The Coroners Act 2009

IN THE LOCAL COURT OF NEW SOUTH WALES
CORONIAL JURISDICTION

Name of Deceased:	**Lachlan Charles Cumbo**
File Number:	**1698/08**
Hearing Dates:	**17 – 19 October 2011**
Location of Inquest:	**Grafton**
Date of Finding:	**19 October 2011**
Coroner:	**Magistrate Scott Mitchell, Deputy State Coroner**

Appearances:

- Mr I Bourke of Counsel instructed by Ms L Molloy of the NSW Crown Solicitor's office, appeared to assist the Coroner
- Ms M England of Counsel appeared for the Department of Family and community Services (formerly the Department of Community Services
- Mr J Harris, Solicitor, appeared for Lachlan's mother

INQUEST INTO THE DEATH OF LACHLAN CHARLES CUMBO

FINDINGS

1. Lachlan Charles Cumbo was born on 29 April, 2002, the son of Kristy Pace, now of 27 Cranworth St., Grafton and Sandy Cumbo of Mount Druitt. On 20 September, 2008 his mother found him submerged in water in the bath at home. He was taken by ambulance to Grafton Base Hospital where further resuscitation efforts proved unsuccessful and pronounced dead at 8.15pm by Dr. Mupudzi. This is an inquest into his death.

2. Mr. Ian Bourke of Counsel instructed by Ms. L. Molloy appeared to assist the Coroner. Ms. M. England of Counsel appeared for the Department of Family and Community Services, formerly the Department of Community Services, and Mr. J. Harris, solicitor, appeared for Lachlan's mother. Those who appeared to give evidence at the inquest included:-

- Detective Senior Constable Anthony King, the *Officer in Charge* of the investigation;
- Paramedic Craig Hyde;
- Lachlan's mother, Kristy Pace;
- Lachlan's father, Sandy Cumbo;
- his maternal grandmother, Geraldine Pace;
- Associate Professor Richard Franklin;
- Professor John Pearn AO
- Ms.Pamela Swinfield.

3 The formal documents consisting of the *P79A*, the *Report of Death*, an *Identification Statement*, the *Autopsy Report* prepared by Dr. Tim Lyons and Dr.Kevin Lee of the Department of Forensic Medicine at Newcastle and the accompanying *Toxicology Certificate* from the Division of Analytical Laboratories are **EXHIBIT 1.** The Coronial Brief is **EXHIBIT 2**.

4 Lachlan was one of Kristy Pace's five children. His oldest brother is Dylan, the son of Kristy Pace and Cliff Sheperd, who is now 14 years of age. Then came Monique, Lachlan's older sister, who is now 12 years of age, the daughter of Kristy Pace and Sandy Cumbo. Lachlan was the second child of that relationship. Kristy Pace and Sandy Cumbo separated in 2004 and she then formed a relationship with Peter Greogor and there are two children of that relationship, namely Hannah, now 5 years of age and Alexis now three years of age.

5 Lachlan was born at Campbelltown Hospital while his mother and the two older children were living at Ingleburn. By the time he was old enough to start school, his father, Sandy Cumbo was no longer living with the family Peter Groegor had moved in to take his place. The family moved from Ambarvale, where Lachlan started school, and then for a few months at Nyngan and, finally, in October, 2007, to Grafton. His entry into school at Ambarvale was problematic and, the *OIC* was informed, *"he was pulled out of school because he was below standard."* He restarted school at Grafton where, despite some problems with speech and with concentration, one of his family members described him as *"going well."*

6 Lachlan was described as *a happy kid*, friendly and loving, into everything with tons of energy and enthusiasm. He loved babies and he liked helping people. On the morning of his death, Lachlan mowed his uncle Mark's lawn and Kristy Pace told the inquest that he often liked to help her with the housework. From what I have heard and read about him, he was a dear little boy and I know that his parents and family miss him dreadfully. Nothing that I can say and do will affect that and I am sure that those at the bar table would wish me to extend on their behalf as well as the Court's our deepest sympathy.

