QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of a 13-year-old child ("the 13-year-old Child")**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
FILE NO(s):	2021/1526
DELIVERED ON:	26 February 2024
DELIVERED AT:	Brisbane
HEARING DATEs:	15-16 August 2023; 13 October 2023
FINDINGS OF:	Carol Lee, Coroner
CATCHWORDS:	CORONERS – INQUEST – Child death in care – recreational activities – swimming at falls in national park – care and supervision – risk assessments.

REPRESENTATION:

Counsel Assisting:	Mr Benjamin Dighton
Next of kin – Father:	Ms Lucy Barnes, instructed by Caxton Legal Centre Inc.
Next of kin – Mother:	Mr Adrian Canceri, instructed by CMC Lawyers
Department of Child Safety, Seniors and Disability Services *(formerly Department of Children Youth Justice and Multicultural Affairs)*:	Ms Karen Carmody, instructed by in-house Legal Unit
Hope Support Services and Mr La La:	Mr Patrick Wilson, instructed by Gilshenan & Luton Legal Practice
Queensland Parks and Wildlife Service and Partnerships, as part of the Department of Environment and Science:	Mr Alex Vanenn, Crown Law

Contents

Introduction

1. The deceased was a 13-year-old Child.[1] He was in the care and custody of the Department of Child Safety, Seniors and Disability Services (formerly the Department of Children, Youth Justice and Multicultural Affairs ('the Department') under an Interim Child Protection Order pursuant to the *Child Protection Act* 1999 (CPA).

2. Since March 2021, the 13-year-old Child had been living in accommodation run by a service provider, Hope Support Services ('HSS') at Bahrs Scrub. HSS was engaged by the Department to accommodate and care for children who had difficulties in foster care, kinship care or other care placements. As part of the care, it provided lifestyle and activities for children including recreational activities they would have otherwise experienced in an intact family. This was integral to establishing normalcy in these children's lives, in circumstances where they often came from complex and unstable backgrounds where they had often experienced trauma.

3. There had been substantial departmental involvement during the 13-year-old Child's life, with the 13-year-old Child and his half siblings first entering departmental care in 2016. Following an unsuccessful placement with his father, the 13-year-old Child re-entered departmental care on 2 April 2020. The 13-year-old Child was suspended from school and subsequently came to the attention of Queensland Police Service ('Police') in respect of various matters.

4. In the three days leading up to his death, the 13-year-old Child had been absent without permission from HSS. On Thursday 8 April 2021, a HSS youth worker Mr La La met the 13-year-old Child with another child resident of HSS at the Eagleby Police Beat, after they had been successfully located. In an effort to reengage the boys back into placement at HSS, Mr La took them for lunch at McDonalds Beenleigh and thereafter discussed an afternoon activity they could do together. Both boys wanted to go for a swim. The decision was made to go to Cedar Creek Falls (Falls)[2] because they had enjoyed swimming at that location several times before. The plan was that Mr La would check out the Falls and if it was not suitable conditions, they would instead go to a public pool.

[1] Having been born on 30 October 2007.
[2] Located in a national park within the Mount Tamborine Mountain area.

5. Mr La and the two boys arrived at the car park of the Falls at approximately 16:30-17:00 hours on 8 April 2021, following which they made their way down the walking track to the Falls. Once the water came into sight, Mr La observed that it was flowing roughly and told the boys that it looked unsafe. The boys rejected the suggestion of going to a public pool and, ignoring Mr La's directions, entered the water.

6. The 13-year-old Child swam in the rock pool of the Falls for a short period of time, under the supervision of Mr La. He then swam into a deeper area of the rock pool where, out of his depth, he could no longer swim in the turbulent conditions. Despite the efforts of Mr La and a bystander, the 13-year-old Child drowned at the Falls.

7. Queensland Ambulance Service ('QAS'), Queensland Fire and Emergency Service ('QFES') and Police attended the scene; the latter of whom commenced an investigation.

8. Ultimately, Police did not identify any suspicious circumstances surrounding the 13-year-old Child's death.

Non-Publication Order

9. On 9 February 2023, a Non-Publication Order[3] (NPO) was made in order to protect the identity of children, including the 13-year-old Child, who were children *'in care'* and subject to child protection orders for the purposes of the *Coroners Act* 2003 (CA) and the CPA[4].

