New South Wales

CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Arianna Maragol
Hearing dates:	23, 24, 25 & 27 February 2026; 2, 3, 5 and 6 March 2026
Date of Findings:	6 May 2026
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Judge Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, streptococcus pneumoniae, invasive pneumococcal disease, sudden explained death in childhood, febrile convulsion, early childhood education and care, children's health and safety, safe sleeping, supervision and monitoring of sleeping children, Berry Patch Kellyville Ridge, National Quality Standard, National Quality Framework, Australian Children's Education & Care Quality Authority, assessment and rating process, Red Nose Australia
File numbers:	2018/262446
Representation:	Ms K Richardson SC & Ms B Epstein, Counsel Assisting, instructed by Ms S Najjar & Ms A Thorne (Crown Solicitor's Office) Mr D Lloyd SC & Mr R Sud for Berry Patch Preschool Kellyville Ridge Pty Ltd instructed by Minter Ellison Ms G Mahony SC & Ms J Chapman for the NSW Department of Education and NSW Early Learning Commission instructed by Moray & Agnew Lawyers Mr J Sheller SC & Ms M Rabsch for Mr J Maragol and Mrs A Eyvazians instructed by Clayton Utz Ms R Rodger for Ms G Cruden, instructed by Gilchrist Connell

Findings:	Arianna Maragol died on 24 August 2018 at The Children's Hospital at Westmead, Westmead NSW 2145. The cause of Arianna's death was rapidly developing *streptococcus pneumoniae infection* leading to invasive pneumococcal disease. Arianna died after being placed down to sleep in a cot room at a childcare centre in circumstances where she was not actively and effectively supervised whilst sleeping to ensure her safety and well-being. Prior to being found unresponsive approximately three hours after she had been placed down to sleep, no educator had entered Arianna's cot room for approximately 56 minutes.
Non-publication orders	See Annexure A

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1. Introduction

1.1 At around 7:24am on 24 August 2018, Arianna Maragol, a 16-months-old little girl, and the daughter of Jozef Maragol and Anet Eyvazians, was dropped off at her usual childcare centre by her father. That morning, Arianna had something to eat, played by herself for a short time and wandered around the childcare centre.

1.2 At around 9:02am, Arianna was put down to sleep in a cot in one of the rooms at the centre that was used for children to sleep and rest. There was a closed circuit television (**CCTV**) camera in the room.

1.3 At around 11:09am, an educator at the centre entered the room where Arianna was sleeping and reportedly heard Arianna making a deep breathing sound. At 12:06pm, the same educator returned to the room and found Arianna lying on her stomach, unresponsive and showing no signs of life.

1.4 Other educators were notified and resuscitation efforts were initiated. Emergency services were also contacted. Arianna was taken by ambulance to hospital where resuscitation efforts continued. However, Arianna could not be revived and was tragically pronounced life extinct at 1:21pm.

2. Why was an inquest held?

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

2.2 Arianna's death was considered reportable because she had died suddenly and unexpectedly, and therefore both the cause and manner of her death were unclear. Further, the coronial investigation which followed Arianna's death raised several questions about the circumstances in which she died: her medical history and health prior to 24 August 2018, what happened at the childcare centre on that day, whether Arianna was appropriately monitored after she was put down to sleep, what policies and procedures were in place at the childcare centre regarding supervision of sleeping children, and regulatory oversight of the childcare centre by the NSW Department of Education (**Department**). For all of these reasons, it was determined that an inquest should be held.

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

2.4 It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a lengthy one. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated. In Arianna's case, this impact has been particularly profound, complicated largely by other related proceedings in the criminal jurisdiction which were not finally resolved for some time. This resulted in an extensive delay in holding an inquest into Arianna's death. The additional burden that this delay placed on Arianna's parents and its emotional toll is enormous.

3. Arianna's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Yet inquests often spend very little time hearing and learning about a person's life and how the loss of that life has affected the relatives and loved ones of that person. Therefore, it is important to recognise and acknowledge Arianna's life in a brief, but hopefully meaningful, way.

3.2 Arianna was born to her parents, Anet and Jozef, on 2 April 2017 at Blacktown Hospital. Arianna's parents described her as a child who noticed everything. Arianna had a particular love of music. When she heard music playing her little hands would move and she would smile. Every morning, Arianna's parents played Persian children's songs for her in the car. Hearing the songs would transform Arianna's face into a smile in an instant.

3.3 Arianna met all her developmental milestones in rolling, crawling and eventually walking. She enjoyed playing in the garden at home, dancing with Anet in the kitchen and sitting on Jozef's lap in the lounge room drinking her milk. Arianna was curious and inquisitive. She often pointed at the television and laughed or said some words in her small, clear voice.

3.4 Arianna's parents describe her as bringing a depth of love into their family that cannot be measured. She opened their hearts wider than they had ever imagined and bonded the family in ways they did not think were possible. Jozef and Anet also describe Arianna's life as powerful and how she changed them both permanently in the most beautiful way. It is devastating to know that Arianna's brothers will never meet her. But Anet and Jozef will tell them all about Arianna and they will grow up knowing her.

3.5 The loss felt by Arianna's parents, and the depth of their grief and mourning, is immeasurable. For them, each day is an agonising reminder of the beauty of Arianna's life but also of the painful physical separation from her and her smile, her laugh, and her touch. Yet despite this pain and the knowledge that Arianna's life ended so abruptly and all too soon, Arianna's light continues to shine. Jozef and Anet have described how Arianna's presence has shaped them, how her love has changed them and how her memory guides them every single day.

4. Arianna's medical history[1]

4.1 Arianna had a mild egg allergy which, when active, resulted in skin reaction but no anaphylaxis. Arianna's parents avoided giving Arianna cooked eggs but she could be fed with baked egg products.

4.2 Arianna had received the following vaccinations:

(a) 4 April 2017: hepatitis B;

(b) 25 May 2017: Infanrix Hexa (diphtheria, tetanus, pertussis, Hib, hepatitis B, polio), Prevenar 13 (pneumococcal), Rotarix (rotavirus);

(c) 15 August 2017: Infanrix Hexa, Prevenar 13, Rotarix;

(d) 17 October 2017: Infanrix Hexa, Prevenar 13; and

(e) 7 April 2018: MMR II, Menorix.

4.3 At the time of her death, Arianna had met the length, weight and head circumference percentiles for her age.

5. Previous presentations to medical practitioners

5.1 On 7 January 2018, Arianna presented to the Ponds Medical Centre with an upper respiratory tract infection. She showed symptoms of fever, runny nose, cough and mild red throat. It was recommended that she take Panadol or Nurofen and to return if symptoms worsened.

5.2 On 21 January 2018, Arianna presented to the ponds Medical Centre again with an upper respiratory tract infection.

5.3 On 24 January 2018 Arianna presented to the ponds Medical Centre following two loose bowel motions the previous day. She showed no signs of an upper respiratory tract infection and was noted to be feeding well. It was also noted that the lungs were clear and that she had no rash.

5.4 On 19 February 2018, Arianna presented to the ponds Medical Centre with symptoms of an upper respiratory tract infection. Arianna was noted to be a febrile, alert and happy. Panadol or Nurofen was recommended if necessary with advice given for Arianna to return for review if not better by the following week.

5.5 On 11 March 2018, Arianna presented to the ponds Medical Centre with a runny nose, cough and fever for the previous two days. On examination, it was noted that Arianna's lungs were clear and that she had a red throat. She was diagnosed with a common cold.

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

5.6 On 13 March 2018, Arianna presented to the ponds Medical Centre with a cough and runny nose. No signs of respiratory distress were observed on examination and conservative management was recommended.

5.7 On 26 March 2018, Arianna presented to Rouse Hill Medical Centre with a fever, runny nose, purulent discharge and very swollen tonsils and refusing to eat. No rashes or wheezing were observed.

5.8 On 16 April 2018, Anet observed that Arianna had a high fever and had become floppy, turned purple and was unresponsive for two minutes. An ambulance was called and Arianna was taken to the emergency department (**ED**) at The Children's Hospital at Westmead.

5.9 On examination, it was noted that Arianna's cardiorespiratory functioning was unremarkable. Following observation for several hours, with no further convulsions observed, Arianna was discharged home with a plan for GP follow-up if she experienced another episode of convulsions or apnoea.

5.10 On 17 April 2018, Arianna presented to The Children's Hospital at Westmead following a second episode of high fever and fogginess. On admission, Arianna was noted to have a fever, cough and runny nose for two days.

5.11 An examination revealed bilateral enlarged tonsils. Investigations revealed raised inflammatory markers (white cell count, procalcitonin, neutrophili and C-reactive protein) and positivity for bocavirus, enterovirus and adenovirus. Blood and urine cultures were found to be negative and an electroencephalogram was found to be normal during wakefulness. Intravenous antibiotic (cefotaxime) therapy was instituted.

5.12 On 18 April 2018, it was observed that Arianna had slight tachycardia while awake and while febrile. On 19 April 2018, Arianna was discharged.

5.13 On 20 April 2018, Arianna presented to a general practitioner as her parents were concerned about future episodes of convulsions. Arianna's parents were advised that Arianna was at "*higher risk for febrile convulsion*" and to call an ambulance for convulsions lasting more than 10 minutes.

5.14 On 2 May 2018, Arianna presented to a general practitioner with fever, nausea, vomiting and diarrhoea. It was noted that her temperature was 36.7°C at the time of assessment.

5.15 On 5 May 2018, Arianna presented to a general practitioner with a runny nose and a cough. It was noted that her nausea, vomiting and diarrhoea had subsided and that her chest was clear with no rash. Arianna's temperature was noted to be 37.1°C at the time.

5.16 On 19 May 2018, Arianna presented to a general practitioner with a purulent runny nose and reductive cough. She was prescribed Amoxil sugar-free and her temperature was again noted to be 37.1°C.

5.17 On 7 August 2018, Arianna presented to the ponds Medical Centre with a fever (temperature of 38 to 39°C across two days), cough, runny nose and watery discharge. She was diagnosed with an upper respiratory tract infection and prescribed amoxicillin. Arianna's temperature was recorded as 37.8°. A throat swab detected human adenovirus. According to Anet, the GP called around two days later and said that it was "*just a cold*".

5.18 On the 15 August 2018, Arianna did not attend Berry Patch Kellyville Ridge (**Berry Patch**). Although Anet recalled that she took Arianna to see a GP around this time, there are no available medical records to indicate such an attendance.

5.19 On 17 August 2018, Arianna had a runny nose but still attended Berry Patch. However, Arianna had to be collected from Berry Patch during the day. After returning home, Arianna's temperature was noted to be 37.8°C and Anet gave her some Panadol.

5.20 On 22 August 2018, Arianna attended Berry Patch. Anet emailed the staff to inform them that Arianna had been sick over the weekend. Anet recalls that Arianna was distressed and crying and that she didn't "look fine" when picked up. According to Jozef, Arianna was normal and no longer crying later that evening.

5.21 On 23 August 2018, Arianna remained at home with Anet as she usually did not attend Berry Patch on Thursdays. Arianna's parents both recalled that she appeared well with Anet noting that she was playing outside and eating normally.

6. The events of 24 August 2018

6.1 On 24 August 2018, Arianna woke up between 4:30am and 5:00am, which was earlier than usual. She was noted to be crying and unsettled with a slight runny nose and some coughing.

6.2 At around 5:00am, Arianna's temperature was measured to be 37.7°C. At around 5:30am, according to her parents, Arianna was given either Nurofen or Panadol.

6.3 At around 6:00am, Joseph took Arianna's temperature and noted that it was 36.8°C. Arianna was given a bottle of milk and drank between 140 to 160 mL.

6.4 At around 7:24am, Joseph dropped Arianna at Berry Patch and handed her over to Gabrielle Cruden (nee Cahill). According to Ms Cruden, Joseph told her that Arianna did not have a good night's sleep, woke up early and may be more tired than usual. Ms Cruden asked Arianna for a cuddle and took her from Joseph.

6.5 Arianna was taken to Baby Berries 3, one of three rooms on the "Baby Berries" side of Berry Patch which was for children between the ages of six weeks and two years. The other side of Berry Patch, which also had three rooms, was for children between the ages of two and six years.

6.6 At around 7:28am, Arianna ate a bowl of Weet-Bix with full cream milk. Arianna remained in the Baby Berries 3 room for most of the morning. CCTV cameras captured Arianna moving between Baby Berries 3 and the meals room, playing with toys independently, interacting with Berry Patch staff members, having her nappy changed and sitting in a high chair at various points during the morning.

6.7 At 9:02am, Ms Cruden picked up Arianna and took her into Cot Room 2. She placed Arianna on her back into one of the cots which was located near the door. Two other children were in cots in the room. Arianna was wearing a long-sleeved shirt and long pants at the time. Ms Cruden placed a flat sheet at the end of the cot.

6.8 At 9:05am, Ms Cruden used the Kinder M8 app to record a check for Arianna. Kinder M8 is described as an "all-in-one childcare management platform".

6.9 At 9:11am, Ms Cruden took another child into Cot Room 2 and saw Arianna lying on her stomach. According to Ms Cruden, Arianna was "deep breathing", "like a little snore".

6.10 At 9:24am, Ms Cruden recorded a Kinder M8 check for Arianna.

6.11 Sometime between 9:00am and 9:30am, Anet called Berry Patch twice. During the first call, she was told that Arianna was sleeping. During the second call, another staff member told Anet that Arianna was "*having a long sleep today*".

6.12 At 9:30am, Ms Cruden recorded a Kinder M8 check for Arianna.

6.13 At 9:53am, Ms Cruden heard on the baby monitor that one of the children in cot room 2 was crying. She went into the room and collected the child. CCTV footage appears to show that Arianna was fidgeting but asleep at the time. According to Ms Cruden, she heard Arianna snoring.

6.14 At 10:58am and 10:08am, Ms Cruden recorded two further Kinder M8 checks for Arianna.

6.15 Between 10:00am and 11:00am and 10:17am, CCTV footage appears to show Arianna rolling around in her cot, moving her head from facing towards the left to face down on the mattress. Arianna appears to pull her knees under her body towards her stomach and torso and raise her head slightly before again placing her face down onto the mattress. Arianna also rubs her face on the mattress while rocking up and down.

6.16 At 10:14am, Ms Cruden entered Cot Room 2, walked past Arianna, picked up another child and left the room. CCTV footage appears to show Arianna still lying face down in her cot at the time, with her right leg outstretched. According to Ms Cruden, Arianna was "*heavily breathing*" and in her "*usual sleeping position*", lying on her stomach with her head to the side.

6.17 At 10:17am, CCTV footage appears to show Arianna moving in her cot for the last time.

6.18 At 10:24am, Ms Cruden recorded a Kinder M8 check for Arianna.

6.19 At around 10:50am, it is likely that Anet rang Berry Patch and spoke to Ms Cruden who told her that Arianna had eaten breakfast but did not want any watermelon and was rubbing her eyes so she was put down for a nap early. Anet and Ms Cruden had a brief discussion during which Anet reported that Arianna had woken up early with Ms Cruden reporting that this Arianna appeared tired. Anet also reported that Arianna had been "*a bit sick lately*" and had been given her dummy "*a bit more*". Ms Cruden indicated that Arianna had been wanting her dummy that morning.

6.20 At 10:54am and 11:07am, Ms Cruden recorded two further Kinder M8 checks for Arianna.

6.21 At 11:09am, Ms Cruden entered Cot Room 2 and picked up another child. CCTV footage appears to show that Arianna did not move at this time. Ms Cruden reported that when she was in the room she could hear Arianna breathing deeply or heavily.

6.22 At 11:30am, Ms Cruden recorded a further Kinder M8 check for Arianna.

6.23 At some point during the morning, Ms Cruden heard the Kinder M8 alarm for cot room to activate. Ms Cruden did not hear any crying and assumed that Arianna was sleep as she normally slept until 11:00am or 11:30am. Ms Cruden did not enter Cot Room 2 or check on Arianna using the CCTV monitor as she had another child in her arms at the time.

6.24 At 11:54am and 11:55am, Ms Cruden recorded two further Kinder M8 checks for Arianna.

6.25 At around 12:00pm, Paige Orr, a trainee educator, spoke to Ms Cruden in Baby Berries Room 1. Ms Cruden indicated that she had to put another child down for a nap but that she did not want to

wake Arianna up. Ms Orr enquired how long Arianna had been asleep for and Ms Cruden told her, "*at least three hours*". Ms Cruden also indicated that if the other child was placed in Cot Room 2 he would cry and wake Arianna up.

6.26 According to Brianna McPherson, a casual educator, she saw Ms Cruden "*complete a cot room check for Arianna and the other children*" prior to midday.