7 Between 2003 and 2008, Lachlan was taken to hospital on eight occasions regarding fits and convulsions. His mother told the inquest that there were many other occasions when he fitted but was not taken to hospital because she had been told that, if he recovered within about 3 to 5 minutes, it was not necessary that he attend hospital. At one point, Kristy Pace estimates that Lachlan was experiencing a fit on an average of about once every eight weeks. When the

seizure was short lived, she used to lie Lachlan down on his side, ensure that his tongue was free and try to keep him cool.

8 She was told that his were *febrile* convulsions and it was her experience that, usually, they were associated with rises in his temperature. Her medical advice was to try to reduce any rises in temperature with *Nurofen.* Ms. Pace told the inquest that there had been some occasions when Lachlan had fitted without an elevated temperature but these were exceptional cases. On the other hand, her evidence is that there were occasions when a heightened temperature did not herald a fit but that such was the exception rather than the rule.

9 Kristy Pace says she was never given any brochure or leaflet or other material explaining Lachlan's condition and she seems to have had very littler understanding of it. She told the inquest that she was not sure whether he had ever undergone any tests. She says that, apart from resorting to *Nurofen*, she was never given any advice as to how to manage him and even her practice of putting him down on his side was the product of some sort of common knowledge rather than of medical advice. She admitted, however, that sometimes, after a hospital visit, she was given a referral to Lachlan's local doctor but she was *"not too sure"* if she ever took advantage of that because she and her children never had a regular *GP*.

10 To my observation, Kristy Pace is a quite unsophisticated and submissive person who seems to have been pushed around a bit in the past. She gives the impression of having sometimes struggled under the load she found herself carrying with five infant children, two of whom with significant learning difficulties, a number of failed relationships and a sometimes uncertain future. I doubt that she was well equipped to deal with all of the professionals she encountered in connection with Lachlan's various medical and developmental problems and I don't think she understood a great deal about his seizures, contenting herself with the day to day care of the children in her care. But family and neighbours whom police have approached have spoken quite positively about the quality of her parenting, Child protection case workers have found nothing of concern in relation

to her care of the children and, when inspected, the home appeared neat and tidy and in good order. There is no suggestion of drug or alcohol abuse.

11 According to his mother and to Geraldine Pace, Lachlan's maternal grandmother, there was often little warning of an oncoming fit and I think that, sometimes, the warning was very subtle. Geraldine Pace recounted an incident in about September, 2004, the first seizure she witnessed, when she took Lachlan to Liverpool Hospital when the only warning was that the boy had seemed *"a bit restless"* but certainly not sick. On another occasion, Geraldine Pace recalled, Lachlan suddenly collapsed at Liverpool Mall during a shopping expedition with his mother and grandmother and, according to Mrs. Pace, the only warning was that he was a bit *picky* with his food at lunch time.

12 Sandy Cumbo, Lachlan's father, gave evidence that he had witnesses Lachlan's seizures on six or seven occasions, usually while the boy was staying with him and his parents during *contact* weekends and holidays. Mr. Cumbo and Ms. Pace separated in 2004 but Mr. Cumbo maintained his interest in his son. Mr. Cumbo agrees with Kristy Pace that they were told that, so long as the period of a seizure did not exceed 2 or 3 minutes, there was no need to take Lachlan to hospital and the experience was that Lachlan recovered from these shorter seizures without ill effects. He would simply be placed on his side and watched and, quite soon, he would regain consciousness and almost immediately be his old self again. There were, however, some occasions when Mr. Cumbo or, when he was absent at work, his parents took Lachlan to hospital after longer than usual seizures.

13 Like Kristy Pace, Sandy Cumbo was told at hospital that Lachlan experienced febrile convulsions and that he would grow out of them by the age of about five. When Mr. Cumbo asked at various hospitals whether Lachlan was epileptic, he was told that this was not the case. Evidently Kristy Pace had similar experiences of being assured that Lachlan's condition was not epilepsy and Geraldine Pace told the inquest that she, too, had been reassured at Liverpool Hospital that Lachlan was not suffering from epilepsy. Sandy Cumbo complained to the inquest that *"we never got a proper diagnosis from the hospitals"* and that seems to be Kristy Pace's experience as well.