The Coronial Jurisdiction

10. Under the CA, a Coroner has jurisdiction to investigate a '*reportable death*'.[5] A violent or otherwise unnatural death that happened in Queensland is a reportable death.[6] An inquest may be held into a reportable death (including multiple deaths) if the Coroner investigating the death considers it desirable to hold an inquest.[7]

[3] CA, s 41.
[4] CPA, ss 159P, 189.
[5] CA, s 11.
[6] Ibid, s 8.
[7] Ibid, ss 28, 33.

11. The 13-year-old Child's death was a reportable death under the Act.[8] His death was a *'death in care'* within the meaning of the CA because he was a child in the custody of the chief executive (Child Safety) under the CPA at the time of his death.[9] The circumstances of the 13-year-old Child's death raised issues about the nature and standard of his care and the risks to which he was exposed.[10]

12. On 7 December 2022, the parties were given a notice that an inquest would be held.

The scope of the Coroner's Inquiry and Findings

13. A Coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible, the Coroner is required to find:

    - who the deceased person is;
    - how the person died;
    - when the person died;
    - where the person died; and
    - what caused the person to die.[11]

14. The scope of a Coroner's jurisdiction to inquire into the circumstances of a death and make statutory findings goes beyond merely establishing the medical cause of death.[12]

15. A Coroner may, whenever appropriate, comment on matters connected with a death investigated at an inquest and make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.[13] A Coroner must not include in the findings or comments made any statement that a person is, or may be, guilty of an offence or civilly liable for something.[14]

---

[8] CA, s 8(3)(f).
[9] CA, s 9(1)(d).
[10] CA, s 27(1)(a)(ii).
[11] CA, s 45(2).
[12] However, it has been held that the '*findings*' referred to in s 45 of the CA are '*to the matters required to be 'found' in s45(2) of the Act*'. It is said to be '*clear*' from the text of the CA that these '*findings*' are '*the ultimate findings which a coroner is required to make by s 45(2)*': *Hurley v Clements & Ors* [2009] QCA 167 at [20] per McMurdo P, Keane JA and Fraser JA.
[13] CA, s 46(1).
[14] CA, s 45(5), s 46(3).

16. As a former State Coroner of Queensland has observed: '*an inquest is not a trial between opposing parties but an inquiry into the death…..The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths*'.[15]

17. Fundamentally, an inquest is '*investigative, inquisitorial and does not result in findings which bind participants inter partes. The standard of proof which applies is not the criminal standard*.'[16]

The Admissibility of Evidence and the Standard of Proof

18. The Coroner's Court is not bound by rules of evidence but may inform itself in any way it considers appropriate. The inquiry undertaken by a Coroner '*must be sufficient for the purpose of investigating the death and making, if possible, the findings required by the Act*'. The Coroner *'cannot be limited to investigating the material placed before (the Coroner) by other persons*'.[17] That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a Coroner greater scope to receive information that may not be admissible in litigated proceedings and to have regard to its provenance when determining what weight should be given to the information.

19. This flexibility has been explained by reference to the nature of an inquest as a fact-finding exercise rather than a means of attributing blame: an inquiry rather than a trial.[18]

20. In *Doomadgee v Clements*[19], Justice Muir stated the test as follows:

> *'It is significant also that the rules of evidence do not bind a coroner's court and that it may inform itself in any way it considers appropriate. That does not mean that there are no constraints at all on coroners in relation to the gathering of evidence. The evidence relied on by the coroner must be relevant to the*

[15] Findings of former State Coroner Michael Barnes in the Hamilton Island air crash *Inquest into the deaths of Joanne Bowles, Michael Bowles, Sophie Bowles, Kevin Bowles, Andrew Morris & Christopher Andre le Gallo*, Brisbane, p 2.
[16] See *Domaszewicz v The State Coroner* (2004) 11 VR 237 at par [81]; cf *Musumeci v Attorney-General (NSW)* (2003) 57 NSWLR 193 at 199 where the juristic nature of an inquest was described as a '*hybrid process*' containing both adversarial and inquisitorial elements.
[17] *Plover v McIndoe* (2000) 2 VR 385 at [19] per Balmford, J.
[18] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625.
[19] *Doomadgee v Clements* [2005] QSC 357 at [35].

matters within the scope of the coronial inquiry. The coroner may act "on any material which is logically probative"; that is, "the decision must be based upon material which tends logically to show the existence or non-existence of facts relevant to the issue to be determined, or to show the likelihood or unlikelihood of the occurrence of some future event the occurrence of which would be relevant.'