6.27 At 12:02pm, Ms Cruden recorded a Kinder M8 check for Arianna.

6.28 At 12:06pm, Ms Cruden entered Cot Room 2 and saw that Arianna was "*sleeping on her stomach with her face slightly tilted to the side*" in her usual sleeping position. Ms Cruden observed that Arianna was not moving and could not hear her to be snoring. Ms Cruden picked up Arianna turned her over and placed her back in the cot on her back. She ran out of the room, saw Nicole Turner, the room leader for Baby Berries 2, and said, "*I think Arianna is dead*".

6.29 At 12:07pm, Ms Turner entered Cot Room 2 and saw that Arianna was "*a little bit sweaty on her forehead*" but "*still warm*". Ms Turner also observed that Arianna was "*blue around the mouth and her skin was a little bit yellow around her face*". Ms Orr also entered the room at this time and saw that Arianna was lying on her back, with her face pale but that she "*still had some colour on her face*". Ms Orr shook the cot and nudged Arianna stomach to see whether she would wake up. Ms Orr noted that Arianna was warm to the touch and felt for a pulse but could not find one. Ms Turner observed that Arianna was not breathing and initially indicated that she did not know what to do before suggesting that cardiopulmonary resuscitation (**CPR**) should be commenced.

6.30 At 12:08pm, Ms Turner picked Arianna up and felt that she was limp. Ms Turner passed Arianna to Leah Henning, the room leader for the Blueberries Room, who took Arianna to Baby Berries 2 and placed her on a mat. Ms Henning and Ms Turner commenced resuscitation efforts, taking turns at breathing and performing chest compressions.

6.31 Also at 12:07pm, two separate calls were made by Berry Patch staff members to Triple Zero. During this time, Ms Henning moved Arianna to Ms Turner's office where resuscitation efforts continued.

6.32 The Triple Zero operator provided instructions for Arianna to be laid flat on her back, to check for breathing, and to check Arianna's mouth for food or vomit. A staff member reported that Arianna was not breathing and that there was nothing in her mouth.

6.33 Shortly after resuscitation efforts were commenced, Arianna began vomiting what appeared to be watered down blood and mate gurgling sounds. The Triple Zero operator provided instructions to clear out the vomit and to continue CPR.

6.34 At 12:13pm, a New South Wales Police Force (**NSWPF**) officer, Sergeant Graham O'Toole, arrived on scene and took over the resuscitation efforts from Ms Turner. Sergeant O'Toole observed that Arianna was "*very pale/grey and not breathing*" with vomit coming from her nose. Sergeant O'Toole checked Arianna's mouth but could not see or feel any obstruction.

6.35 At 12:15pm, leading Senior Constable Todd Kirk and the Senior Constable Alisha Harvey arrived on scene and assisted Sergeant O'Toole with the resuscitation efforts.

6.36 At 12:16pm, two NSW Ambulance (**NSWA**) crews arrived on scene. The attending paramedics observed that Arianna was showing symptoms of being in cardiac arrest at the time. She was not breathing, pale and in asystole when defibrillator pads were placed on her chest. Attending paramedics continued resuscitation efforts. Arianna was unable to be intubated but was given eight rounds of adrenaline and Hartmann's solution intravenously to no effect. One of the intensive care paramedics considered that Arianna had been in cardiac arrest for more than 15 minutes prior to the arrival of the NSWA crews as she had fixed and dilated pupils and purple nails, indicating prolonged cardiac arrest.

6.37 Between 12:23pm and 12:26pm, two Care Flight doctors and an intensive care paramedic arrived on scene via helicopter. An endotracheal tube was successfully inserted and at 12:45pm, Arianna was taken by ambulance to The Children's Hospital at Westmead. Whilst in transit, Arianna was provided with paediatric advanced life support measures.

6.38 At around 1:00pm, Arianna arrived at the Children's Hospital at Westmead. She was found to have a temperature of 33°C with her pupils 3mm and unreactive to light. It was noted that Arianna was "*pale and cool*" and that she had "*low/absent blood pressure*".

6.39 At around 1:05pm, Arianna was admitted to the ED. By this time her downtime was approaching 45 minutes. Dr Andrew Cook, ED staff specialist, noted that Arianna was in asystole cardiac arrest with no detectable cardiac output, and was unresponsive with fixed and dilated pupils unresponsive to light. It was also noted that Arianna had no spontaneous respiratory effort and that she required a bag to endotracheal tube ventilation with 100% oxygen.

6.40 Resuscitation efforts continued for a further 20 minutes. However, Arianna could not be revived and at 1:21pm, she was pronounced life extinct. Dr Cook later recorded an impression that Arianna had a nonsurvivable out-of-hospital cardiac arrest "*likely aspiration/primary respiratory arrest as trigger*".

7. Post-mortem examination

7.1 Arianna was later taken to Forensic Medicine Sydney on the evening of 24 August 2018. On 28 August 2018, a postmortem examination was performed by Dr Elsie Burger, forensic pathologist. The examination identified the following relevant findings:

(a) The aortic valve had a bicuspid configuration with the fused cusp spanning two ostial orifices;

(b) microscopic sections of the lungs showed widespread features of aspiration of stomach contents;

(c) neuropathological examination did not identify any obvious macroscopic abnormalities and microscopy also did not identify any significant pathological abnormality.

(d) virology studies of a nasal swab showed enterovirus RNA and respiratory Syncytial Virus (**RSV**) RNA but polymerase chain reaction (**PCR**) of the lung swab, heart and liver tissues were negative.

(e) *Streptococcus pneumoniae* (***S. pneumoniae***) was cultured from blood and from swabs of both lungs. *Staphylococcus aureus* was also cultured from the lung swabs, but the growth was not as pronounced as that of *S. pneumoniae*; and

(f) toxicological analysis of preserved blood showed low concentrations of ibuprofen and paracetamol.

7.2 Dr Burger noted that whilst *S. pneumoniae* was cultured from blood and from swabs of both lungs, it was cultured in in combination with other organisms and there were no features of inflammation in the microscopy of the lungs. Notwithstanding, Dr Burger also noted:

> It is, however, known that children can succumb to bacterial infections in a short time span, sometimes with minimal microscopic features of inflammation.

7.3 Dr Burger also noted that enterovirus and respiratory syncytial virus and/or *S. pneumoniae* could cause fever and "*by inference fever convulsions in a susceptible child*". Dr Burger also noted that the "*peak incidence of febrile convulsions is between 12 and 18 months of age, and children who have had previous febrile seizures are at significant risk of having a repeat event*", with the majority of children having their febrile seizures on the first day of illness. Dr Burger noted that such seizures may be atonic and that it is possible Arianna may have had an atonic seizure during sleep. Further, if Arianna had vomited during this convulsion, it may explain the fatal aspiration of stomach content that was noted with microscopy. Dr Burger explained that antemortem or terminal seizure activity cannot be assessed at autopsy.

7.4 Dr Burger also noted that bicuspid aortic valve is "*the most common inborn abnormality of the heart*" which usually presents with clinical symptoms during adulthood but "*has been described to cause rare cases of sudden unexpected death in infancy and early childhood*". However, Dr Burger noted that in Arianna's case there was no evidence that she suffered any of the complications (such

as an incompetent valve, a stenotic valve, constriction of the aorta, abnormal coronary arteries or heart failure) that would have caused sudden death due to bicuspid valvular disease.

7.5 Finally, Dr Burger noted that the possibility that Arianna suffered from "*a de novo cardiac rhythm disturbance or a genetic cardiac rhythm disturbance cannot be assessed at autopsy and can thus not be excluded*".

7.6 Ultimately, in the autopsy report dated 21 June 2019, Dr Burger opined that the cause of Arianna's death could not be ascertained.

7.7 During the post-mortem examination, cerebrospinal fluid, blood cultures (aerobic and anaerobic) and swabs (nasal, left run, right lung and rectum) were collected with specimens sent by courier to NSW Pathology for microbiological studies. These specimens were recorded as having been received by NSW pathology on 31 August 2018.

7.8 On 2 August 2019, a multidisciplinary paediatric SUDI review was convened to consider Arianna's case. The review agreed with the cause of death recorded in the autopsy report. I note from the review, written by Dr Burger recorded the following:

> Some discussion re calling it S pneumoniae infection. Most agreed however w/ unascertained.

8. What issues did the inquest consider?

8.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficient interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues for consideration:

(1) Whether the cause of Arianna's death can be determined.

(2) The contribution, if any, of Arianna's recent virus and/or elevated temperature to her death.

(3) The actions and/or inaction of Berry Patch and its employees in respect of Arianna's sleep on 24 August 2018, including the following matters:

(a) the frequency with which Arianna was checked:

(i) physically; and

(ii) via CCTV monitoring (and the quality of the CCTV);

(b) items, including a loose blanket, being left in/around the cot;

(c) allowing Arianna to roll and remain in a prone position; and

(d) allowing Arianna to sleep for the length of time before she was found unresponsive.

(4) Whether the Berry Patch sleep and rest policy in place as of 24 August 2018 was followed in relation to Arianna.

(5) In relation to Arianna being found unresponsive:

(a) Whether there was a reasonable opportunity to identify at an earlier point in time that Arianna was unwell and/or unresponsive, and if so:

(i) what steps could then have been taken by Berry Patch staff; and

(ii) what would have been the consequences, had this been identified.

(b) Upon discovering she was unresponsive, whether Berry Patch staff responded in an appropriate and timely manner.

(c) Whether the response of Berry Patch staff impacted Arianna's chance of resuscitation.

(d) Whether the CPR and emergency response training for Berry Patch staff was adequate.

(6) The regulatory oversight of Berry Patch by the Department of Education prior to Arianna's death, including the following matters:

(a) The last assessment and rating visit that took place prior to Arianna's death in March 2014 and the NQS Assessment and Rating Report issued after this visit.

(b) The adequacy of the policies, practices and procedures of the Department as of August 2018 in relation to the monitoring and assessment of the quality and standard of care provided by childcare centres in NSW.

8.2 For convenience, some of the issues have been considered together and chronologically below. In addition, during the inquest Issue (6)(b) was focused primarily on Issue (6)(a) and has been considered accordingly below.

8.3 In order to assist with consideration of some of the above issues, opinions were sought from the following independent experts as part of the coronial investigation:

(a) Professor Simon Craig, paediatric emergency physician and Adjunct Clinical Professor, Department of Paediatrics, Monash University;

(b) Professor Peter Fleming, Emeritus Professor of Infant Health and Developmental Physiology, University of Bristol and Honorary Consultant Paediatrician, University Hospitals Bristol and Weston Foundation NHS Trust;

(c) Professor Richard Leventer, paediatric neurologist and Professor of Paediatrics and Neurology, University of Melbourne;

(d) Dr James Newcombe, infectious diseases and microbiology staff specialist and Head, Molecular Microbiology Section & COVID-19 Diagnostics, Royal North Shore Hospital;

(e) Adjunct Associate Professor Sarah Parsons, senior forensic pathologist, Victorian Institute of Forensic Medicine; and

(f) Associate Professor Andreas Pflaumer, consultant cardiologist and Honorary Clinical Associate Professor, Department of Paediatrics, University of Melbourne.

9. What was the cause of Arianna's death?

9.1 As noted already, Arianna's post-mortem examination did not, in the opinion of Dr Burger, demonstrate a cause of death which could be scientifically proven. There is, however, a difference between whether the cause of a person's death can be scientifically proven and whether a finding can be made in accordance with section 81(1)(c) of the Act, on the balance of probabilities, about the cause of a person's death.

9.2 Notwithstanding the above, certain findings from the post-mortem examination and considerations identified by Dr Burger raised several possibilities as to the cause of Arianna's death. These are dealt with in turn below.

A cardiac cause of death?

9.3 Associate Professor Pflaumer explained that a bicuspid aortic valve is "*the most common congenital (inborn) heart defect in humans, recognised in 0.5% to 1% during lifetime and even in up to 2% in post-mortem examinations*". However, there is a wide range of bicuspid valves ranging from extremely severe to very mild and never causing any problem in life.

9.4 Associate Professor Pflaumer noted the post-mortem examination did not reveal signs of severe cardiac disease or an association with another cardiac abnormality. Associate Professor Pflaumer therefore considered the bicuspid aortic valve in Arianna's case to be an incidental finding and "*very unlikely related to [her] death*". Associate Professor Pflaumer also noted that even if the bicuspid aortic valve had been diagnosed earlier in life by chance, "*the only consequence would have been a cardiac follow-up every 3-5 years to recognise changes early in [Arianna's] life*".

9.5 Associate Professor Pflaumer explained that cardiac rhythm disturbances can be inherited (genes passed on by the parents) or de novo (via a new genetic mutation or a disease acquired during life). A disease caused by dysfunctional ion channels (also known as a channelopathy) can make the heart vulnerable to disturbances which can interrupt normal de-polarisation and re-polarisation leading to circulatory arrest and sudden/unexpected death.

9.6 Associate Professor Pflaumer noted that "*in about 10 to 30%*" of cases where a cause of death cannot be ascertained following a post-mortem examination, "*extensive examination of 1st degree relatives and genetic testing then can reveal a cardiac rhythm disturbance/channelopathy as the underlying cause, though it is believed that the percentage is higher and we are just not able to make the diagnosis*". However, even with post-mortem genetic testing and extensive family examination, about 70% of cases remain with an unascertained cause of death.

9.7 Professor Fleming noted that unless some structural abnormality of the conduction system is found it is not possible to accurately identify an arrhythmic cause of death from pathology. Rather, genetic investigation would be required to confirm this. As no genetic investigation was performed and no structural abnormality was identified, Professor Fleming therefore considered that there is no evidence supporting cardiac arrhythmia as the cause of Arianna's death.

A neurological cause of death?

9.8 Professor Leventer considered that Arianna had two likely febrile convulsions on 17 and 18 April 2018 in the context of a febrile, viral illness with three respiratory viruses being detected. He explained that febrile convulsions are common in childhood (with up to 1 in 20 children experiencing at least one febrile convulsion) and are separated into simple and complex convulsions. Professor Leventer explained that the febrile convulsions would be classified as complex given that Arianna had more than one febrile convulsion in a 24-hour period. However, Professor Leventer noted that Arianna had none of the other features of complex febrile convulsions. Overall, Professor Leventer considered that Arianna "*was at a moderately high risk of recurrent [febrile convulsions] and a mildly higher risk for later development of epilepsy than most children*".

9.9 Professor Leventer considered that the presence of enterovirus RNA and RSV RNA seen from post-mortem microbiology is likely relevant to Arianna's illness leading up to her death, and that this illness would have been a risk factor for both febrile convulsions and Sudden Unexpected Death in Childhood (**SUDC**). However, Professor Leventer noted that the relationship between febrile convulsions and SUDC is unclear with several studies of children finding that sudden death following a history of febrile convulsions is very rare. Professor Leventer expressed the view that Arianna's history of febrile convulsions "*would be very common, with SUDC being extremely rare*".

9.10 Professor Leventer gave evidence that mortality is typically associated with long seizures (of over five minutes) and that there is no evidence that Arianna's febrile convulsions were of this nature. Indeed, Professor Leventer gave evidence that from the descriptions provided the episodes "*did not sound like […] significant events in terms of the spectrum of febrile convulsions*". Overall, Professor Leventer gave evidence that it could not be said with certainty that Arianna's death was caused by any neurological abnormality.

9.11 Dr Burger noted that aspiration of stomach contents may be consistent with a seizure, especially when Arianna was seen to be lying face forward. However, Dr Burger also explained that it is a common finding that is also consistent with the effects of resuscitation and as a terminal event with other types of deaths including cardiac deaths.

9.12 Dr Burger gave evidence that Arianna's history of febrile convulsions, the fact that she was found in a prone position and the fact that she had a fever at the time of her death were factors that could lead to a diagnosis of sudden unexpected death in childhood (**SUDC**) being the cause of her death. However, Dr Burger gave evidence that as she considered the finding of streptococcus pneumoniae to be "*an unusual finding in the post-mortem scenario*" she chose to describe the cause of Arianna's death as undetermined rather than SUDC.

Streptococcus pneumoniae

9.13 Dr Newcombe explained that *S. pneumoniae* is a highly pathogenic organism that commonly colonises in the throat. In fact, up to 75% of children of Arianna's age would have *S. pneumoniae* in small quantities in their throat.

9.14 From the post-mortem examination, *S. pneumoniae* was cultured from blood taken from the aorta (two out of two bottles) and from swabs of both lungs. Dr Newcombe gave evidence that a positive blood culture of *S. pneumoniae* in a child "*would be definitive evidence of invasive pneumococcal disease unless there was some strong evidence that there was a contamination event*". Dr Newcombe explained that by invasive, what is meant is that the organism has invaded from non-sterile site (such as the lungs) and entered a sterile site (such as blood in the aorta) and therefore caused an invasion into that site.