14 In particular, Sandy Cumbo had the idea that Lachlan's tonsils should come out. Like his son and like his daughter, Monique, Mr. Cumbo had experienced febrile seizures as a child and these had continued from the age of 3 to 6 months until about four and a half years of age – indeed, until a specialist had told his parents that his tonsils needed to be taken out. Once he had undergone that procedure, his fitting stopped and Mr. Cumbo long wondered whether the same thing might have applied to Lachlan. But, perhaps because fashions come and go, Mr. Cumbo was told at both Liverpool and Mount Druitt Hospitals that *"we don't remove tonsils from young people"* or words to that effect and Lachlan's fitting continued.

15 According to Kristy Pace, the advice that Lachlan would simply grow out of his febrile convulsions was bourn out, to some extent, by similar advice she had received regarding Monique and, in that instance, there had been no fits since she was about five years of age. Indeed, Lachlan himself might have been seen as having turned a corner given that, apart from an incidendent on the 9 August 2008, his most recent fit had occurred back in July, 2006 so that his mother might well have felt a degree of confidence that the crisis had passed.

16 Kristy Pace's evidence is that Saturday 20 September, 2008 was a normal busy day for Lachlan who played cricket in the morning and helped his uncle mow the lawn in the afternoon. He seemed perfectly well when they arrived home and, while his mother packed a bag for Monique who was going away for a while, Lachlan had a bath. Usually, Lachlan had a bath with Hannah and so it was on that day but, for some reason, Hannah finished early and left the bathroom, leaving Lachlan alone in the bath. No doubt he was quite pleased about that. His mother told the inquest that Lachlan, who was able to dress himself and was keen to try things out by himself, liked to have a bath by himself. She felt that he was old enough to do so and, because, apart from an incident on 9 August, 2008, Lachlan had not experienced a fit since 9 July, 2006, a little more than two years earlier, and seemed perfectly well without any elevation in temperature, she felt secure that he would be alright. Furthermore, she had never been advised, she

told the inquest, that a bath presented any particular danger for Lachlan and, on this occasion, she remained close by in an adjoining room.

17 On the evening of Lachlan's death, Kristy Pace was the sole carer of four young children. Her fifth child, Dylan, was spending the evening at a friend's house. Her then nine year old daughter, Monique, presented a degree of autism which no doubt heightened the difficulty associated with her care. Ms. Pace told Police that the youngest, Alexis, aged about 3 months at the time, was *screaming* for a bottle and Hannah was still under three years of age.

18 Police measured the level of water in the bath to find it was only about 9" deep and, while that was evidently enough to allow Lachlan to get into trouble, it probably seemed quite safe to his mother as she ran the bath.

19 Professor John Pearn AO RFD MD PhD DSc MPhil FRCP FRACP DCH FRCP(Edin), the Professor of Paediatrics and Child Health at the Royal Children's Hospital, Brisbane has provided an expert report and attended to give evidence. Regarding on the *Autopsy Report*, Professor Pearn endorses the pathologists' findings, commenting that *"the post mortem descriptions of the state of the lungs are totally consistent with the general forensic literature of death by water immersion, followed by cardiopulmonary resuscitation attempts to restore or maintain life."* Furthermore, Professor Pearn expresses the opinion *"that all paramedic care, pre-hospital care and emergency room management was skilled, appropriate and consistent with current best practice."*