21. It is generally accepted that the civil standard of proof applies in coronial investigations in relation to factual findings that are to be made. However, the '*clarity*' of the proof required (or the degree of satisfaction called for by application of the civil standard) may vary according to the '*gravity*' of the factual matter to be determined.[20] A Coroner must apply the civil standard in a way that is '*appropriate to the gravity of the allegations*' made against a person; if a finding may have an '*extremely deleterious effect*' upon a person's character, reputation or employment prospects, that circumstance will generally demand '*a weight of evidence that is commensurate with the gravity of the allegations*'.[21]

22. A Coroner is not required to exclude every possibility, but rather to establish, if possible, what is more likely to have occurred upon findings '*reasonably supported by the evidence*'.[22]

23. It is also clear that a Coroner is obliged to comply with common law rules of natural justice and act judicially.[23] Coroners must accord procedural fairness to parties that appear at an Inquest.[24]

The Issues and witnesses

24. The following list of issues were proposed at the Pre-Inquest Conference (PIC) undertaken on 9 February 2023, following production of further material from the Department:

    1. The findings required by section 45(2) of the CA; namely the identity of the 13-year-old Child, when where and how he died and what caused the death.

[20] See *Briginshaw v. Briginshaw* (1938) 60 CLR 336 at p 362 per Dixon J, as qualified by *Rejfek v. McElroy* (1965) 112 CLR 517.
[21] *Anderson v Blashki* [1993] 2 V.R. 89 at 96-97 per Gobbo J.
[22] *Hurley v Clements & Ors* [2009] QCA 167 at [16].
[23] *Harmsworth v State Coroner* [1989] VR 989 at 994.
[24] *Annetts v McCann* (1990) 170 CLR 596, 600; *Danne v Coroner* [2012] VSC 454, [21]; *Victoria Police Special Operations Group Operators 16, 34, 41 and 64 v Coroners Court of Victoria* (2013) 42 VR 1, [36]; [2013] VSC 246.

2. The circumstances surrounding the death and, in particular, the chain of decision-making in the lead up to it by relevant individuals from the Department and HSS responsible for the custody and care of the 13-year-old Child.
3. The adequacy of policies and procedures of the Department governing issues around notice, consent and supervision with respect to children in the custody and care of the Department undertaking potentially risky recreational activities.
4. The placement history of the 13-year-old Child and the level of supervision, both generally and in the days leading up to the death, exercised by the Department in relation to his daily care and activities.
5. What actions have been taken since the death to prevent deaths from happening in similar circumstances in the future.
6. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the CA.

25. The parties who had been granted leave to appear[25] were provided the opportunity to make submissions on the proposed issues and witnesses.

26. Following the PIC, the following parties sought leave to appear in the proceedings:

    a. On 15 February 2023, HSS, which was granted on 17 February 2023.

    b. On 6 June 2023, CMC Lawyers on behalf of the 13-year-old Child's mother, which was granted on 13 June 2023.

27. Those parties were also provided the opportunity to make submissions on the proposed issues and witnesses.[26]

28. Submissions were received on the proposed issues; the sum of which was reduced to the following categories:

    a. The process undertaken by the Department in the use of structured decision-making risk assessment tool during the investigation phase into relevant child safety concerns; and
    b. The circumstances of the death as they relate to relevant control measures put in place at the site, either previously or subsequently, by the Queensland Parks and Wildlife Service and Partnerships

[25] At that stage, only the 13-year-old Child's father and the Department.
[26] Crown Law, acting on behalf of the QPWS as part of the DES, was granted leave to appear at the Inquest on 5 September 2023, after the first 2 hearing days had occurred.

('QPWSP') as part of the Department of Environment and Science (DES).