9.15 However, in a post-mortem setting there are particular challenges with interpreting a finding of *S. pneumoniae*:

(a) in Arianna's case post-mortem microbiology was performed four days after her death. Dr Burger explained that most of the literature indicates that microbiology should be performed as soon as possible, ideally within 18 to 48 hours of death; and

(b) much of the literature indicates that a microbiological finding cannot be interpreted in and of itself. In other words, a microbiological finding should be correlated with another finding. Dr Burger gave evidence that evidence of bacterial infection is most likely found in the lungs and brain. In Arianna's case, significant lymphocytic infiltration was found in the lungs. However, lymphocytic inflammation is typically associated with viral infections and not bacterial infections. Neutrophilic inflammation is typically associated with bacterial infections but there was no evidence of such inflammation in this case. Dr Burger therefore explained that there was no histological evidence that Arianna had a bacterial infection.

9.16 Dr Burger gave evidence that the above matters were discussed during the multidisciplinary meeting in the context of considering the significance of the *S. pneumoniae* culture and it was considered that the cause of death should remain as unascertained. Adjunct Associate Professor Parsons similarly gave evidence that with positive microbiology but without any histological features of inflammation or infection she would also describe Arianna's cause of death as unascertained.

9.17 As to the timeframe for microbiology testing, Adjunct Associate Professor Parsons agreed that guidelines indicate that it should be performed within 18 to 40 hours of death. However, Adjunct Associate Professor Parsons noted that where it is not possible, the body of the deceased person should be refrigerated as soon as possible at 4°C, which is what appears to have occurred in Arianna's case, "*to decrease the amount of contamination*".

9.18 As to the absence of any histological findings to correlate the *S. pneumoniae* culture, Professor Fleming gave evidence that the nature of *S. pneumoniae* is that it is an organism which can cause death in the absence of any histological findings. Professor Fleming explained that "*one of the characteristics of children presenting with very acute bacterial infection and sepsis is that death can occur before there's been time for tissue responses*". He went on to explain that pneumococcal disease can cause an overwhelming "*whole range of responses*" which has been described as a "*cytokine storm*".

9.19 Professor Fleming gave evidence that he personally had experience of paediatric patients in an intensive care unit with positive blood cultures for pneumococcus who died "*of this very rapidly progressive disease without evidence of any overt histopathology changes*". Professor Fleming also gave evidence that he had seen an onset as rapid as presumed in Arianna's case.

9.20 Professor Fleming described his experience with rapidly progressive pneumococcal infection in live patients:

> I'm probably the only clinician involved in this case who is old enough to remember looking after children before we had pneumococcal immunisations, and it was not an uncommon event in the 1970s and 1980s when I started in practice to find children brought into the emergency department with a very high fever, very ill, and when we took a blood culture, we got a positive pneumococcal sample, but we didn't find a focus of infection. We would treat them and they would almost always get better, or if we didn't treat them quickly enough, they might die. So it's a characteristic of this organism that it can cause a very rapid onset of a severe illness before there's any obvious evidence of involvement of any of the major organ.

9.21 Dr Newcombe also noted that it has been reported in the literature that death can occur from invasive pneumococcal disease leading to abrupt sepsis and the lack of histopathological findings. Dr Newcombe explained:

> The rapidity of the changes, of the pathophysiology of what's going on, also the toxins released by the bacteria and the body's response to that, I imagine, in a very rapid setting, wouldn't cause actual visible changes. So it just causes this rapid vasodilation septic shock, which causes circulatory collapse very quickly without requiring there to be underlying visible changes in the histopathology.

9.22 Adjunct Associate Professor Parsons gave evidence that even with a rapidly developing infection with *S. pneumoniae* and no histological correlation, some findings would still be expected from a post-mortem examination. She explained:

> We still would expect to see some changes, such as small thrombi within vessels, some neutrophils within the vessels, without overt infection, like in the alveoli of the lungs. So in the cases that I've seen where it has been fast onset, we still do see minor things which are not seen in this case. But, yeah, I can't exclude that this is a rapid onset, and we haven't sectioned the actual area where these findings are.

9.23 The matters identified above raised a number of further considerations regarding whether the finding of *S. pneumoniae* in Arianna's case was a true pathogen and that therefore related to the cause of her death, or whether the finding could be explained by some other factor and therefore unrelated to the cause of Arianna's death. These considerations are dealt with below.

9.24 *First*, Dr Newcombe explained that for a live patient, *S. pneumoniae* is a "*very rare contaminant*" and not something that would be picked up incidentally when collecting blood from a patient. He gave evidence that a finding of *S. pneumoniae* "*in blood is almost always a pathogen*". Dr Newcombe also gave evidence that he has never seen *S. pneumoniae* in his career "*as a contaminant in life*" leading to his conclusion that in an antemortem setting, a finding of *S.*

pneumoniae in the blood is, even without histopathology correlation, definitive evidence of invasive pneumococcal disease.

9.25 Professor Fleming also described *S. pneumoniae* as a "*very, very rare contaminant*" in the post-mortem setting. He explained that *S. pneumoniae* is "*temperature vulnerable*" with a characteristic feature of the organism being that it will not grow below 10°C. Professor Fleming gave this evidence:

> Everybody has said that they don't see pneumococcus as a contaminant very often. And the reason for that is that you refrigerate the body. And you know, this is an organism which is very thermolabile. It doesn't - it doesn't stand cold storage.
> […]
> And so when you've got a blood culture that shows a pure growth of *S. pneumoniae*, that is much more indicative. It can't - one can never be certain, but it's much more indicative that this was a real infection in the blood at the time [Arianna] died.

9.26 *Second*, Dr Newcombe noted that in Arianna's case the microbiology results indicate that the testing of the blood cultures commenced at 3:36pm on 31 August 2018 with a positive result reported at 7:09am on 1 September 2018. Dr Newcombe explained that this meant that the microbiology testing produced a positive result within about 16 hours with the likelihood that this time to positivity was even less given that the testing was performed overnight and not reported until the next morning. Dr Newcombe noted that a time to positivity within 24 hours indicates that a large bacterial load was present in the sample, being "*large enough to cause a disease process*" rather than "*just one or two bacteria that were picked up incidentally or managed to get into the blood culture bottle in another way*".

9.27 Professor Fleming also agreed with Dr Newcombe's assessment regarding time to positivity. He explained:

> [T]o become heavily positive within such a short period of time is highly significant, particularly with an organism that does not grow in the cold conditions. I think that's a crucial feature.

9.28 In the case of a contaminated specimen the time to positivity will usually be within 48 to 72 hours, implying that only a small number of organisms are present. The rapid time to positivity in Arianna's case implies a large number of organisms were present in the blood culture therefore suggesting that it was pure growth rather than a contaminant. Relevantly, Professor Craig gave evidence that in his experience when blood cultures are taken from children admitted to hospital with severe overwhelming infection, blood cultures will return a positive result within 6 to 12 hours.

9.29 *Third*, the finding of *S. pneumoniae* in Arianna's case raised the possibility of translocation. Dr Burger explained that in a post-mortem setting, "*the normal kind of structural borders that we have in a living person […] don't count in deceased people*". This means that because of "*post-mortem breakdown processes*" organisms can move between structures. For example, as S. *pneumoniae* is a coloniser in the throat it could have moved with agonal spread to the lungs during the resuscitation process. Further, as the cultured blood sample was taken from aorta, which is structurally next to the lungs, Dr Burger noted the organism may have translocated from the lungs into the bloodstream where it was cultured from the aorta.

9.30 However, Dr Newcombe explained that where translocation occurs it is often multiple bacteria that are translocated and not a single organism. In Arianna's case, although Staphylococcus aureus was also cultured in the lungs, there was no finding of this same organism in the blood. Only *S. pneumoniae* was cultured from the blood sample collected from the aorta.

9.31 Professor Fleming similarly explained that in cases of translocation it is common to see a mixture of different organisms and not just a pure growth of one particular organism. He considered the finding of Staphylococcus aureus to be less important as it is an organism that "*grows really well across all temperatures as a very common contaminant*". In contrast, Professor Fleming explained:

> [I]f you get what seems to be a pure growth of a very temperature-sensitive organism which does not thrive under cold conditions, that is very different.

9.32 Adjunct Associate Professor Parsons explained that available literature indicates that if there is pure growth in an area that should be sterile then that is more likely a potential pathogen. Noting that the blood sample was taken from the aorta, Adjunct Associate Professor Parsons explained that "*the heart is a much more protected area*" from where sterile samples are more readily obtained. Whilst acknowledging that the aorta is against the heart, creating the potential for translocation, Adjunct Associate Professor Parsons considered that pure growth in the heart of *S. pneumoniae* is "*quite a significant finding*".

9.33 Professor Fleming ultimately expressed the view that whilst he could not say that pneumococcal infection was the definite cause of Arianna's death, it is the most likely explanation. Professor Craig gave evidence that he would defer to Professor Fleming's experience regarding the rapid onset of *S. pneumoniae* and agreed that in Arianna's case *S. pneumoniae* infection was probably the likely cause of her death.

9.34 *Fourth*, the post-mortem examination did not identify any evidence of raised inflammatory markers for C-reactive protein (**CRP**) or procalcitonin levels. Evidence of inflammatory markers can corroborate whether an active severe infection process was occurring and such evidence would have been a "*tipping point*" for Dr Burger in interpreting the finding of *S. pneumoniae* as a pure growth. However, tests for these inflammatory markers were not performed in Arianna's case. Dr Burger explained that this is because there was only a finite blood sample available for testing. Dr Burger considered that it was important to use the available blood sample to perform toxicology testing to rule out any possible toxicological contribution to Arianna's death and because she considered that ultimately "*histology would give the answer*".

9.35 Adjunct Associate Professor Parsons gave evidence that she was involved in writing the relevant guidelines issued by the Royal Australian College of Pathologists for sudden unexplained death in infants and children, which she described as being "*quite general*" as they cover all of Australasia. However, Adjunct Associate Professor Parsons explained that the guidelines recommend that electrolytes and toxicology are examined on every test and if there are sufficient samples remaining, additional tests such as procalcitonin and CRP can be considered. However, Adjunct Associate Professor Parsons noted that these test results are "*very dependent on post-mortem change*" and therefore "*not always useful*". Adjunct Associate Professor Parsons also noted that at

the Victorian Institute of Forensic Medicine, procalcitonin and CRP are not tested for in every case because glucose and electrolytes are more helpful and relevant to the cause of death, particularly in the absence of evidence of inflammation at autopsy. Adjunct Associate Professor Parsons noted that in Arianna's case, there was evidence of viral infection and the inflammatory markers would therefore likely be raised, making such information of less assistance with diagnosing potential sepsis.

9.36 *Fifth*, Professor Fleming also gave evidence that the observations made of Arianna in the morning of being unsettled, having woken earlier than usual, having a temperature of 37.7°C which decreased to 36.8° after being given paracetamol or ibuprofen, eating some food, walking around and then taking a nap earlier than usual were very similar to instances that he was aware of where children have experienced survivable or nonsurvivable pneumococcus. Professor Fleming explained:

> There can be an early - an early phase when they are slightly unwell, an apparent slight improvement, and then a catastrophic deterioration during a period, usually within a few hours after that. So yeah, that would not - that would be, I think, in my opinion, completely compatible with that explanation.

9.37 *Sixth*, Professor Fleming and Dr Newcombe both ultimately expressed the view that whilst it is not possible to be definite, the most likely cause of Arianna's death was pneumococcal infection. Professor Craig similarly agreed that, on the balance of probabilities, *S. pneumoniae* infection was most likely the cause of Arianna's death. Dr Burger indicated that, having regard to the evidence given during the expert witness conclave during the inquest (which involved Dr Burger, Dr Newcombe, Professor Leventer and Associate Professor Pflaumer), she was content to consider the strong possibility that the finding of *S. pneumoniae* was true growth "*and that this may have been the cause of death*" even without histological confirmation. Dr Burger noted that *S. pneumoniae* in the blood could have caused death by way of overwhelming sepsis, or could have caused a febrile convulsion, aspiration or cardiac arrhythmia. Dr Newcombe agreed that all of these terminal pathways were reasonable possibilities.

9.38 Professor Leventer gave evidence that if the culture of *S. pneumoniae* was considered to be pathological then pneumococcal sepsis would be expected to cause a fever with a rapid rise in fever being a strong trigger for a febrile convulsion which could in turn have resulted in death.

9.39 **Conclusions:** The expert evidence establishes that the finding of *S. pneumoniae* from Arianna's post-mortem examination most likely represents pure growth of a pathogen. Whilst there are no histopathology results to correlate this finding there is other persuasive evidence to suggest that the finding is not the result of contamination or translocation.

9.40 First, *S. pneumoniae* is an organism which can cause of rapid onset of infection and death without leaving any histological evidence. Although Adjunct Associate Professor Parsons gave evidence that some other finding would be expected, the possibility of rapid onset cannot be excluded. Second, *S. pneumoniae* is a temperature-sensitive organism. Given that usual refrigeration protocols were followed as part of the post-mortem examination process, it is unlikely that the finding of *S. pneumoniae* represents post-mortem overgrowth and instead, and more likely represents true infection at the time of Arianna's death. Third, the rapid time to a positive result in microbiology testing indicates a significant bacterial load making the possibility of contamination from a small amount of organisms unlikely. Fourth, no other organism was cultured with *S. pneumoniae* in an otherwise sterile site which makes the possibility of translocation unlikely. Finally, the observations made of Arianna on the morning of 24 August 2018 and her subsequent rapid deterioration are consistent with the clinical course of *S. pneumoniae* infection.

9.41 *S. pneumoniae* infection may have caused overwhelming sepsis or triggered a febrile convulsion or cardiac arrhythmia leading to death. However, a seizure and cardiac arrhythmia can only be diagnosed in life and not demonstrated from post-mortem examination. Equally, *S. pneumoniae* infection, viral infection, a febrile convulsion, or a cardiac arrythmia could have caused Arianna to aspirate. The actual terminal mechanism leading to Arianna's death cannot be clearly identified but the finding of *S. pneumoniae* infection makes it most likely that this was the precipitating event.

9.42 Therefore, the cause of Arianna's death was, on the balance of probabilities, rapidly developing *S. pneumoniae* infection leading to invasive pneumococcal disease.

10. Did Arianna's recent viral illness and/or elevated temperature contribute to her death?

10.1 Dr Burger gave evidence that she was "*very hesitant*" to infer anything from Arianna's temperatures on the morning of 24 August 2018 although considered it possible that Arianna had developed a fever again. Dr Burger also gave evidence that she was content to defer to any opinions expressed by the expert clinicians regarding this issue.

10.2 Dr Newcombe gave evidence that one or both of the enterovirus and RSV positivity contributed to the infective symptoms that Arianna was displaying in the week prior to her death. He explained that these findings are not inconsistent with a finding of streptococcus pneumoniae because bacterial infections in children are often preceded by viral infections. Dr Newcombe went on to explain that the viral infections "*dampen down the immune response, cause inflammation in the upper respiratory tract where these bacterial live and then predispose them to become invasive*". Dr Newcombe gave evidence that Arianna's temperatures were "*low-grade*" and "*mildly supportive evidence*" of a subsequent febrile convulsion or possible early infection leading to sepsis.

10.3 Professor Fleming agreed with the views expressed by Dr Newcombe. Professor Fleming gave evidence that in his experience one of the characteristics of pneumococcal infection is that it occurs within a few days to a week following an acute viral infection. In other words, it would be consistent for a child to have a virus, appear to improve, and then develop a secondary infection.

10.4 **Conclusions:** Arianna's recent viral illness prior to 24 August 2018 and the temperatures taken from her that morning are entirely consistent with a clinical course of invasive pneumococcal disease causing death. The expert evidence establishes that viral infections, such as enterovirus and RSV which were identified in Arianna's case, commonly precede bacterial infections such as *S. pneumoniae*. It is equally consistent with a clinical course of invasive pneumococcal disease that Arianna showed symptoms of a viral illness, appeared to improve, and then develop a secondary bacterial infection and rapidly deteriorated.

11. Serotyping

11.1 During the course of the inquest an additional issue arose regarding Arianna's post-mortem examination. A serotype is a distinct variation within a species of bacteria. When a bacterium is identified from microbiology testing, serotyping can be performed to distinguish different strains of the bacterial organism.

11.2 Professor Fleming explained that one of the characteristics of *S. pneumoniae* is that there are multiple serotypes but each immunisation package only has some of these serotypes. Professor Fleming also explained the importance identifying the particular serotype of *S. pneumoniae* for two reasons:

(a) a case of overwhelming infection in a patient vaccinated against a particular serotype would be a cause for public health concern; and

(b) if an immunisation package which a patient had received did not include a particular serotype then from a public health perspective consideration could be given to having that serotype included in a future immunisation package.