20 Professor Pearn closely reviewed all aspects of Lachlan's prior medical history, background and relevant clinical and paediatric notes and noted a history of serial convulsions, dating from infancy, a family history relating to Sandy Cumbo and Monique and, in particular, Lachlan's admission to hospital on 20 August, 2005 when he was aged 3 years and 4 months and when he was reported to be not febrile at the time of admission and a further admission to hospital on 9 July, 2006. He noted, too, six other epileptiform seizures, the first three at least of which occurred in the context of an intercurrent febrile (viral) illness. He told the inquest that as many as one in five children who experience a febrile convulsion may go

on in later life to exhibit signs of having suffered epilepsy from childhood. Taking those matters into account, Professor Pearn concluded that *" Lachlan almost certainly suffered from primary epilepsy."*

21 In his expert report, Professor Pearn went on to explain that "approximately one per cent of the general population has idiopathic epilepsy, often with a positive family history. Some five per cent (1 in 20) of all normal children have one or two febrile convulsions during their first year of life, but have no further trouble. By contrast, children diagnosed with epilepsy at some period after infancy almost always have a past history also of seizures being triggered by the fever associated with intercurrent viral infections…

22 …it is my opinion that Lachlan almost certainly suffered from an epileptiform seizure while he was alone in the bath, became submerged and drowned. There is nothing in any of the clinical history or observed forensic findings which is inconsistent with such a diagnosis; and the diagnosis of death by drowning due to epilepsy whilst bathing is well recognised as an (uncommon) but well documented sub-syndrome of drowning in the family bathtub."

23 In the Autopsy Report, reference is made to what Professor Pearn described as *"the theoretical possibility of a genetic cardiac dysrhythmia."* He suggested that the family might wish to submit first degree relatives (brothers, sisters and parents) to genetic testing at centres nominated in his expert report but, as far as Lachlan himself is concerned, restated that the cause of death is drowning due to epilepsy while admitting that *"there exists a very small chance of the drowning being consequential upon a cardiac dysrhythmia,"* which, *"at the present state of scientific knowledge, cannot be excluded…"*

24 Having reached that conclusion, Professor Pearn in his report lamented the absence in Lachlan's case of one single *GP* with the opportunity to treat him and get to know him over a period of time. Longitudinal care might have provided the opportunity for consistent observation leading to a better diagnosis and, consequently, to long term, daily administration of anti-epileptic drugs which cross-sectional care could never offer.

25 In Court, Professor Pearn discussed the failure to submit Lachlan to any tests to establish, during his lifetime, whether he suffered from *primary* epilepsy or whether what was being repeatedly seen were merely instances of febrile seizures. Statistically, one would have thought that, given the frequency of the seizures, the probability of epilepsy was high enough to warrant tests. Those tests might have involved an *EEG* or even an *MRI* necessitating, as it does, general anaesthesia. And there are other tests, Professor Pearn explained, less elaborate than those two which might usefully have been undertaken.

26 The point is that, despite repeated presentations with a history of serial seizures, to various hospitals - Campbelltown, Liverpool, Mount Druitt and Grafton, no significant tests seem to have been undertaken in Lachlan's case and no diagnosis of epilepsy was reached. Perhaps one factor contributing to this omission was the variety of hospitals visited by Lachlan during his short life so that the intensity of his symptoms might not have been appreciated. In this regard, Professor Pearn told the inquest that he would have expected a major hospital to have initiated tests on its own account after the second or third such visit. It is noted, though, that Lachlan never visited any single hospital more than twice.

27 Another factor might have been Kristy Pace's apparently unsophisticated and unassertive affect. I doubt she would have had it in her to appreciate the need for tests or to challenge hospital authorities and to advocate very effectively on her own or Lachlan's behalf. But I think she did her best.

28 Professor Pearn told the inquest that there might have been significant benefit to Lachlan had epilepsy been diagnosed. In the first place, appropriate medication might have been prescribed which, over time, might have reduced the incidence of fits to manageable numbers and might have eliminated them altogether. And, secondly, a diagnosis might have prompted a coherent programme of information and education for Lachlan's carers, particularly his mother.

