seen that the real thrust of these recommendations is to encourage and assist *licensees* and *authorised supervisors* to develop and enforce procedures and systems which will ensure that all concerned, the *licensees* themselves, *authorised supervisors* (and their staff) and *primary carers* comply properly with the terms of the *Regulation* and, thus ensure a proper standard of care for children in day care. In this way, it is hoped that the failures which became apparent in Jayden's case will not be repeated.

59. I think that these recommendations are worthwhile and I propose making them. Mr. and Mrs. Lynch do not want Jayden's life to "*go for nought"* and if these recommendations which Mr. Saidi told me *"are embraced wholeheartedly by the Department"* are accepted, the good they may do will form part of Jayden's legacy. The rest of his legacy will be the joy he brought and the love he gave to so many people who were lucky enough to have known him. He will not be forgotten.

Findings

My findings, then, are that JAYDEN MATTHEW LYNCH, born on 6 December, 2005, died on 15 December, 2008 at Yamba NSW or *en route* to hospital or at Maclean District Hospital, Maclean, NSW of asphyxia secondary to epilepsy.

Recommendations

I make the following recommendations to the Minister for Human Services, Community Services, namely;-

1. That the NSW Department of Human Services, Community Services, use its best endeavours to take steps to encourage and assist the *New South Wales Family Day Care Association* and other peak bodies to inform and educate their member associations, whether by way of newsletters, seminars or other appropriate means, of the duties and obligations of *licensees* and *authorised supervisors* to comply with the provisions of the *Children's Services Regulation 2004* and, in particular, with:-

(i) Clauses 25(5), 66(1) to (3) inclusive, 92 and 96;

(ii) Clauses 1 and 2 of Schedule 1; and

***(iii)* Clauses 9 and 11 of Schedule 1A thereof.**

2. Without limiting (1) above, that in any formulation of such information and education of such associations, guidelines be provided as to :-

(i) The effective supervision of children being provided with care whilst both awake and asleep;

(ii) The requirement for *licensees* to develop procedures so as to ensure that the *authorised supervisor*, members of staff of the service and each family day carer who is registered with the services comply with the provisions of the *Regulation* that apply to them;

(iii) That the written records maintained with respect to each child be kept up to date at all times;

(iv) That such written records be maintained in a safe and secure area of the Association's premises;

(v) That such records clearly record any medical condition applicable to such child and the treatment to be given in the event of the child appearing to be severely affected by such condition while being provided with the service; and

(vi) That such records set out any special requirements concerning the child with respect to the child's medical condition.

3. In any such programme implemented, the Department endeavour to assist in any information or education programme so as to have the *NSW Family Day Care Association* and other peak bodies take steps to ensure that carers registered with each said association fully understand and comply with the obligations imposed upon them by the said Regulation.

Magistrate Scott Mitchell,
NSW Deputy State Coroner
15 October, 2010.