11.3 As part of the microbiology testing in Arianna's case, serotyping was performed by NSW Health Pathology. This identified serotype 15C on 11 September 2018. Arianna had previously the 13cPCV (**Prevenar13**) vaccine which protects against various serotypes of *S. pneumoniae* but did not provide protection against serotype 15C.

11.4 The identification of serotype 15C was not communicated to Dr Burger or to Arianna's parents at the time that the serotyping results became known. Indeed, clarity about the results was only obtained at the time of the inquest. Dr Burger gave evidence that serotyping results are "*irrelevant to the post-mortem interpretation in general or post-mortem practice*". She explained, "*we don't need that information in order to prescribe appropriate antibiotics to patients*".

11.5 Enquiries made during the course of the inquest revealed that in 2018 all serotyping results, including those in Arianna's case, were referred to NSW Health Protection in accordance with usual practice. Information provided to the inquest by NSW Health Protection further revealed the following:

(a) serotyping of *S. pneumoniae* isolates is undertaken for disease surveillance purposes as the serotype does not affect the clinical management of invasive pneumococcal disease;

(b) the role of NSW Health Protection is to collect surveillance data to monitor the epidemiology of invasive pneumococcal disease in NSW to inform the prevention and response to invasive pneumococcal disease at a national level;

(c) the data and serotype information is sent to the Australian Centre for Disease Control (previously the Australian Department of Health) to inform national vaccination recommendations and other prevention strategies;

(d) NSW Health Protection did not in 2018, and does not currently, notify the person or the family of the person from whom the isolate was cultured of serotype results reported by the laboratory which performed the serotyping;

(e) from 1 September 2025, a new vaccine, 20cPCV (**Prevenar20**) replaced Prevenar13 as the National Immunisation Program vaccine for children under 18 years old;

(f) Prevenar20 is the vaccine recommended by the Australian Technical Advisory Group on Immunisation for children at two, four and 12 months of age;

(g) Prevenar20 covers serotype 15B but not serotype 15C; and

(h) There is some evidence that vaccination against serotype 15B offers some cross protection against serotype 15C.

11.6 Follow up enquiries were made with both Professor Fleming and Dr Newcombe to determine whether the serotyping results in Arianna's case change any aspect of their evidence

11.7 In a supplementary report, Professor Fleming noted that serotype 15C is not included in Prevenar13 and that therefore Arianna's response to this organism "*would be very similar to the pattern of illness commonly seen in the pre-immunisation era*" when *S. pneumoniae* "*commonly caused an acute, rapidly progressive infection that sometimes lead to death from acute sepsis before there was any identifiable histological response seen in post-mortem*". This makes it clear that the serotyping results in Arianna's case did not change Professor Fleming's opinion but rather supported it.

11.8 In further correspondence, Professor Fleming noted the following:

> S. Pneumoniae is spread mostly via contact with respiratory secretions.
> […]
> S. Pneumoniae is known to spread relatively easily in childcare facilities and may be transmitted by contact with objects - particularly soft toys etc - that have been in contact with other children and may also spread from contact with hard surfaces with which other children have had contact, and which have not been effectively cleaned.

11.9 Professor Fleming went on to express this view:

> It is thus probable (but not certain) that Arianna acquired S Pneumoniae in the few days before she died, and this was most likely (but not certainly) to have occurred in the childcare facility.
>
> It is also possible that she acquired this organism at home or in the local community.
>
> She was made more vulnerable to invasive disease by her documented recent viral upper [respiratory] tract infection.

11.10 Dr Newcombe indicated that the results of serotyping in Arianna's case were not relevant, and did not change, his evidence. Dr Newcombe also indicated that the identification of serotype 15C has no other significance in Arianna's case which he wished to draw attention to.

11.11 It was submitted on behalf of Arianna's parents that:

(a) identification of serotype 15C is relevant evidence of the cause of Arianna's death and it is open to infer the serotyping results would have been relevant information to Arianna's parents;

(b) "*it was an avoidable omission on the part of the authorities, including NSW Health*" to not share with the Coroner and Arianna's parents the serotyping results; and

(c) sharing of the serotyping results might have a led to the coronial process unfolding "*in a different way*" with a "*simpler enquiry without the need to investigate other causes of death*"; and

(d) sharing of the serotyping results "*may have permitted a line of enquiry directed towards hygiene practices at Berry Patch*".

11.12 Having regard to the above, Senior Counsel for Arianna's parents submitted that consideration ought to be given to making a recommendation to NSW Health that "*in circumstances in which testing undertaken post death reveals a significant scientific fact*", the fact be "*disclosed to appropriate family members of the deceased person*" and "*the Coroner where an inquiry is considered possible*".

11.13 *First*, it can be readily inferred that Arianna's parents would have been in 2018, and are, interested in any information relevant to the cause of Arianna's death. The identification of serotype 15C is relevant because it confirms that Arianna was not vaccinated against this particular serotype. This in turn adds weight to the opinions expressed by Professor Fleming and Dr Newcombe regarding the cause of Arianna's death being invasive pneumococcal disease. However, both Professor Fleming and Dr Newcombe indicated that the serotyping results did not change their evidence.

11.14 *Second*, there is no evidence to support the submission that it was an "*avoidable omission*" on the part of NSW Health to not report the serotyping results other than in the manner indicated above. It should be noted that NSW Health was not a sufficiently interested party and did not appear, and was not represented, at the inquest. The information provided by NSW Health Protection set out above was obtained through correspondence and not oral evidence. Therefore, there was no ability to test the evidence or to further enquire about the reporting process for serotyping results and whether there may be legitimate reasons why reporting only occurs in the manner described above. As a matter of procedural fairness, NSW Health and NSW Health Pathology were afforded an opportunity to make submissions after oral evidence in the inquest and substantive submissions from Counsel Assisting and the sufficiently interested parties had already concluded but did not do so.

11.15 *Third*, there is no evidence that earlier sharing of the serotyping results likely would have led to the coronial process unfolding in the manner submitted by Senior Counsel for Arianna's parents. As already noted in detail above, consideration of the possible causes of Arianna's death was not confined solely to the possibility of *S. pneumoniae* infection and invasive pneumococcal disease. Arising from the post-mortem examination, consideration also needed to be given to possible neurological and cardiac causes of death. Further, consideration of the possibility of

S. pneumoniae did not focus on the question of whether Arianna had been vaccinated against a particular serotype of *S. pneumoniae*. Instead, this consideration focused on determining whether it could be scientifically established that the finding of *S. pneumoniae* was representative of a true pathological process and not the result of contamination or translocation.

11.16 *Fourth*, there is no evidence that earlier sharing of the serotyping results might have allowed for an enquiry into "*hygiene practices at Berry Patch*". Professor Fleming indicated that it is recognised that transmission of *S. pneumoniae* can occur in childcare settings, including by way of contact with hard surfaces which have not been effectively cleaned. However, there is no evidence that transmission occurred in this way in Arianna's case or that any deficiencies in cleaning contributed to transmission. Available literature tendered into evidence in the inquest noted the following:

> The organism is transmitted by direct contact with respiratory secretions from patients and healthy carriers. Transient nasopharyngeal colonization, not disease, is the normal outcome of exposure to pneumococci. The highest carriage rates are in young children, with reported rates of 30–50% in industrialized countries. Factors associated with higher carriage rates include age <2 years, nursery attendance and out-of-home childcare, crowding, winter season and parental smoking.[2]

11.17 It can be seen from the above extract that childcare attendance is but one factor associated with transmission rates of *S. pneumoniae*. Whilst all the factors may not have been relevant in Arianna's case, the literature highlights the difficulties associated with identifying transmission in a single case.

11.18 **Conclusions:** It can be inferred that since 24 August 2018, Arianna's parents have wanted to receive any information relevant to the cause and circumstances of Arianna's death. The identification of a serotype of a bacterium which most likely caused Arianna's death, and which she was not vaccinated against, is obviously relevant information to Arianna's parents. It can readily be recognised that the delay in communicating this information has added to the grief and emotional burden that Arianna's parents have carried for almost 8 years.

11.19 However, there is no evidentiary basis upon which a conclusion could be reached that it is necessary or desirable for a recommendation to be made of the kind which Senior Counsel for Arianna's parents referred to in submissions. Due to the timing of when the serotyping issue arose, the inquest simply did not receive sufficient evidence regarding reporting processes and protocols in relation to serotype testing, both in 2018 and presently. It is also a relevant consideration that NSW Health was not notified of having a sufficient interest in the inquest and did not appear, and was not represented, at the inquest.

[2] Iovino F. *Streptococcus pneumoniae* Methods and Protocols. Springer Nature. 2019.

12. Legislative and policy framework

12.1 Before going on to consider the remaining issues which the inquest examined it is necessary to describe the legislative and policy framework relevant to these issues.

Legislative framework

12.2 The Australian Children's Education and Care Quality Authority (**ACECQA**) is the independent national authority that assists governments in administering the National Quality Framework (**NQF**) for the education and care of children. The NQF provides a national approach to regulation, assessment and quality improvement for early childhood education and care and outside school hours care services across Australia.

12.3 The operative legislation which works under the NQF is, relevantly, the:

(a) *Children (Education and Care services) National Law (NSW) 2010* (**National Law**); and

(b) *Education and Care Services National Regulations (NSW) 2011* (**National Regulations**)

12.4 The National Quality Standard (**NQS**) sets a national benchmark for early childhood education and care and outside school hours care services in Australia. The NQS includes seven quality areas that are important to outcomes for children including, relevantly, Quality Area 2 relating to the health and safety of the children. The aim of Quality Area 2 under the NQS is to "*safeguard and promote children's health and safety, minimise risks and protect children from harm injury and infection*". The NQS notes the following in relation to Quality Area 2:

> Children have the right to experience quality education and care in an environment that safeguards and promotes their health, safety and well-being.

12.5 Within each Quality Area there are 15 Standards and 40 Elements.

12.6 Berry Patch Preschool Kellyville Ridge Pty Ltd (**BPPKR**) was registered as a corporation on 23 April 2008 with Melinda Brown and Helen Jacobs as directors. In 2008, BPPKR was granted provider approval and granted service approval on the 31 December 2008 to operate Berry Patch. As at 24 August 2018, Ms Brown and Ms Jacobs were the persons nominated as having management and control of Berry Patch. Ms Jacobs was also the Nominated Supervisor of Berry Patch.

12.7 In October 2017, the National Regulations were amended so that the approved provider of an education and care service must ensure that the service has in place policies and procedures in relation to health and safety including matters relating to sleep and rest for children.

12.8 Regulations 81(1) and 81(2) of the National Regulations provided that the Approved Provider and Nominated Supervisor, respectively, of an education and care service must take reasonable steps to ensure that the needs for sleep and rest of children being educated and cared for by the service are met, having regard to the ages, development stages and individual needs of the children.

12.9 Berry Patch had in place a *Safe/Comfortable Sleep/Rest for Children Policy* (**Sleep Policy**) which was revised on 25 September 2017 and due for revision on 25 February 2018.

12.10 The Sleep Policy relevantly provided the following:

> Caregivers are required to conduct and record ten minute checks on sleeping infants.
> […]
> Sleep/rest times will be recorded on day charts in the child's room for parents to view.

13. Was the Berry Patch Sleep and Rest Policy in place as at 24 August 2018 followed in relation to Arianna?

13.1 As noted above, the Sleep Policy required educators to check on sleeping children every 10 minutes. These checks were known at Berry Patch as cot checks. Educators at Berry Patch commonly used iPads to set a timer for when cot checks were to be performed and to log the cot checks using the Kinder M8 application. When logging a cot check on Kinder M8 the application recorded the time of the cot check and recorded the educator logged into the application as performing the check. This meant that if the educator who performed the cot check was not the same educator who was logged into Kinder M8, the cot check would be recorded as having been done by a different educator. Parents of children at Berry Patch could also use Kinder M8 to see when the cot checks were performed and also access other information about their child.

13.2 Nicole Taylor was one of the Directors of Berry Patch in August 2018. She gave evidence that as at 24 August 2018, Berry Patch was trialling 15 minute checks because the 10 minute checks were not "*practical*". In a statement made to the Department on 22 August 2020, Ms Taylor said the following:

> On 24 August 2018, we were exclusively using Kinderm8 to log cot checks. We were conducting 15 minute cot checks during this time. We did this due to feedback from staff saying they were finding it difficult to stick to the 10 minute checks. From that point we agreed to trial the 15 minute cot checks. This was my decision as Director.

13.3 Evidence given by the educators, together with the evidence from Ms Brown and Ms Jacobs, collectively established that the Sleep Policy did not provide for how the cot checks were to be performed.

13.4 Megan Schneidereit commenced working as an educator at Berry Patch in 2011 and became a Room Leader in 2015. Ms Schneidereit described the practice of performing cot checks in this way:

> A cot check in 2018 was done by checking the CCTV monitor or the sound check via the portable monitor. When we put other kids down, we would do a quick sight check while in the room. It was just done as we walked past their cots. We would not physically touch and check the children. When we did the checks on the CCTV monitors, we were looking for children that were awake, children that had started to stir. There were limitations to the CCTV monitors because you could not see if they were breathing or the colour of their skin. Back then our cameras appeared black and white in the cot room. During that time, it was possible for several checks in a row to be done without going into the room. It would be unusual for the duration between physically entering the room to exceed 30 minutes as the kids were regularly waking up or being taken in to the cot room.

13.5 Ms Schneidereit stated that she had learnt the above practice from Room Leaders when she first started working at Berry Patch and that she trained Ms Cruden in the same practice. Ms Cruden gave evidence that as at 24 August 2018, cot checks were performed using the methods set out below.

13.6 *First*, an educator could physically enter a cot room to put a child down to sleep or pick up a child who was awake and look at, and listen to, other children in the room (**Physical Check**). Ms Cruden gave evidence that when performing a Physical Check she:

(a) would look to see what sleeping position a child was in and whether there were any unsafe objects in a child's cot;

(b) could "*normally hear the breathing*" of a child and could sometimes hear a child snoring; and

(c) would not touch a child so as to not wake them up.

13.7 *Second*, an educator could look at a monitor outside a cot room which displayed footage from a CCTV camera inside the cot room (**CCTV Check**). The video shown on the monitor was black and white, contained no audio and, due to the position and angle of the camera, captured most but not the entirely of a cot room. Ms Cruden gave evidence that a CCTV Check was used to see whether a child was awake and moving around in their cot or standing up.

13.8 *Third*, an educator could use a portable audio monitor to listen for crying or other sounds indicating that a child was awake (**Audio Check**).

13.9 Evidence given by educators working at Berry Patch, Ms Brown and Ms Jacobs supports the use of the Physical Check, CCTV Check and Audio Check at Berry Patch in the manner described above:

(a) Ms Cruden gave evidence that she was never provided with any training as to within what timeframe she should enter a cot room to check on a child if the child had not been heard to be awake from an Audio Check and if the child had not been seen on a CCTV Check to move for a period of time. Ms Cruden also gave evidence that if a child was not heard from an Audio Check and if no movement was seen from a CCTV Check it would be assumed that a child was asleep. This meant that an educator would not enter a cot room so as to avoid accidentally waking a child.

(b) Ms Turner gave evidence that when she first started working at Berry Patch in about January 2020 she was provided with informal on the job training by a more experienced educator about performing cot checks using the Physical Check, CCTV Check and Audio Check. She also gave evidence that the CCTV Check was used to ascertain if a child was awake or not and the Audio Check was "*like an extra source to determine if children were awake*".

(c) Ms Taylor gave evidence that the primary purpose of the CCTV Check was to establish whether a child was awake or asleep, and that if an educator could not see a child moving during a CCTV Check it was expected that the child was asleep.

(d) Ms Brown gave evidence that the Sleep Policy was "*really about a policy to check when a baby woke up*". Ms Brown agreed that what Ms Cruden was doing on 24 August 2018 was consistent with the procedure at Berry Patch at the time which permitted an educator to do a CCTV Check in order to perform a cot check.

(e) Ms Jacobs gave evidence that educators at Berry Patch were trained that a cot check could be performed using the CCTV Check In her statement to the NSWPF on 30 August 2018, Ms Jacobs relevantly stated the following:

> Our centre follows the safe sleeping procedure which is the guidelines of sudden infant syndrome (SIDS).
> […]
> However, our Centre policy includes that cots are checked every 10 minutes. The staff members have an Apple iPad, an audible baby's monitor and closed-circuit television (CCTV) footage monitor outside the cots room. These measures are provided to the staff to ensure the safe sleeping policy is implemented.
> […]
> Our Centre provides 1 Apple iPad with her room. I am aware that the staff set a timer every 10 minutes to check on the babies as a reminder. Once the alarm goes off the staff member must check cot rooms.
> […]
> The cheques consist of, either entering the cot room to check on the babies or can consist of viewing the CCTV monitor.