29 Associate Professor Richard Franklin of James Cook University at Cairns is Senior Research Fellow at the Royal Life Saving Society of Australia. He prepared

an expert report for the inquest and for the purposes of this inquest examined details of all drowning deaths of children in Australia aged 0-14 years during the period 1 July, 2002 to 30 June, 2010. The information was gathered from the Royal Life Saving Society itself, the National Coroners Information System, from media reports confirmed by police or other 3rd. parties and child drowning deaths identified by the Commission for Children and Young People and the Child Guardian (CCYPCG) Child Death Register in Queensland. In his research, Professor Franklin found 415 children under the age of fifteen years who drowned in Australia between 1 July, 2002 and 30 June, 2010. Of these, 36 had an underlying medical condition ranging from a genetic disorder to being significantly *"unwell*" and, of this 36, 16 suffered from a *"seizure-type disorder."* It seems therefore that in each year during the surveyed period, 2 Australian children prone to seizure died of drowning. These figures include children drowned in the bathtub as well as children drowning during swimming or surfing or in other circumstances. Of the 16 drowning deaths, 5 children died in the family bathtub.

30 Surprisingly, Professor Franklin was able to demonstrate that the risk of such children drowning increases as the child ages. Of the sixteen fatalities, two involved children under five years of age, six involved children from 5 to 9 years of age and the remaining eight were children aged between ten and fifteen years. He thought that this phenomenon arises because, as children, even those subject to seizures, grow older, they are likely to be subject to less obtrusive supervision.

31 On behalf of the Royal Life Saving Society of Australia, Professor Franklin developed a graduated series of possible prevention strategies, some specific to bathing, others not, ranked in accordance with what he and the Royal Society see as their likely effectiveness.

32 The first of these is "bath specific" and relates to the **depth of water** in the tub and advocates "shallow water bathing" which, the expert report predicts, "would minimise the likelihood of drowning should a seizure occur while in the bath." Indeed, Professor Franklin went further, advocating showering rather than bathing for seizure-prone youngsters old enough to take a shower.

33 The second prevention strategy has to do with supervision**, which** should involve proximity, continuity, attention and preparedness if it is to be effective. Professor Franklin told the inquest that, all too often, supervision is seen as being sufficient if the supervisor is in the general vicinity of the young person irrespective of how busy or preoccupied with other matters the supervisor may be and how well trained that person may be to react appropriately should he or she be called upon to act. There is likely to be less than optimal supervision where the supervisor is occupied reading a book or listening to music through earphones or in an adjoining room or where the supervisor is too old or infirm or untrained as to what to do in the event of an emergency. For instance, if the supervisor of a child in difficulties in a swimming pool is unable to swim, the utility of his or her supervision will be compromised. Similarly, if a supervisor is snoozing or out of the room or otherwise not paying attention, his or her effectiveness is likely to be diminished.

34 The third preventive strategy nominated by Professor Franklin relates to **medication** and suggests that the safe course is to ensure a lengthy period of the young person's compliance with medication before swimming or surfing and heightened surveillance by supervisors in the bath as well as at the beach or in the pool until medication has stabilised the young person.

35 The fourth strategy which does not relate to bathing has to do with what might be called **hard ware** and involves the installation and maintenance of safety equipment including, most particularly, pool fences and the like. As a fifth strategy, allied to the fourth, Professor Franklin advocates the availability and maintenance of appropriate floatation devices such as **life jackets.**

36 The sixth preventive strategy advocated by Professor Franklin is proper **CPR** and, in that regard the importance of proper training of parents and carers is essential. The expert report points out that *"CPR is an important skill and we can assume that the more people who undertake CPR and do it well, the higher the chances of survival of the people who receive it."*

37 Nor surprisingly, the development of **swimming skills** is seen as important in saving lives although, of course, this was not a relevant consideration in Lachlan's case and, at any event, may not be as effective as it seems given that what is being dealt with is protection for young people from the effects of disablement by seizure.

38 Another preventive strategy advocated by Professor Franklin which might have been helpful in Lachlan's case is the use of **alarms**. The expert report warns against excessive reliance on these because machines may give false positives (by going off when they are not supposed to) or false negatives (by not going off when they are supposed to) and Professor Franklin warns that no machine or device can take the place of a watchful parent or carer. Nevertheless, he advocates greater use of alarms and perhaps this would have assisted Lachlan.