29. On 2 August 2023, accepting the submissions of Counsel Assisting, I made the following determination:

    a. The premise raised by the submissions for the 13-year-old Child's father is that the process by which the Department applied the structured decision-making risk assessment tool was flawed. It can be inferred that the relevance of that proposition to the circumstances of the 13-year-old Child's death, and therefore the context and purpose of this inquest, relies on the reasoning that:

        i. The risk assessment of 'high' that resulted from that tool being applied formed, at least in part, the basis on which an application was made to the Children's Court seeking a child protection order for the 13-year-old Child and for interim custody of him to be granted to the Department; and
        ii. If that application had not been made, then the 13-year-old Child would not have been placed into care, and his tragic death could have been avoided.

    b. This is not the forum for this issue to be ventilated, on the following basis:

        i. The relevance of this question to the circumstances of the 13-year-old Child's death must, as matter of logic, necessarily hinge upon the decision of the Children's Court to place the 13-year-old Child in the custody of the Department. This is so because the Coroners Court of Queensland does not have a remit to inquire at large into an important matter or feature of a person's life. Rather, it has an inquisitorial scope that must by force of statute be limited to the circumstances of a person's death. The scope of this inquiry must conform to the limitations as prescribed by the CA, as set out in sections 45 and 46. Whilst the issue raised is a critical one, it falls outside the scope of this inquest. Instead, it may be capable of being pursued through the multiple paths of review and remedies available with respect to administrative decisions made by a public authority;
        ii. This is fundamentally a question of jurisdiction, rather than the merits of what is being raised. The decision to place the 13-year-

old Child into the custody of the Department was a decision of the Children's Court, not the Department. While the application may have been brought as a result of the Department's investigation, that merely engaged the jurisdiction of the Children's Court to make, or refuse to make, a child protection order. That Court cannot make a relevant order, at all, unless it is satisfied that '*the child is a child in need of protection and the order is appropriate and desirable for the child's protection*';

iii. The risk assessment process is an important question about which the 13-year-old Child would have understandable concern and, without commenting on its substance, would warrant careful scrutiny and consideration. But the question for this Court is whether this inquest is the appropriate forum for that to occur, in circumstances where it was an order of a court, and not an administrative power of the Department, that was the basis for the 13-year-old Child being in the custody of the chief executive at the time that he subsequently died while swimming at the Falls; and

iv. Given the question of whether the 13-year-old Child should be placed in departmental care had already been the subject of a judicial determination in the independent exercise of a statutory discretion, then while recognising the otherwise inherent significance of the issue, that a reconsideration of that question and the steps that led to it is not the function of this Court.

c. The issues raised going to the conditions at the site of the Falls at relevant times around the incident and the risk control measures in place, both previous and subsequent, to the 13-year-old Child's death fall within the scope of the current proposed List of Issues, including Issues 2, 5 and 6, and there is a significant amount of material already contained in the brief of evidence for the inquest that bears on these matters. This is acknowledged by submissions on behalf of the 13-year-old Child's mother.

d. With respect to the physical state of the area around the Falls, the person best placed to speak to that description, and a significant reason for his being called to give evidence, is the employee of HSS, Mr La. This is particularly so given his risk assessment of the area as the carer

of two children, and the fact that he was physically in the water himself, are critical aspects of his evidence. That evidence is able to be allied with the video and photos depicting the scene around the relevant time as well as the patrol reports of rangers in the days prior.

e. It should be observed on this point that while the question of control measures is relevant to the circumstances of the 13-year-old Child's death, it seems plain on the evidence available at this stage that the risks to the children posed by swimming in the creek at that time were obvious to Mr La, as indicated by his repeated attempts to prevent them from entering the water at all.

f. In addition to the material referred to above, the Court is awaiting further material from the DES, including with respect to a safety audit report that is being conducted in relation to the site by the Royal Life Saving Society of Australia (RLSSA), which will be provided to the parties once available.

g. It is therefore appropriate for the following additional witnesses to be called to give oral evidence at the Inquest:

    i. Mr John Carter, Principal Ranger; and
    ii. Mr Mark Patenaude, Senior Ranger (as the witness able to speak to the pending safety audit report).

h. Given the Court will have the benefit of Mr La's direct and firsthand account, and the best available evidence, of conditions at the site and in the water at the time, combined with photos and videos of the site as well as the contextual information provided by the statement and materials of Mr Carter, there is limited utility in calling other witnesses to give evidence on the same or similar questions.