13.10 It should be noted that in her statement dated 6 March 2019, Detective Senior Constable Sarah Snowden stated the following regarding a review of the CCTV footage that she conducted with Ms Taylor on the afternoon of 24 August 2018:

> Whilst reviewing the CCTV Nicole [Taylor] said "that's not how we are supposed to do our checks, she wasn't doing those checks properly" referring to Gabrielle [Cruden] not going in to the room and checking [Ariana] whilst she was sleeping.

13.11 In her statement to a Department investigator dated 22 Augst 2020, Ms Taylor said this about the above review with Detective Senior Constable Snowden:

> There was no procedure on how [the educators] should check the child. When I was reviewing the CCTV footage of [Ms Cruden] doing cot checks on 24 August 2018, I saw [Ms Cruden] not going into the cot room regularly enough, not as often as I would have expected. This is what prompted me to say to NSW Police whilst reviewing the CCTV footage words to the effect of "That's not how we do check, she didn't do them properly". [Ms Cruden] was doing what was in place at the time.

13.12 However, Ms Taylor gave evidence that on 24 August 2018, Ms Cruden was in fact doing what she had been trained to do: that is, only entering a cot room to put a child down to sleep, collect a child who was awake, or attend to a child in distress. Ms Taylor gave evidence that she did not know what prompted her to say to Detective Senior Constable Snowden on 24 August 2018 that Ms Cruden had not performed cot checks consistent with the practice at Berry Patch and did not perform the checks properly. Ms Taylor gave evidence that her initial comments to Detective Senior Constable Snowden might have been due to the fact that she was upset and that the events of the day were a "*pretty overwhelming situation*". Ultimately, Ms Taylor gave evidence that, on reflection, Ms Cruden was on 24 August 2018 doing what she was trained to do.

Kinder M8

13.13 Ms Cruden gave evidence that an iPad would be used to log a check on Kinder M8. However, Ms Cruden described certain limitations with using Kinder M8:

(a) if a person was logged into Kinder M8 and recorded a check performed by another staff member, Kinder M8 would record the person logged into the app as the person who performed the check rather than the actual person who did so;

(b) after performing a check, she may not have immediately recorded the check on Kinder M8 if she was busy performing other duties which meant that the accurate time of a check would not always be recorded.

13.14 Ms Cruden also gave evidence that given these limitations it is not possible to determine from the Kinder M8 records exactly when Arianna was checked on and who performed each individual check.

13.15 **Conclusions:** In its terms, the Sleep Policy required an educator to check on a sleeping child every ten minutes and to record such checks so that they could be viewed by a child's parents. However, the Sleep Policy was silent in relation to how such cot checks were to be performed.

13.16 What had developed at Berry Patch dating back to at least 2011 was a practice where educators would be provided with on-the-job training about using a Physical Check, CCTV Check and Audio Check to perform a cot check. In essence, the CCTV Check and Audio Check were used to determine if a child had woken from a nap or was in distress. The Physical Check was used incidentally if an educator needed to enter a cot room to put a child down to sleep or collect a child who was awake or in distress.

13.17 Ms Cruden was trained in this practice and followed them on 24 August 2018. That is, she used the CCTV Check and Audio Check to determine if a child was awake or in distress, and she used the Physical Check for Arianna when she entered the cot room to put a child down to sleep or to pick up a child who was awake or in distress. Ms Cruden therefore followed the Sleep Policy to the extent that

13.18 However, a finding that Ms Cruden followed the terms of the Sleep Policy and the practice at Berry Patch as at 24 August 2018 is distinct from the adequacy of the Sleep Policy and practice at the time. These issues are dealt with separately below.

14. The action and/or inaction of Berry Patch and its employees in respect of Arianna's sleep on 24 August 2018

14.1 Two issues may be conveniently dealt with at the outset.

Bedding material and Arianna's sleeping position

14.2 There is no evidence that the cot that Arianna was sleeping in contained a blanket or any extraneous material that:

(a) was inconsistent with any guideline regarding safe sleeping practices; or

(b) contributed to her death.

14.3 The evidence established that Arianna referred to sleep in a prone position and regularly did so. Given her age and ability to roll, there is no evidence that Arianna's sleeping position:

(a) was inconsistent with any guideline regarding safe sleeping practices; or

(b) contributed to her death.

Safe sleeping guidance material

14.4 The ACECQA *Guide to the Education and Care Services National Law and the Education and Care Services National Regulations 2011* (**ACECQA Guide**) was published in 2011 and applied up to August 2018. Its purpose was to assist providers of education and care services, nominated supervisors and educators to understand and meet their obligations under the National Law and the National Regulations.

14.5 The ACECQA Guide is organised into chapters with, relevantly, the use of a text box highlighted in a particular colour referring a reader to guidance information. The topic of sleeping children is dealt with in relation to the need for adequate supervision pursuant to sections 165, 167 and 174 of the National Law and regulations 101, 166, 168 and 176 of the National Regulations.

14.6 The highlighted guidance section in relation to sleeping children relevantly provides the following:

> Sleeping children should always be within sight and hearing distance so that educators can assess the child's breathing and colour of their skin to ensure their safety and wellbeing. Rooms that are very dark and have music playing may not provide adequate supervision of sleeping children. Supervision windows should be kept clear and not painted over or covered with curtains or posters.

14.7 In October 2017, Red Nose revised and printed its *Safe Sleeping Child Care Kit* (**Safe Sleeping Kit**). According to Red Nose, it was developed to:

> […] inform educators, coordinators and staff employed by education and care services, including long day care, family day care to ensure all those who care for babies are **aware** of best practice

> guidelines to reduce the risk of Sudden Unexpected Death in Infancy including SIDS and sleeping accidents [original emphasis].

14.8 The Safe Sleeping Kit contains a section titled, *Questions and Answers specifically for Education and Care Services*. One of the questions listed in this section is titled, *How often should be checked sleeping babies?*, and contains the following answer::

> All children must be adequately supervised at all times. Best practice would be to supervise at all times, been the same room and to be able to see and hear the babies. Supervision needs to be active and effective. Every sleeping baby and toddler needs to be monitored actively and diligently by educators.
> […]
> There is no specific time recommended check the sleeping baby stated in the National Law and Regulations so it is specified that 'sleeping children should always be within sight and hearing distance so that educators can assess the child breathing and colour on the skin to ensure their safety and well-being'.

Actions by Ms Cruden on 24 August 2018

14.9 During her oral evidence, Ms Cruden agreed that on 24 August 2018 she went in and out of the cot room a total of four times, apart from the two occasions when she entered to put Arianna down to sleep and when she found Arianna to be unresponsive. On each of these four occasions, Ms Cruden agreed that she:

(a) entered the cot room to put another child down to sleep or pick up a child who was awake;

(b) did not visually assess Arianna's chest movement;

(c) did not visually assess Arianna's skin colour;

(d) did not lean over Arianna to listen to her breathing closely; and

(e) did not touch Arianna.

Engagement by Berry Patch directors with the safe sleeping guidance material

14.10 Ms Taylor gave evidence that prior to 24 August 2018 she:

(a) had never seen the Safe Sleeping Kit and was unaware of its messaging or similar messaging contained in the ACECQA Guide;

(b) never made any enquiries to ascertain what messaging had been provided to childcare centres regarding the supervision of sleeping children;

(c) recalled educators at Berry Patch being provided with some training or guidance from Red Nose about preventing the risk of SIDS; and

(d) could not recall the details of the training or guidance, expressed the belief that the training or guidance did not provide details of precisely how educators should conduct a cot check.

14.11 Ms Brown initially gave evidence that prior to 24 August 2018:

(a) she had never seen the Safe Sleeping Kit and was unaware of its contents;

(b) if the Department had sent out an email newsletter titled *Spotlight* to all childcare approved providers she would have read the information provided by the Department but "*probably not*" each and every time;

(c) she was aware that it was the Department's expectation that a childcare centre would maintain adequate supervision of children during sleep and rest time, including checking/sleeping children at regular intervals;

(d) she was unaware of any messaging from Red Nose (or SIDS and KIDS as it was previously known), ACECQA and the Department regarding the need to check a child's breathing and the colour of their skin to ensure their safety and well-being; and

(e) she attended a training course provided by Red Nose, which she described as the "*leading body*", and considered that such attendance was sufficient to satisfy her responsibilities as an approved provider.

14.12 Later in her oral evidence, Ms Brown accepted that if the Safe Sleeping Kit was available and in force in 2018 then she would have ordered and received it. However, Ms Brown gave evidence that she could not recall seeing any reference in the Safe Sleeping Kit to information regarding how often a sleeping baby should be checked on. Ms Brown conceded that it is possible that such information was contained in the Safe Sleeping Kit but that she did not read it.

14.13 When asked questions by her own Senior Counsel, Ms Brown gave evidence that before being shown the contents of the Safe Sleeping Kit during the inquest, she could only recall ever seeing posters, stickers and a sample safe sleeping policy. Ms Brown gave evidence that it is possible that she did not see or look at the reference in the Safe Sleeping Kit (which was about 70 pages in length) to the need to check a child's breathing and the colour of their skin to ensure their safety and well-being.

14.14 Mr Jacobs gave evidence that prior to 24 August 2018:

(a) she could not recall ever purchasing, receiving or reading the Safe Sleeping Kit but agreed that if the Safe Sleeping Kit has been in her possession she would have reviewed it as the Nominated Supervisor of Berry Patch;

(b) she was unaware that SIDS and Kids previously promoted the same messaging contained in the Safe Sleeping Kit;

(c) she took no steps to find out what messaging Red Nose or SIDS and Kids had disseminated other than taking part in an e-learning package in June 2018;

(d) she was aware of the ACECQA Guide and had read some of it but "*not every single page*";

(e) she could not recall reading any messaging regarding the need to check a child's breathing and the colour of their skin to ensure their safety and well-being; and

(f) acknowledged that as an approved provider part of her role was to engage with current recommended evidence-based practices regarding safe sleeping for children.

14.15 Notwithstanding the above, Ms Jacobs gave evidence agreeing that performing a CCTV Check in August 2018 meant that the guidance provided by the ACECQA Guide could not be implemented.

Version provided by Ms Taylor regarding how cot checks were performed

14.16 Ms Taylor provided a statement to a Department investigator dated 22 April 2020. She gave evidence that she read her statement carefully before signing it and that everything stated in the statement was true and correct to the best of her belief at the time. In that statement, Ms Taylor said the following:

> During August 2018, when the alarm on the iPad went off, the staff would use the CCTV monitor to conduct cot checks so as not to disturb the children.
> […]
> The only reason they would go in there was to take a child in or out or check on a distressed child. The other method they could use was looking through the cot room windows. The Educators had discretion to determine how to conduct a cot check. There was no instruction, policy or procedure on how many checks could be done by CCTV monitor. It would have been possible for an Educator to not enter the Cot Room for, 30 minutes, an hour, or even longer on some occasions.

14.17 When asked about this aspect of her statement, Ms Taylor gave evidence that whilst CCTV Checks were performed, "*in person checks*" were performed as well. Ms Taylor sought to explain that this was information that she recalled after giving her statement. Ms Taylor then sought to explain that what she said in her statement about entering a cot room only to "*take a child in or out or check on a distressed child*" was incorrect. Instead, Ms Taylor gave evidence that it "*was meant to be an alternating in-person CCTV system*".

14.18 Ms Taylor agreed that there was no mention in her statement of any such alternating system and again sought to explain that it was only something that she recalled after making her statement. Ms Taylor later agreed that everything that she had said in her statement was completely inconsistent with the concept of there being "*some type of procedure where an educator needed to go [into a cot room] at a particular time*".

14.19 Ultimately, Ms Taylor agreed that the initial evidence that she gave about a purported alternating system was incorrect. She subsequently withdrew this evidence. Ms Taylor gave evidence confirming the contents of her 2020 statement that the only reasons why an educator would enter

a cot room was to put a child to sleep, collect a child who was awake, or attend to a child who was distressed.

14.20 Ms Taylor also gave evidence that:

(a) if a child was not heard to be awake or seen to be moving then educators would assume that the child was asleep;

(b) in this case there would therefore be no reason for an educator to enter a cot room; and

(c) it would therefore be possible for an educator to not enter a cot room for an hour or longer on some occasions.

Version provided by Ms Brown regarding how cot checks were performed

14.21 Ms Brown provided a statement on 30 August 2018 (**August 2018 Statement**) to Detective Senior Constable Snowden in which she stated the following:

> In relation to sleeping our centre has a policy that we check on the children every 10 to 15 minutes. [Berry Patch] has CCTV throughout the centre. The CCTV monitors the four cot rooms in the centre. Outside the cot rooms there is a CCTV monitor that gives a visual of what is happening in that cot room. The staff use the CCTV monitor to do those checks on the cots. We do not have audio or movement monitors in the centre. Staff do not have to go inside the cot room to do those checks.

14.22 Following the events of 24 August 2018, and in the context of an investigation conducted by the Department, Ms Brown co-signed a letter with Ms Jacobs dated 24 October 2019 on Berry Patch letterhead (**October 2019 Letter**) and attaching a copy of the Sleep Policy which was sent to a Department investigator. The letter relevantly stated:

> Checks are done on the cot rooms by entering the rooms or checking CCTV monitors outside the cot room to ensure that children are not awake, distressed or in danger.

14.23 Ms Brown gave evidence that the letter was sent to the Department knowing that it would be taken into account as a "*serious description*" by Ms Brown of the policy and procedure regarding cot checks that was in place at the time of Arianna's death.

14.24 On 21 May 2020, the Department served Ms Brown with a Show Cause notice regarding an intention to cancel the service approval for Berry Patch. On 23 June 2020, solicitors engaged by Ms Brown sent a letter to the Department responding to the notice (**Show Cause Letter**). Ms Brown gave evidence that she carefully read the Show Cause Letter before it was sent on her behalf. The Show Cause Letter annexed the Sleep Policy and stated:

> [The Sleep Policy] did not permit checks on sleeping infants to be carried out by CCTV or audible monitor. There is no mention or suggestion in this policy that checks could be done by CCTV or audible monitor.

> We are instructed that at that time, in respect of an infant who had been placed in the Cot Room to sleep but who could clearly be seen moving around on the CCTV screen, educators would not enter the room to check on them. If moving, an infant would not be considered to be asleep. However, once still and sleeping, the Provider's policy and practice was to require in person checks on the infant in person every ten minutes.

14.25 In evidence, Ms Brown agreed that the Sleep Policy was silent about how a cot check was to be performed. She also agreed that in the August 2018 Statement made five days after Arianna's death, she had stated that the procedure in place at Berry Patch was that the CCTV monitor was used to perform cot checks.

14.26 Ms Brown initially disagreed with a suggestion that the relevant section of the Show Cause Letter sought to convey a clear impression to the Department that CCTV was not being used to perform cot checks. When Senior Counsel Assisting suggested to Ms Brown that it was misleading to allow the Show Cause Letter to be sent to the Department and failing to reveal the true position (as stated in the August 2018 Statement) which was that educators were using CCTV monitors to perform cot checks, Ms Brown gave evidence that she thought the Department "*actually knew that we were using CCTV footage*".

14.27 There followed this exchange between Senior Counsel Assisting and Ms Brown:

> Q. You've read 56 and 57 [of the Show Cause Letter]. It's under a heading where you are describing both your policy and your practice. In circumstances where you knew the true position to be that staff were trained and entitled to use a CCTV monitor as a standalone option to do a cot check, and that they did not have to go inside to do a check, that it was misleading for you to allow a letter to be sent to the department where you put the material that you allowed to be put in 56 and 57 [of the Show Cause Letter]. Do you agree with that?
> A. Yes.
>
> Q. It was misleading, wasn't it?
> A. Yep.

14.28 Senior Counsel Assisting pressed Ms Brown and suggested that she knew that it was misleading at the time that she provided instructions for the Show Cause Letter to be sent. In response, Ms Brown requested an explanation as to what was meant by "*misleading*". Following an objection by Senior Counsel for Ms Brown that the questions put to Ms Brown were unfair, Senior Counsel Assisting approached the issue in this way:

> Q. You agree with me that you knew, at the time you were speaking to your lawyers in June 2020 as part of preparing the show cause response, that the truthful position was that staff were entitled to use the CCTV monitor, they were entitled to assume a baby was asleep if there was no movement, and they did not have to go inside the cot room. Correct?
> A. Correct.
>
> Q. Please reread the last sentence of paragraph 57?
> A. "If moving" - the last—
>
> Q. The top of page—

A. 150 - no. 461?

Q. 461.
A. The last one. “However, once still and sleeping, 5 the provider’s policy and practise was to require checks on the infant in person every ten minutes”.