39 Lastly, as a preventive strategy, Professor Franklin suggests setting and enforcing **rules** for children in their bathing habits and otherwise in their approach to water although he concedes that children tend to ignore rules or disobey them which may explain why this particular strategy has been relegated to the last place on his list.

40 I am grateful to Professor Franklin for his research and I note that Professor Pearn strongly endorses his findings. It seems to me that only good can come of his suggestion that the Department of Health in consultation with concerned non-government bodies such as the Royal Life Saving Society of Australia and the Epilepsy Council of Australia explore useful means of informing the public generally of the risk of drowning posed to children with seizure-related conditions by water sports and in the bath and the development of useful strategies to prevent such tragedies in the future.

41 Finally, another matter which arose in connection with Lachlan's death involves the provision of information to Police by the Department of Family and Community Services. It is a concern of Detective Senior Constable King that, in his investigation of the circumstances surrounding Lachlan's death, there were delays in securing information from the then Department of Community Services. This

information was related to allegations against Lachlan's mother apparently made to *DOCS* by Peter Groegor, Ms. Pace's former *de facto* partner and the father of two of her children to the Department. There is no need for me to go into the detail of those allegations which have now been fully explored by Police. Police and, as I understand it, the Department of Family and Community Services are satisfied that those allegations were without substance. But when he first learned of Lachlan's death and was appointed to lead the investigation, Mr. King was not aware of that.

42 According to Mr. King, on 20 September, 2008, the day of Lachlan's death, he telephoned *DOCS* to be told that Lachlan's mother, Kristy Pace *"had extensive prior history of neglect and abuse towards her children and a notation on their records that Kristy pace is bi-polar and previously avoided DOCS intervention."* Mr. King says that, on the basis of that information, Police decided to treat the death as suspicious. Later that evening, Mr. King obtained a *crime scene warrant* and a crime scene was set up at the home.

43 Next day, Sunday 21 September, 2008, Mr. King contacted *DOCS* seeking information regarding that *history* and, some time later, he received a phone call from a man who introduced himself as Tim Goth, the *HELPLINE* supervisor. Mr. King's recollection is that Mr. Goth told him that *"if Police required information held by DOCS a subpoena would be required. Tim Goth was apologetic but stated that this was the stance he was advised to take."*

44 Seeking to inspect records held by *DOCS* and hoping to learn what they knew of Kristy Pace, Detective Senior Constable King then arranged to obtain and serve on caseworkers Emanuel and Johnson an order under section 14F only to discover that the original *DOCS* file had been sent to the Department's Child Death Review Team in Sydney and, accordingly, was unavailable to him. Mr. King was told that the file would be produced by the Sydney office.

45 At the same time that he was informed that the disposition of the file, no longer in Grafton, would be decided by *DOCS* in Sydney – at about 3.50pm on Monday, 22 September, 2009, Mr. King was advised by local caseworkers, informally, that the

files contained allegations concerning Kristy Pace having read and perhaps having retained a newspaper article regarding a mother's murder of a young child in the bathtub. These allegations, it is now clear, had originated from Peter Groegor.

46 By that stage, the crime scene which had been set up at Lachlan's home had been released and Detective Senior Constable King's concern was and remains that his ability to be fully informed of the allegations and, thus, to investigate them properly during the early stages of the investigation had been gravely compromised. Mr. King told the inquest that the general view of Police is that the first 72 hours of the investigation of a possible homicide is particularly vital to the success of that investigation and that, as a result of *DOCS* reluctance to provide him with the information and documents he sought, he had been prevented from adequately investigation one possibly vital aspect of the case. Had he enjoyed access to the information he sought during the period while the crime scene was in place, he says he would have been able to conduct better and more effective searches.