Q. So an “in person check” is physically going in the cot room. Correct?
A. Yes.

Q. So given what you knew to be the truthful position as at the time of Arianna’s death, as at the time you spoke to the detective, and as at the time you were speaking to the lawyers in 2020, you agree with me that what is in that sentence is inaccurate. Correct?
A. Okay. Correct.

Q. And you knew that was inaccurate at the time you gave instructions to the lawyers to send this response to the government. Correct?
A. Correct.

Q. You knew it was misleading, didn’t you?
A. Correct.

14.29 The Show Cause Letter went on to state:

> In the Notice, the Department refers to a letter from the Provider dated 24 October 2019 which states “Checks are done on the cot rooms by entering the rooms or checking the CCTV monitors outside the cot room”. The Provider wishes to clarify this statement by confirming that the only checks which can be done using the CCTV monitors outside the cot room are checks on babies who are moving around (and therefore not yet asleep) and checks undertaken in addition to the 10 minute in room checks.

14.30 Ms Brown agreed in evidence that the Show Cause Letter did not clarify that:

(a) as at 24 August 2018 the procedure at Berry Patch permitted the use of a CCTV Check as a standalone basis for performing a cot check; and

(b) if a child was not seen to be moving an educator was entitled to assume that a child was asleep and not required to go into a cot room.

14.31 Ms Brown made a second statement to the NSWPF dated 3 December 2020 (**December 2020 Statement**) following the Show Cause process which occurred after criminal proceedings were commenced against Ms Brown in July 2020. Ms Brown gave evidence that she had legal assistance with preparing the December 2020 statement, that she carefully checked it before signing it, and that she understood that it would be relied upon in the coronial proceedings.

14.32 In the December 2020 Statement, Ms Brown stated the following:

> I would like to correct paragraph 14 of my [August 2018 Statement] as it does not clearly represent my beliefs and knowledge of the policy and procedure that was in place at the time. I would like to

> add that, in addition to the CCTV monitors in the four cot rooms in the Centre and outside the cot rooms, there is also a visual monitor of all four cot rooms in the Director's office. Further, my statement that '*The staff use the CCTV monitor to do those checks on the cots',* in relation to visual checks of what is happening in that cot room, should have read *'The staff use the CCTV monitor to supervise the children between checks on the cots'.*

14.33 Ms Brown gave evidence agreeing that the addition of the last sentence of the above paragraph was an inaccurate statement as to how Berry Patch educators were trained regarding cot check procedures at the time of Arianna's death. There followed this exchange between Senior Counsel Assisting and Ms Brown:

> Q. And you knew that at the time of Arianna's death. Correct?
> A. Yes.
>
> Q. And you knew it at the time you were doing this witness statement. Correct?
> A. (No verbal reply)
>
> Q. I want to suggest to you that it is misleading for you to have signed a statement, for his Honour to rely on in his coronial inquest, to say that that statement, your earlier statement, should have read that they only use the CCTV monitor to supervise the children between checks on the cots. Do you accept that that was a misleading piece of evidence to give?
> A. It was not my intent to mislead, but I accept it, yes.
>
> Q. Well, you accept it's misleading?
> A. Mm-hmm.
>
> Q. And you accept that, if his Honour relied on it, he'd be misled?
> A. (No verbal reply)
>
> Q. Sorry, you can't just nod. Is that a yes?
> A. Yes. Sorry, yes. Yes.

14.34 Ms Brown initially sought to explain that she was "*blurred*" in relation to the above portion of the December 2020 Statement, meaning that she had some difficulty in distinguishing between describing the practice at Berry Patch in 2020 when the statement was made and the practice at Berry Patch in August 2018. However, Ms Brown eventually conceded that:

(a) she understood that in the December 2020 Statement she was seeking to describe the practice at Berry Patch in 2018;

(b) content of her statement was therefore misleading; and

(c) the Court would be misled if reliance was placed on that aspect of the December 2020 Statement.

Version provided by Ms Jacobs regarding how cot checks were performed

14.35 Ms Jacobs gave evidence that as at 24 August 2018, educators at Berry Patch were trained that a CCTV check could be used to perform a valid cot check, that it was not possible to hear any sound from within a cot room when performing a CCTV check, and that the video from a CCTV Check was in black and white and contained a "*very sort of dim picture*". Following these series of answers, the following exchanged occurred between Senior Counsel Assisting and Ms Jacobs:

> Q. So do you agree with me that, by looking at the CCTV monitor, if a child was still, in the sense of not moving and wriggling around, you could not tell whether their chest was moving from the CCTV. Correct?
> A. No. It was only to be used as a cot check if they were - if they could see them moving.

14.36 Ms Jacobs went on to give evidence agreeing that the contents of her 30 August 2018 to the NSWPF and the October 2019 Letter truthfully described how cot checks were performed at Berry Patch as at 24 August 2018. Ms Jacobs gave evidence agreeing that any suggestion by her of a different procedure where an educator could only use a CCTV Check if a child could be seen to be moving was incorrect.

14.37 Ms Jacobs initially sought to explain this suggestion by her was because she "*thought that's what was happening*" and later sought to explain the suggestion by expressing the belief that "*Nicole Turner gave that evidence*". After Senior Counsel Assisting confirmed with Ms Jacobs that Ms Turner did not in fact give such evidence, there followed this exchange between Senior Counsel Assisting in Ms Jacobs:

> Q. […] You told the truth to the department in 2019, and you told the truth to the detective. My proposition to you, I'm asking you to engage with it please. Any later suggestion by you in evidence that there was some other aspect to a procedure that where a baby could not be seen clearly on CCTV, that an educator was required to go into the room, is inaccurate evidence; do you agree with me?
> A. Yes.
>
> Q. It's not just inaccurate, it's misleading; isn't it?
> A. Yes.

14.38 Ms Jacobs went on to give evidence that to the extent that any of her oral evidence at the inquest suggested that there was a cot check procedure as at 24 August 2018 that was different to what she had described in her August 2018 to the NSWPF and in the October 2019 Letter, it would be inaccurate and should not be relied upon.

Assertions regarding the frequency of educators entering cot rooms

14.39 Ms Turner gave evidence that she was not trained to perform a cot check within any particular timeframe but said that she thought that "*you would still go in and out regularly enough*". She explained:

> I think you also were going in just to check on them in general, make sure everyone's settled in there and everyone's okay. We were still entering the cot room, yes.

14.40 Ms Taylor gave evidence that as a matter of practice, she observed educators entering cot rooms at Berry Patch. She gave evidence that she could not recall the frequency with which this occurred although there would not be a case where a child was left sleeping for three hours without an educator that room. Ms Taylor also gave evidence that an educator would enter the room "*a lot more frequently than that*".

14.41 Ms Brown gave evidence that during the times that she was at Berry Patch she observed educators going into cot rooms every 10 minutes.

14.42 Ms Jacobs gave evidence that from time to time when she was at Berry Patch she would observe educators going into cot rooms to collect children when an alarm would go off but that she would "*also see them going into the room and just looking around at all the children*". When asked how frequently she made these observations, Ms Jacobs gave this evidence:

> If it had been infrequent, I would have made a point of making a comment about it, because that's why we went to the centres to check that they were engaging in what we thought was the correct practice.

14.43 **Conclusions:** There are reasons to doubt the assertions made by Ms Brown and Ms Jacobs regarding how frequently in practice they observed educators entering and leaving cot rooms. As already noted above, Ms Brown was not a credible witness and any self-serving statement made by her must be approached with caution. In addition, the assertions are inconsistent with what the CCTV footage shows occurring on 24 August 2018 with no educator entering Arianna's cot room for almost 60 minutes. This is more consistent with the description initially given by Ms Taylor in her statement that it was possible for an educator to not enter a cot room for 30 minutes, 60 minutes or even longer. Finally, Ms Brown and Ms Jacobs were not present at Berry Patch on a day-to-day basis and it is therefore unclear how often or regularly they were in a position to make the observations which they asserted.

Consideration

14.44 Senior Counsel for Arianna's parents submitted that a recommendation should be made pursuant to section 82(2)(b) of the Act that the "*Department review the standing of the owners and operators of Berry Patch as approved providers*". It was submitted that Ms Brown and Ms Jacobs made certain "*seriously wrong statements*" as to their systems in their capacity as approved providers which raise questions about their fitness. Here, Senior Counsel for Arianna's parents referred to the different versions provided by Ms Brown and Ms Jacobs (as well as Ms Taylor) about how cot checks were performed which have been described above.

14.45 Section 21 of the National Law provides that the Regulatory Authority may at any time assess whether an approved provider continues to be a fit and proper person to be involved in the provision of an education and care service. Given that the NSW Early Learning Commission (**ELC**), as the independent regulator for early childhood education and care in NSW, was a sufficiently

interested party at the inquest, a question arises as to whether it is necessary or desirable to make the recommendation sought by Senior Counsel for Arianna's parents. Senior Counsel for the Department and the ELC submitted that whilst such a recommendation does not compel the ELC to undertake such an assessment, there is "a compulsion that travels with [such a] recommendation that consideration has to be given to it.

14.46 **Conclusions:** The different versions provided by Ms Brown and Ms Jacobs regarding how cot checks were performed at Berry Patch raise some disquiet. Both Ms Brown and Ms Jacobs gave evidence that they understood the seriousness of the information that they were providing and that it would be relied upon. In addition, there can be no doubt that both Ms Brown and Ms Jacobs understood the significance of the information and that it related directly to the adequacy of safe sleeping practices at Berry Patch. It is also a matter of some concern that the different versions provided by Ms Brown and Ms Jacobs were favourable to Berry Patch and to themselves and did not accurately describe how cot checks were being performed in practice in August 2018. Both Ms Brown and Ms Jacobs also conceded that their versions were not only inaccurate but misleading.

14.47 In addition, Ms Brown was an unimpressive witness. At various times Ms Brown was argumentative, evasive and reluctant to engage with the substance of straightforward questions that she was asked by Senior Counsel Assisting and Senior Counsel for the Department which required simple, direct answers. The evidence extracted above in which Ms Brown conceded she had made inaccurate and misleading statements only came after protracted and repeated questions which Ms Brown was largely non-responsive to.

14.48 Notwithstanding, whilst Ms Brown and Ms Jacobs conceded aspects of their evidence were inaccurate and misleading, these concessions fall short of establishing that the evidence was deliberately misleading. It is typically conduct of this kind which makes it necessary or desirable for a recommendation pursuant to section 82(2)(b) to be made. Equally, the demeanour of a witness and the quality of their evidence, falling short of such conduct, does not often give rise to such a recommendation being made.

14.49 Overall, given the involvement of the ELC as a sufficiently interested party in the proceedings, the apparent latitude afforded by section 21 of the National Law, and that in the discharge of its statutory functions the ELC should give consideration to the application of section 21 of the National Law, it is neither necessary nor desirable to make the recommendation sought by Senior Counsel for Arianna's parents.

14.50 Senior Counsel for Arianna's parents separately submitted that a recommendation ought to be made to SafeWork regarding the absence of adequate training provided to Berry Patch educators as to how to perform cot checks. It was submitted that the absence of such training created an unsafe workplace and the risk that educators may suffer psychological harm in circumstances where the adequacy of cot checks was related to the death of a child.

14.51 **Conclusions:** This issue was raised for the first time in submissions. It was not canvassed with any witness who gave evidence during the inquest. No evidence was sought to be adduced, either orally or in documentary form, about this issue. Relevantly, the inquest received no expert evidence about the type of risks and the safety of a workplace which the submissions referred to. There is therefore no evidentiary foundation to indicate that such a recommendation is necessary or desirable.

14.52 Senior Counsel for Berry Patch submitted that a finding should not be made that any safe sleeping policy or procedure at Berry Patch in August 2018 should have required educators to check the skin colour of a sleeping child. It was submitted that although guidance about safe sleeping was provided by the ACECQA Guide, Red Nose Kit, and the Department, such guidance was not mandatory. It was further submitted that the Safe Sleeping Sample Policy contained in the Red Nose Kit makes no mention of checking the colour of a child's skin, and that the guidance material lacks detail regarding what part of a child's body should be checked and how such checks are to be performed for children with different skin tones. Lastly, it was submitted that it is unclear whether such detail could readily be located from, for example, ACECQA sources online.

14.53 **Conclusions:** Certain provisions of the National Law are relevant here. Section 3(3)(f) in essence provides that one of the guiding principles of the NQF is that best practice is expected in the provision of education and care services. Section 51(1)(a) relevantly provides that service approval is granted subject to the condition that the education and care service is operated in a way that ensures the safety, health and well-being of the children being educated and cared for by the service.

14.54 Therefore, the approved providers of Berry Patch were under an obligation to inform themselves in a manner which allowed them to meet the conditions of their service approval. In other words, the responsibility rested with the approved providers of Berry Patch to identify how it would, relevantly, develop robust safe sleeping practices for children and implement such practices adequately and effectively.

14.55 The evidence established that both Ms Brown and Ms Jacobs had received the Safe Sleeping Kit prior to August 2018 but either did not read in full or missed the references to the need to check a child's breathing and the colour of their skin to ensure their safety and well-being. In addition, Ms Jacobs received the ACECQA Guide but did not read it in its entirety or missed the references of this kind. Finally, apart from enrolling in an e-learning training package, neither Ms Brown or Ms Jacobs took any active steps to seek out or identify what information had been disseminated by Red Nose regarding safe sleeping practices and procedures.

14.56 These omissions meant that the Sleeping Policy lacked sufficient details and instruction to inform educators how to perform effective cot checks to ensure that sleeping children were kept safe. Further, the omissions prolonged the use of CCTV Checks which were only used to identify if a child was awake or in distress and prolonged the ineffectiveness of Physical Checks which were incidental to other responsibilities that educators were engaged in.

14.57	There is no evidence that seeking information and guidance about how safe sleeping practices could be implemented at Berry Patch was particularly onerous. Whilst it was submitted on behalf of Berry Patch that the guidance material from ACEQCA and Red Nose lacked detail, particularly with regard to how a child's skin colour should be checked, the fact remains that neither Ms Brown nor Ms Jacobs read this material despite it being available to them. Even if the material had been read it remained incumbent upon Ms Brown and Ms Jacobs, in accordance with the condition of their service approval, to seek clarification or more information about any aspect of safe sleeping practices that was unclear.

15. Was there a reasonable opportunity to identity at an earlier point in time that Arianna was unwell/unresponsive?

15.1 Consideration of this issue requires examination of three separate periods of time on 24 August 2018:

(a) the period when Arianna was dropped off at Berry Patch;

(b) the period prior to Arianna being placed down to sleep; and

(c) the period after Arianna was put down to sleep.

Period when Arianna was dropped off at Berry Patch

15.2 The Berry Patch Administration of First Aid/Incident, Illness, Injury Trauma Policy (Children and Staff) (**Illness Policy**) relevantly provide the following:

> If a child has had a sustained high temperature (38 degrees or above) overnight before their day of attendance they must not attend the centre until they have not had a high temperature for at least 24 hours.
> […]
> Families must always inform the centre if medication has been administered to the child for attending.

15.3 Ms Taylor gave evidence that a copy of the Illness Policy was available in a folder in the Berry Patch foyer for parents to access. She gave evidence that if Arianna had a temperature of 37.7° at around 5:00am on 24 August 2018 she did not fall within the Illness Policy. However, Ms Taylor gave evidence that if a child had been given Panadol or Nurofen there was an obligation on the child's family to notify Berry Patch of this occurrence. Ms Taylor gave evidence about how staff were trained to deal a notification of this kind:

> So the staff would do regular checks of the children if they knew that they had been a slight temperature, and we would do things like checking the temperature every half an hour or so, and that included while they were sleeping as well they might go in and check like the body and just see if they feel warm, if they were sleeping by that time, checking them before they went down to sleep.

15.4 In a statement made to the NSWPF on 30 August 2018, Ms Cruden recounted her interaction with Jozef when Arianna was dropped off on the morning of 24 August 2018:

> I left the kitchen and went to Babies Room 3 where I greeted Arianna and her father. I don't know her father['s] names [sic]. Arianna was being held by her father.
> I said, "Good Morning, how are you? Hi Arianna".
> Dad said, "Arianna didn't have a good night sleep, she woke up early. She maybe tired earlier than usual".
> I said, "No worries we will see how she goes".
> I said to Arianna, "Can I have a cuddle?"

15.5 Ms Cruden made no mention in her statement of Jozef telling her that Arianna had a temperature that morning or that she had been given Panadol or Nurofen.

15.6 Ms Cruden similarly gave evidence that she had no recollection of Jozef telling her on the morning of 24 August 2018 that Arianna had been given Panadol or Nurofen. She explained:

> Well, I know, previously, there's been parents that have dropped off mentioning a temperature, and I've said that we're not allowed to take them. So I think it would have been something I would have remembered if I was told that.

15.7 On 18 September 2018, Jozef took part in an interview with Detective Senior Constable Snowden. During the interview, Jozef was asked if he told any educator at Berry Patch that Arianna had a temperature on the morning of 24 August 2018 when he dropped her off at Berry Patch. Jozef answered:

> So when I, I gave Arianna to Gabby I said, look Gabby, she wake up a little bit early, um, now I can't really a hundred per cent remember if I said there was a temperature. Uh, I would of said that she had a temperature uh because uh they, they not allowed to give her Panadol or any medication. Uh, so um that, yeah, so I can't really remember a hundred per cent if I, have, have mentioned but I, I'm certain that I have told in some way that she, she, because I told her she wakes up a little bit early, I would of told her as well that uh, that she had a little bit temperature and what, what they usually do, if they, if she had a temperature uh they, they would check on her.

15.8 Later, when asked whether he told Ms Cruden that he had given Arianna Panadol that morning, Jozef answered:

> Uh, I can't remember to be honest. Uh, if she had a temperature, well I'm, I'm just trying to think over and over uh - - -
> Um, it, it's, I've told her that she waked up earlier than usual. Uh, I would've told her that she had a temperature and we've given it, we've given her, giving her uh medication to bring down the temperature. So I would of told her but I don't want to, I'm, I'm not a hundred per cent.

15.9 In a statement dated 11 February 2026, Jozef recounted his interaction with Ms Cruden on the morning of 24 August 2018:

> We walked through Baby Berries Room 1, placed Arianna's bag in the cubby on the white shelving unit, then continued to Baby Berries Room 3 where I saw Ms Cahill (Berry Patch). To the best of my recollection, Ms Cahill (Berry Patch) greeted us: *"Good morning, how are you? Hi Arianna."* I told her that Arianna *"didn't have* a *good night's sleep, she woke up early and may be tired earlier than usual."* Ms Cahill (Berry Patch) replied, *"No worries, we will see how she goes."* Arianna reached for Ms Cahill (Berry Patch) and I handed her over. I told my daughter *"I Jove you, Arianna"* and she waved goodbye.

15.10 During his oral evidence, Jozef was asked whether the above extract captured the substance of his interaction with Ms Cruden when Arianna was dropped off. Jozef gave this evidence:

> More or less correct. I can't recall the fact that - not only mentioning that she was she woke up early, but also that we have given her a Panadol as well.

15.11 Later, Jozef gave evidence that his recollection of the events of 24 August 2018 was stronger in 2018 when he took part in the interview with the NSWPF than in 2026 when he gave evidence at the inquest.

15.12 The only apparent corroboration of either of the accounts given by Ms Cruden and Mr Maragol comes from the 6 March 2019 statement of Detective Senior Constable Snowden in which she stated the following:

> Nicole Taylor told me that [Arianna] had recently been sick and that her parents had given her Panadol before coming to the centre in the morning.

15.13 However, Detective Senior Constable Snowden gave evidence agreeing that there was no record in her NSWPF regarding his conversation with Mr Taylor. She also gave evidence that there was no reference to this conversation in Detective Senior Constable Sanan Gorges' statement and that the only reference contained in Detective Senior Constable Gorges' NSWPF notebook about Arianna being given Panadol or Nurofen related to an interview that Detective Senior Constables Snowden and Gorges had with Arianna's parents on the evening of 24 August 2018. Detective Senior Constable Snowden gave evidence that she no longer has an independent memory of that conversation and accepted that the reliability of that particular aspect of her statement "*is not high*". She gave evidence agreeing that that aspect of her statement is not reliable and should be put to one side.

15.14 Senior Counsel for Arianna's parents submitted that Jozef's account of his interaction with Ms Cruden should be accepted and that he did tell Ms Cruden that Arianna had been given Panadol or Nurofen on the morning of 24 August 2018. It was submitted that the fact that Jozef had prevaricated about whether he had told Ms Cruden or not about Arianna being given Panadol or Nurofen was "*a sign of his credit*". It was also submitted that Ms Cruden is not a reliable historian as there were a number of inaccuracies in her first statement to the NSWPF and she was mistaken about aspects of the Illness Policy.

15.15 **Conclusions:** Ms Cruden's account of the interaction between herself and Jozef on the morning of 24 August 2018 when Arianna was dropped off was first given six days later. This account remained consistent during her evidence at the inquest almost 8 years later. It could not be said that Ms Cruden's memory of the events of 24 August 2018 is unreliable. Indeed, her memory of the occasions when she went in and out of the cot room where Arianna was put down to sleep was largely consistent with the records kept on Kinder M8.

15.16 In contrast, Jozef expressed some doubt and hesitation in his 2018 NSWPF interview regarding his account of the interaction between himself and Ms Cruden. This is entirely understandable given his account was given only shortly after the devastating events that he and his family had experienced. Notwithstanding, when describing his interaction with Ms Cruden in his 2026 statement, Jozef made no mention of informing Ms Cruden that Arianna had been given Panadol or Nurofen that morning. In oral evidence, Jozef sought to explain that the substance of his 2026 statement was correct save that he had omitted to mention anything about the Panadol or

Nurofen. However, Jozef conceded in evidence that his recollection of events was better in 2018 when he participated in his interview than in 2026.

15.17 Having regard to the matters set out above, it is most likely that when dropping Arianna off on the morning of 24 August 2018, Jozef did not tell Ms Cruden that Arianna had been given Panadol or Nurofen earlier that morning.

Period prior to Arianna being placed down to sleep

15.18 Dr Newcombe gave evidence that even if Arianna has been taken to see a GP on the morning of her death nothing about her presentation would have prompted an urgent referral to a hospital ED. Dr Newcombe also gave evidence that if, hypothetically, Arianna had presented to an ED it is likely that there would have been a thorough examination followed by a period of observation. If any vital sign observations had indicated the possibility of sepsis, blood tests would have been performed and empirical antibiotics would have been commenced.

15.19 Professor Fleming similarly gave evidence that if Arianna had presented to a GP it is almost certain that no treatment would have been instituted. Professor Fleming explained that in his experience, and applying applicable guidance used in the United Kingdom, if a child of Arianna's age presented with a febrile illness that had apparently responded to antipyretics the recommendation would have been "*to observe rather than to treat*". Professor Fleming went on to explain that even if Arianna had presented to an ED the standard recommended approach would also have been to observe and treat with antipyretics.

15.20 Professor Craig gave evidence that if he had seen Arianna in the ED on the morning of 24 August 2019 he "*probably would have sent her home based on how she looked on the CCTV*" footage. He explained:

> [I]n general, the way we approach children with a fever is - the first thing is, are you a sick-looking child or are you a well-looking child? If you're looking unwell, as in might have sepsis, might have something horrible going on with you, you need tests, you need treatment and so on. If you're looking relatively well, which includes grizzly children, which includes children that are still eating and drinking, which includes children who are sort of toddling around - then your assessment and treatment is based on what you think's going on.

15.21 Professor Craig also gave this evidence:

> [A] lot of children are a bit irritable and a bit miserable when they come to a strange place and are a bit unwell, and some of them an hour later will be running around the department playing with things, and otherwise, others won't have improved, and then we'll then decide to do more things, but based on the snapshot that we've got, there would be nothing in what we've got, without further information suggesting something bad was happening, that would mandate early treatment based on what - the information we have.

15.22 **Conclusions:** If Arianna had been taken to see a GP on the morning of 24 August 2018, it is unlikely that any action would have been taken to refer her to hospital. Similarly, if Arianna had presented

to a hospital ED, she likely would have been treated with antipyretics (if these had not already been given to her) and not admitted.

15.23 The expert evidence established that Arianna's apparent response to the antipyretics she had been given on the morning of 24 August 2018 and the absence of any clear symptom or presentation that she was acutely unwell would have led to an observe rather than treat approach. Therefore, it does not appear that there was a reasonable opportunity to identify that Arianna was unwell prior to her being placed down to sleep.

Period following Arianna being placed down to sleep – phone call by Anet to Ms Cruden

15.24 In an interview with the NSWPF on 18 September 2018, Anet recounted a call she made to Berry Patch at around 10:50am on 24 August 2018 when she spoke to Ms Cruden:

> I called, and I asked for Gabby, or Megan, let Gabby answer, Gabby answer the phone. And I said to Gabby, that Gabby, I just want to check on Arianna, how is she. And she said, Yeah, she's all right. She had her breakfast. And, um, we offer her watermelon after, and she didn't want to had watermelon. She was rubbing her eyes. And she went, I put her to nap early. I said, Oh, that, OK, that's OK, because she woke up early, and probably she was tired, because she said she was rubbing her eyes.

15.25 Anet gave evidence that during the morning of 24 August 2018 she saw that on Kinder M8 there was no other details after an entry indicating that Arianna had something to eat that morning. Anet gave evidence that she called and spoke to Ms Cruden "*just to make sure that [Arianna was] doing well*". Anet then described her conversation with Ms Cruden in this way:

> [Ms Cruden] said to me she put her to sleep, and she said to me that she's sleeping more than usual, and I said to her probably because she was tired and sleep - she woke up early on that day.

15.26 In her 30 August 2018 statement to the police, Ms Cruden recounted her recollection of her conversation with Anet in this way:

> Anet called the centre and I had a conversation with her. Anet said something like, "Arianna woke up early."
> I said, "Yeah she seemed tired, I put her down earlier."
> Anet said, "Thank you."
> I said, "How has Arianna been going without her dummy at home?"
> Anet said, "As she has been a bit sick lately we have been giving to her a bit more."
> I said, "She was wanting it this morning."
> I think after that the conversation ended and I returned to Babies Room 1.

15.27 Ms Cruden gave evidence agreeing that Anet told her that Arianna had been "*a bit sick lately*" but that this did not make her think at the time that she needed to check on Arianna in different way. Ms Cruden later gave this evidence:

> I didn't notice anything abnormal about the morning. I think that for a child having a rough night or being tired, I think all the things that she showed was very common and what you'd expect from a child that hadn't had a great sleep. So I guess other than that, there was nothing I noticed.

15.28 Anet gave evidence that she could not recall any conversation with Ms Cruden about Arianna having been "*a bit sick lately*" or wanting her dummy.

15.29 Senior Counsel for Arianna's parents submitted that the conversation between Anet and Ms Cruden *"was probably the last chance of something*". In other words, the submission was understood to mean that because Anet assumed that a close monitoring system was in place she might have enquired whether Arianna could have been checked on at the time of the call.

15.30 **Conclusions:** There is no evidence that during her phone call with Anet, Ms Cruden was told that Arianna had been unwell or had been given Panadol or Nurofen earlier in the morning on 24 August 2018. Although Ms Cruden agreed that Anet told her that Arianna had been "*a bit sick lately*", this was entirely consistent with Arianna having woken up early that morning, feeling tired whilst at Berry Patch, and being put down to sleep early. There is no evidence to suggest that any aspect of the conversation represented a missed opportunity to take any action to check on Arianna or was, as submitted, "*the last chance of something*".

Period following Arianna being placed down to sleep – observations of Arianna

15.31 Professor Fleming gave evidence that he was not critical of the observations, or lack of observations, made by Berry Patch staff on 24 August 2018 because it is unclear how carefully they were looking for signs of movement or breathing in Arianna. Notwithstanding, Professor Fleming explained that if Arianna was dying of sepsis any final observations of her "*would not have been dramatic at all*". He explained that in sepsis the final events leading to death is failure of peripheral vasomotor control meaning that "*blood pressure control goes*" and "*blood vessels in the skin open up*" so that a "*child may look better*".

15.32 Professor Fleming gave evidence about the difficulty in making observations of a child dying from sepsis whilst asleep. He explained:

> I have fortunately never been in the position of standing next to a child who is dying in this way, so I can't say whether I would have observed. I honestly think I wouldn't. But there's nothing specific that would be identifiable just from looking at the child. If the child had stopped breathing, and you could see no breathing movements by looking very closely, that would indicate that the child had died, but it would not predict what was happening.

15.33 Professor Craig explained that in an ED setting, deterioration in a patient would hopefully be recognised by changes in vital signs and presentation and/or "*with parents giving us cues that [a patient is] not right*". However, Professor Craig gave this evidence as to the possibility of recognising such deterioration in a non-hospital setting:

> If a deterioration is happening while you're asleep, it's a lot harder. If the child is asleep, you can't look more sleepy than asleep, and you're not going to wake the child all the time in a - in a non-clinical setting to check on them. You're going to let a sleeping baby sleep.

15.34 Professor Craig explained that if it is assumed that Arianna had developed sepsis from severe infection with *S. pneumoniae* as the cause, then it might be anticipated that she would have a very rapid pulse or very rapid breathing, "*a bit of an altered conscious state*", very cold hands or very cold feet or a "*blotchy rash*". He explained that these would be signs of infection and the body starting to decompensate.

15.35 However, Professor Craig noted that Arianna did not display any of these symptoms on the CCTV footage and that any signs that she might have had might have been subtle or missed or "*proceeded incredibly rapidly over a few hours*". Professor Craig gave evidence that such symptoms would have been "*difficult for a medical person to perceive if they were subtle*". Professor Craig also gave frank evidence acknowledging the following:

> [I]f we had normal or near normal vital signs and a child that looked like Arianna did on the CCTV footage, she may well have been sent home from the emergency department and then had something horrible happen a couple of hours down the track.

15.36 Senior Counsel for Arianna's parents submitted that if Arianna had been monitored closely on 24 August 2018, the fact that she had stopped breathing would have been identified at an earlier point in time than at around 12:06pm. It was further submitted that the absence of any close monitoring prevented any sign of unresponsiveness from being detected and therefore "*extinguished any chance Arianna had of surviving or being resuscitated*".

15.37 **Conclusions:** It is not possible to discern what symptoms Arianna may have been showing in the period after she was placed down for a nap on 24 August 2018. This is because no close and effective observations or monitoring were made of her by a Physical Check or CCTV Check.

15.38 However, the expert evidence established that depending on the timing of any close and effective observation or monitoring, if this had in fact occurred, Arianna likely would have been showing no identifiable symptoms, only subtle symptoms that could be easily missed by a person with no medical training or even showing symptoms of appearing to be well. The evidence given by Professor Fleming expressing doubt that he could observe any symptom indicating that a child was in extremis is significant given his extensive experience, including direct experience in treating children suffering from acute *S. pneumoniae* infection. Given these matters, it is most unlikely that there was any reasonable opportunity in the period after Arianna was placed down to sleep to identify that she was unwell, even if close and effective observations or monitoring had been performed.

15.39 It has already been noted that no educator entered Arianna's cot room between about 11:09am and 12:06pm. This was consistent with the Sleep Policy and practice at Berry Patch at the time which permitted cot checks to be performed by way of a CCTV Check and for educators to only enter cot rooms if a child was awake or in distress.

15.40	Having regard only to the Sleep Policy and practice at the time, there was therefore no reasonable opportunity to identify whether Arianna was unwell or unresponsive. However, when assessed against the NQS requirement to safeguard a child's health and safety, minimise risks and protect a child from harm, together with the guidance provided by both ACECQA and Red Nose, it was not reasonable for Arianna to have been left for a period of about 57 minutes without any effective check being performed to ensure her safety and well-being.

16. What steps could have been taken by Berry Patch staff? What would have been the consequences if Arianna had been identified as being unwell or unresponsive at an earlier point?

16.1 Dr Newcombe gave evidence that if Arianna had a terminal event due to sepsis that would have been "*very late in the pathology process*" and that sepsis is "*critically time-sensitive*". He explained that if antibiotic therapy had been instituted, it "*could make a difference*" but "*nothing a layperson would have done would have made a massive difference*". Dr Newcombe considered that the main intervention that a layperson could have instituted would have been to start CPR until Arianna could have been transferred to an intensive care setting.

16.2 However, Dr Newcombe considered that if Arianna was in asystole due to septic shock then "*the chances of survival are low*". Associate Professor Pflaumer gave evidence that if Arianna was in fact in cardiac arrest due to sepsis "*the chances of being resuscitated in a lay setting is zero*". Professor Fleming gave evidence that published studies have reached similar conclusions that there is a 2 to 8% chance of successful resuscitation for a child who experiences an out-of-hospital cardiac arrest.

16.3 **Conclusions:** Even if an effective observation had been made of Arianna in the period after she was placed down to sleep which identified that she was unwell or unresponsive, no other response or treatment could have been instituted beyond what was done. In other words, once Arianna was identified as being unresponsive, appropriate action was taken to initiate resuscitation efforts, contact emergency services, and seek medical care for Arianna as soon as possible.