47 It should be stressed that *DOCS* did ultimately make the file available and that it may have acted in accordance with law and with its agreement with the State Coroner's Office so that there is no question of any impropriety. Further, it is now clear that the information which *DOCS* was holding regarding Mr. Groegor's allegation was false so that, in this particular instance, no harm was done but Mr. King's point is that it is strange and unsatisfactory that, in future cases, the Department of Family and Community Services may find itself unable or unwilling to provide Police in as timely a fashion as the needs of the investigation may demand with what might prove to be information vital to the investigation of a child homicide.

48 It appears that delays in the provision of information and documents to Police may be a product of the *Children and Young Persons (Care and Protection) Act*, known as *"the Care Act,"* or, at least, a current interpretation of it by the Department. It is not clear why the information regarding Mr. Groegor's allegation was withheld until the afternoon of Monday 22 September but it is likely that case workers were

reluctant to provide the information to Mr. King for fear that it might identify the reporter, Mr. Groegor and constitute a breach of section 29(1)(f).

49 According to Pamela Swinfield who gave evidence on behalf of the Department, the current practice is to *redact* from documents whose production is called for any information, which might identify a reported, or informant. She explained the *public policy* interest in protecting the confidentiality of *child at risk* reports and she stated that, with certain exceptions such as those provided in section 29(4A), no information or document will be provided by the Department unless and until this editing process has been accomplished. On the other hand, Ms. Swinfield spoke of the newly introduced Chapter 16A and was able to tell the inquest of the significant *cultural change* in the Department springing from the new perception that the protection of children is no longer the business of the Department, solely, but is a responsibility shared across the board by a wide range of Departments and agencies of which the Department of Family and Community Services may be the first but is one of many concerned agencies. Ms. Swinfield was confident that, if Mr. King had made his request in the new climate, he would have found a much greater readiness promptly to provide him with the information and documents he sought.

50 I am asked to make a recommendation that the Minister for Family and Community Services consider a review of the *Care Act* with a view to simplifying the provisions of sections 29, 245A, 245I, 248 and 254 as they relate to the disclosure of information by the Department to NSW Police and ensuring timely provision of such information in police investigations of the death of a child or young person. These other sections also relate to the disclosure of information in Coronial matters. They are complex difficult to deal with, perhaps because they seem to have been enacted or amended in an apparently piecemeal manner.

51 I think there is scope for such a review and I agree with Counsel Assisting that the difficulties with the legislation relate not just to section 29 of the *Care Act* but that there is a wider problem. I note though that there is already a review of the operation of section 29 being undertaken in the Department of Family and Community Services including among its participants, two senior police officers

with the rank of Superintendent and a representative of the Police Prosecuting Branch. I am reluctant to make formal recommendations on the topic for fear that they may complicate or delay good work already in progress and, accordingly, I will confine myself to the hope that this review might take into account the place and effect of the other sections of the *Care Act* to which I have drawn attention and not just to section 29 and that the work of the review will proceed without delay as Ms. England of Counsel assures me it will.

FINDING

I find that Lachlan Charles Cumbo who was born on 29 April, 2002 died on 20 September, 2008 at his home at 27 Cranworth Street, Grafton, *NSW* when he drowned in his bath apparently having suffered an epileptic related seizure.

I direct that a copy of these Findings together with the evidence including the transcripts of evidence of Detective Senior Constable Anthony King and the evidence including the transcript of evidence of Ms. Pamela Swinfield be provided to the Minister for Family and Community Services, the Director-General of her Department and the Commissioner of Police.

I direct that a copy of these Findings together with the reports and evidence including the transcripts of evidence of Professor John Pearn and Associate Professor Richard Franklin be sent to the Minister for Health so that the Minister might consider:-

- what action is appropriate to increase awareness of the risks of drowning in children with a history of epilepsy or other seizures when unsupervised during bathing or when in or near water; and

  whether and what action should be taken to collaborate with non-government agencies such as the Royal Life Saving Society and the Epilepsy Council of Australia to further increase awareness of such risks.

Magistrate Scott Mitchell,
NSW Deputy State Coroner.
Glebe

18 October, 2011.