16.4 The expert evidence established that at the point that Arianna was experiencing a terminal event due to invasive pneumococcal disease and exhibiting symptoms that could potentially have been recognised as indicating that she was acutely unwell, this would have been a very late stage in the pathological process. This meant that any treatment or therapy instituted at this point, with the assumption that Arianna's condition could have been correctly diagnosed, is unlikely to have made any meaningful difference to the eventual tragic outcome.

17. Did Berry Patch respond in an appropriate and timely manner?

17.1 After Arianna was found unresponsive, she was taken out of her cot. The educators present at Berry Patch did not initially seek to provide first aid. Instead, Arianna was moved to another room where resuscitation efforts were commenced at around 12:08pm and continued for approximately one minute. The resuscitation efforts were paused momentarily whilst Arianna was moved to an office where resuscitation recommenced.

17.2 Professor Craig noted that whilst some of the educators in attendance were up-to-date with their CPR and first aid training, this "*does not guarantee that [CPR] will be commenced rapidly or performed correctly*". Professor Craig noted that overseas research has found that over 25% of participants in a research study would not perform CPR on a child due to concerns about the risk of causing harm to the child. Further, Professor Craig noted that other research has found that laypersons face many challenges in attempting CPR including panic, shock and disbelief. Professor Craig considered that these factors were evident on the CCTV footage.

17.3 Professor Craig ultimately expressed the opinion that although there was a delay in commencing CPR for Arianna and that she was moved once more than necessary, the response provided by the educators at Berry Patch "*was in keeping with what is expected by inexperienced lay rescuers*". Professor Craig further expressed the view that "*trained lay rescuers should not be expected to be held to the same standard as ambulance paramedics and hospital staff working in critical care areas*".

17.4 **Conclusions:** The educators present at Berry Patch on 24 August 2018 responded almost immediately to Arianna being found unresponsive in her cot. There was a minor delay in commencing resuscitation efforts and an equally minor pause in these efforts as Arianna was moved to a different location. The expert evidence established that the minor delay and pause were understandable and attributable to non-medically trained persons being faced with an unexpected and confronting situation of a child being found unresponsive.

18. Did the response of Berry Patch staff impact Arianna's chance of resuscitation?

18.1 In his first report, Professor Craig referred to a recent study from Victoria which found that for children suffering out-of-hospital cardiac arrest only 2.7% with asystole (the cardiac rhythm that Arianna was found to be in) survived to hospital discharge. The study also noted that for children presenting with initial asystole, "*the benefit of bystander CPR in this population is unclear*".

18.2 Professor Craig likewise expressed the view that the delay in providing CPR to Arianna initially and/or the interruption of CPR to move Arianna made no difference to her outcome. Professor Craig also opined that "*even if Arianna had been provided with expert CPR from the time of her discovery at 12:06pm, her outcome would have very likely been the same*".

18.3 **Conclusions:** The expert evidence established that the response by the educators at Berry Patch, including the minor delay and momentary interruption of CPR, had no adverse impact on Arianna's prospects of resuscitation. The context here is relevant and significant. Published studies, with which Professor Craig agreed, have found that the prospect of survival for children presenting with asystole as in Arianna's case is extremely low, and that the benefit of bystander CPR for such children is unclear.

19. Was the CPR and emergency response training for Berry Patch staff adequate?

19.1 As at 24 August 2018, Ms Turner and Ms Henning, who both performed CPR on Arianna, held up-to-date CPR certificates. Ms Cruden also held an up-to-date CPR certificate whilst Ms Orr, who checked on Arianna in her cot, had not completed her CPR training.

19.2 Professor Craig expressed the opinion that the CPR and emergency response training for the educators had no bearing upon the resuscitation efforts or Arianna's eventual outcome. As noted already above, the initial panic and uncertainty experienced by the educators upon finding Arianna to be unresponsive is "*not unusual for inexperienced lay rescuers*". In addition, Professor Craig noted that Arianna was suffering from a "*lethal cardiac arrest rhythm with a very poor prognosis*".

19.3 **Conclusions:** The CPR and emergency response training provided to the Berry Patch educators was adequate. The two educators involved in providing CPR to Arianna held up-to-date CPR certificates. The presence of one educator who had not completed CPR training made no difference to the outcome for Arianna.

20. Regulatory oversight by the Department of Education

20.1 In March 2014, [redacted] was an authorised officer in the Department's Western Sydney region whose role included conducting assessments of childcare centres within the region. Part of [redacted] role as an authorised officer was to conduct monitoring and compliance visits, complete Assessment and Rating (**A&R**) assessments and reports. The A&R assessments were mandated by the NQS which apply to all childcare centres in New South Wales. [redacted] commenced working as an authorised officer in 2012 and was trained in how to undertake A&R assessments pursuant to the NQS. On average, [redacted] completed one A&R assessment per fortnight.

20.2 [redacted]' manager at the time was Faye Lewis who was the Department's Regional Operations Manager, Western Sydney. Ms Lewis stated that [redacted] "*was one of the most skilled authorised officers on [her] team*" and that she considered her "*work to be very thorough*".

20.3 The purpose of the NQS A&R process is to determine whether and at what rating level services meet the NQS and the requirements of the National Law. A NQS assessment and rating report includes a table that summarises the elements that are "*met*" or "*not met*" and the ratings for the standards within each Quality Area. The rating levels are:

(a) Significant improvement required;

(b) Working towards NQS;

(c) Meeting NQS; and

(d) Exceeding NQS.

20.4 Relevantly, Quality Area 2 relates to the health and safety of children and a rating of "*Meeting*" means that "*each child's comfort is provided for and there are appropriate opportunities to meet each child's needs for sleep, rest and relaxatio*n".

Assessment and Rating Assessment in March 2014

20.5 On 25 November 2013, Ms Lewis wrote to Berry Patch to advise that the A&R process was commencing with a view to determining at what rating level the service met the NQS and the requirements of the National Law. In her letter, Ms Lewis requested Berry Patch to provide its Quality Improvement Plan (**QIP**). The QIP was, relevantly, required to demonstrate that a self-assessment of the quality of the practices of the service against the NQS and National Regulations had been completed, and to identify any areas that the approved provider considered may require improvement. On 20 January 2014, Ms Lewis wrote to Berry Patch again to confirm receipt of the QIP.

20.6 In relation to Element 2.1.2 and under the heading, *How will we get this outcome? (Steps)*, the QIP noted the following:

> Staff will reflect on current practices to ensure each child's comfort is being provided for. Safe sleeping practices are implemented. Sleeping infants are closely monitored.

20.7 On 4 and 5 March 2014, [redacted] attended Berry Ratch to conduct an A&R assessment and report. When completing the A&R Rating Instrument, [redacted] wrote the following in relation to an assessment against Element 2.1.2 (**Element 2.1.2 Comments**):

> *Cot checks occur every 10 minutes – ed[ucator] don't actually walk in to the cot room, just check screen – how can you tell ch[ildre]n still breathing. Ed[ucator] answers - we see them moving around then goes in cot room to check.*

20.8 Later in the assessment and rating report, under the heading "*Summary comments*", [redacted] wrote the following (**Summary Comments**):

> *Babies 7 – cot rooms have blinds or windows + door – How can ed[ucator] see? ed[ucator] rocks the cot – tv screen shows cot room.*

20.9 [redacted] made a statement dated 30 July 2025 in which she stated the following regarding the Element 2.1.2 Comments:

> I don't have any specific recollection of the circumstances of making that entry, however based on my usual practice around that time, this notation, which is a very short hand note, would have been based on the practice of a single educator, not the consistent practice of every educator.
>
> From the evidence point written, I would have asked a single educator about her practice when checking the cot room and sleeping children.

20.10 [redacted] went on to state that:

> I can almost say it is without doubt that I would have raised this issue with the nominated supervisor and spoken to the manager about the practice of the single educator.

20.11 [redacted] also stated this regarding her note relation to the Summary Comments:

> I believe that I might have written the first part of that notation regarding the blinds as a prompt to remind myself to ask the educators about the blinds later in time. I cannot now recall whether I asked educators about the blinds or, if I did, what I was told in relation to them. In relation to the "*Ed[ucator] rocks the cot*" part of the notation, I believe that it might have been an observation however, it was not a requirement nor standard practice. My concern around the blinds was likely as to whether there was sufficient visibility for the cot checks via the CCTV.

20.12 [redacted] also stated that she had no concerns regarding the approach by Berry Patch to Quality Area 2 and Element 2.1.2 and that she was "*satisfied with the sleep and rest protocols in place at the time of the assessment*". [redacted] concluded by stating:

> If I was concerned about in relation to a quality area or an element, I would have documented this clearly and I certainly would not have given a '*meeting NQS*' rating. If a childcare centre was not

> "meeting the NQS", I would have documented why I formed that opinion and then discussed it with the nominated supervisor and my manager.

20.13 [redacted] was unavailable to give evidence at the inquest. Instead, Ms Lewis gave evidence relevant to interpretation of the A&R Rating Instrument completed by [redacted] in March 2014.

20.14 Ms Lewis gave evidence agreeing that [redacted] was required to assess Element 2.1.2 by reference to the ACECQA Guide and information provided by the Department that was consistent with the Safe Sleeping Kit. Ms Lewis also gave evidence that if [redacted] had during the A&R process observed that:

(a) educators were using CCTV Checks to conduct cot checks; and

(b) educators only entered cot rooms place a child down to sleep or pick up a child who was awake or distressed;

that this would be inconsistent with the ACECQA Guide and the Safe Sleeping Kit.

20.15 Ms Lewis gave evidence that at the end of an A&R process there would be an opportunity for an authorised officer to speak with the Approved Provider and use that as an opportunity for the authorised officer to raise any concerns they had observed and to gather any additional evidence. Ms Lewis expressed the view that from reading [redacted]' notes and from her understanding of [redacted] as an assessor, [redacted] would have raised concerns recorded in the Summary Comments with an approved person on the day. Ms Lewis gave evidence that in accordance with usual practice, [redacted] "*may have*" raised with her, in her supervisory position, any concerns [redacted] had during the process of drafting the A&R report. Ms Lewis gave evidence that she had no recollection of what occurred at the time and what she and [redacted] may have discussed.

20.16 Ms Lewis also gave evidence, in response to questions asked by Senior Counsel for Berry Patch, that it was open to a service provider in 2014 to determine how frequently to check babies in a cot room in order to discharge their obligations. Ms Lewis was taken to a section of the Safe sleeping Kit which provided the following in relation to how to check on sleeping babies:

> If it is necessary to use another room a monitor may be suggested to ensure that you can hear the baby's breathing. However, it is still important to actively sight the baby as frequently as possible.

20.17 Ms Lewis gave evidence that if the Safe Sleeping Kit were the only document available it would be the Department's expectation that the criteria that a service provider was being assessed against would allow the provider to use a monitor to assess a child's breathing. However, Ms Lewis explained that she could not recall the information provided to assessors at the time to assess that particular element of the NQS. Ms Lewis gave evidence that she could not recall whether any guidance was provided to an approved provider about what body part to look at, or what to actually look for, in assessing the colour of a child's skin.

Consideration

20.18 Various submissions were made regarding how the Element 2.1.2 Comments ought to be assessed and how [redacted] came to reconcile the Element 2.1.2 to allow for a Meeting rating to be given in the absence of [redacted] actually giving evidence herself:

(a) Senior Counsel for Arianna's parents submitted that Berry Patch in its QIP indicated that sleeping children are closely monitored, that during the A&R process in March 2014 [redacted] identified that close monitoring was not occurring, that "*by some means [redacted] was misled to conclude that there was close monitoring when there wasn't*", and that the absence of close monitoring continued from March 2014 to August 2018.

(b) Senior Counsel for Berry Patch submitted that it is most likely that [redacted] identified that CCTV Checks were being used sometimes to perform cot checks and "f*ormed the view that this was an acceptable practice*". This is because three educators who were at Berry Patch in 2014 (Christie Lowndes, Ms Schneidereit and Sarah Thompson) all made statements in which they stated that they thought the use of CCTV Checks was acceptable.

(c) Senior Counsel for the Department submitted that between 2018 and 2022 various Berry Patch educators (Ms Taylor, Ms Lowndes, Caitlin Taylor, Lauren Cupit) in other proceedings and in their statements provided versions of how CCTV Checks and Physical Checks were performed that were different to how they were actually performed in 2018. It was therefore submitted that it was probable that during the A&R process in 2014 [redacted] was "*provided with information or she observed practices consistent with the various practices*" described by these educators.

20.19 **Conclusions:** Each of the above submissions invites a degree of speculation. First, [redacted] was unavailable to give evidence and it was therefore not possible to explore the evidence relied upon in the submissions, or the inferences that might be drawn from the evidence, with [redacted]. Second, apart from Ms Taylor, none of the educators who were referred to in submissions gave evidence at the inquest. Third, none of the matters raised in submissions were explored with Ms Taylor in her evidence. Fourth, Ms Lewis has no recollection of any discussions she may have had with [redacted] in her supervisor capacity. Fifth, the events in question occurred over two days some 12 years ago.

20.20 On the one hand, the evidence given at the inquest suggests that in 2014 CCTV checks were being performed at Berry Patch in the same way they were being performed in 2018. It is therefore unlikely that an educator in 2014 would attempt to reassure [redacted] that a CCTV Check was being performed in a different manner. On the other hand, there is no evidence to detract from Ms Lewis' assessment of [redacted] as one of the "*most skilled authorised officers*" and whose work was "*very thorough*", or from [redacted]' own self-assessment that she was and still is "*very careful*" in performing her role, ensuring she has sufficient evidence to adequately perform an A&R assessment.

20.21 [redacted] was unavailable to give evidence and the content of the submissions referred to above could not be explored with her, or her evidence tested. The evidence left available largely concerns [redacted] usual practice in performing an A&R assessment. Otherwise, consideration of this issue invites speculation about how [redacted] came to be satisfied that Element 2.1.2 and Quality Area 2 had been met, and the circumstances in which this occurred.

20.22 The available evidence therefore does not allow for any conclusion to be reached as to whether there was some deficiency in the A&R process and regulatory oversight provided by the Department in March 2014 at Berry Patch. Indeed, as [redacted] has not been notified as having a sufficient interest in the proceedings it would be procedurally unfair to make any finding on this issue particularly given the degree of speculation that would be required.

21. Findings pursuant to section 81 of the Act

21.1 I acknowledge the exceptional assistance provided by Ms Kate Richardson SC and Ms Belinda Epstein, Counsel Assisting, and their instructing solicitors, Ms Sarah Najjar and Ms Annabelle Thorne from the Crown Solicitor's Office (**CSO**). I also acknowledge the contributions of Ms Kate Holcombe, previous Counsel Assisting, and Ms Caitlin Healey-Nash, the previous solicitor with carriage from the CSO. The entire Assisting Team has worked tirelessly to gather and present all relevant evidence and have demonstrated professionalism, objectivity, fairness, thoroughness and sensitivity during all stages of the coronial process.

21.2 I also thank Detective Senior Constable Snowden for her role in conducting the comprehensive NSWPF investigation and for compiling the initial brief of evidence.

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

Identity

The person who died was Arianna Maragol.

Date of death

Arianna died on 24 August 2018.

Place of death

Arianna died at The Children's Hospital at Westmead, Westmead NSW 2145.

Cause of death

The cause of Arianna's death was rapidly developing *streptococcus pneumoniae* infection leading to invasive pneumococcal disease.

Manner of death

Arianna died after being placed down to sleep in a cot room at a childcare centre in circumstances where she was not actively and effectively supervised whilst sleeping to ensure her safety and well-being. Prior to being found unresponsive approximately three hours after she had been placed down to sleep, no educator had entered Arianna's cot room for approximately 56 minutes.

22. Epilogue

22.1 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences and deepest sympathies, to Jozef and Anet, Arianna's brothers, and her family and loved ones for their most tragic loss.

22.2 Anet and Jozef graciously shared these words at the conclusion of the inquest:

> She was our daughter first. She will always be our daughter first.
> We speak her name with pride.
> We honour her life with love.
> We carry her with us always.

22.3 I close this inquest.

Judge Derek Lee
Deputy State Coroner
6 May 2026
Coroners Court of New South Wales

Inquest into the death of Arianna Maragol

Annexure A

Non-publication orders

Pursuant to s 74(1) of the Coroners Act 2009:

1. The following information in the brief of evidence is not to be published:

   (a) personal information and contact details (including fixed and mobile phone numbers, residential addresses and email addresses) of any witnesses or third parties unrelated to the proceedings; and

   (b) names and personal information of any children who attended Berry Patch Preschool Kellyville Ridge or any other family day care referred to, other than Arianna Maragol.

2. There shall be no publication of any matter (including the publication of any photograph, other pictorial representation, or other electronic material) that identifies [redacted] (also known as [redacted]).

Judge Derek Lee
Deputy State Coroner
6 May 2026
Coroners Court of New South Wales