30. Consequently, the determination was that the list of issues proposed at the PIC remained unchanged, and the witnesses to be called to give oral evidence at the Inquest was confirmed as follows:

a. Mr La La – HSS Youth Worker
b. Mr Eiko Iva – HSS Director
c. Mr Daniel Romero – Child Safety Officer (Department)
d. Ms Hayley Kruger – Senior Team Leader (Department)
e. Dr Meegan Crawford – Chief Practitioner (Department)

f. Mr John Carter, former Principal Ranger for the Gold Coast, Southeast Queensland Region, QPWSP.
g. Mr Mark Patenaude, Senior Ranger for the Gold Coast, Southeast Queensland Region, QPWSP.
h. Mr RJ Houston (General Manager – Capability & Industry, RLSSA).

31. Additionally, it became apparent during the course of the first two hearing days of the Inquest that evidence was required to address the following factors:

a. The adequacy of QPWSP risk management procedures in place at the Falls at the time of the death;
b. The adequacy of the response by QPWSP to the death, including the absence or otherwise of any substantive review of the incident or changes to relevant safety measures; and
c. The adequacy of the organisational structure and approach by QPWSP to risk management and visitor safety at popular or high traffic areas such as the Falls

32. Notice was given to QPWSP as part of DES on 28 August 2023 and on 5 September 2023, Crown Law was granted leave to appear at the resumed Inquest. Mr Ben Klaassen (Deputy Director-General of QPWSP) attended a resumed hearing to give oral evidence.

The Evidence

33. A large bundle of exhibits was tendered into evidence, comprising documents[27] numbered A1-A4, B1-B7.4, C1-C4, D1-D5, E1-E3, F1-F7, G1-G17 and H1-H4.

34. The witnesses listed above attended[28] the Inquest and gave oral evidence.

Chronology of events

35. Set out below is a chronology of the events leading up to the death on 8 April 2021.

36. The summation of evidence helpfully prepared by Counsel Assisting has been largely accepted by the parties, save where I have indicated otherwise.

[27] Including audio, video and photographs.
[28] All in person except Dr Crawford who was granted leave to appear by videoconference.

Living arrangements

37. At the time of the 13-year-old Child's death, he was in the custody of the Department under an Interim Child Protection Order. Since March 2021, he had been placed by the Department in accommodation run by a service provider, HSS, at 1/52 Berzins Court, Bahrs Scrub. HSS employs a number of youth workers, including Mr La, to assist in the care of the children at the residence on a 24/7 basis.[29]

The days preceding the death

38. The 13-year-old Child had run away and was absent from the residence in the three days leading up to 8 April 2021. On 5 April 2021, at 06.00 hours, Mr La commenced his shift at the residence. Mr La cared for the 13-year-old Child without issue. At 14:00 hours, Mr La finished his shift. He completed a handover to Mr Pat Ah Sah who was doing the sleepover shift.[30] That afternoon, the 13-year-old Child and another child left the residence and did not return home.[31]

39. On 6 April 2021, at 06.00 hours, Mr La commenced his shift at the residence. He received a handover from Mr Ah Sah. He was advised that the 13-year-old Child had left the residence the previous afternoon and had not returned home.[32] Both boys remained in contact with their carers while away from the residence.[33]

40. At about 10:15 hours, Mr La attended the Beenleigh Police Station to report the boys missing. He made a missing person report to Constable Patrick Slavin. He also updated the 13-year-old Child's Child Safety Officer ("CSO") and completed incident reports at the residence. At 14:00 hours, he finished his shift and completed a handover to another youth worker named Pat.[34]

41. On 7 April 2021, at 06.00 hours, Mr La commenced his shift at the residence. He was advised that the boys had still not returned home. Mr La spent the shift attempting to find the boys without success. At 2.00pm, he finished his shift.[35]

---

[29] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [11]-[12].
[30] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [7].
[31] Exhibit D5 – Precis of s 93A interview dated 8 April 2021.
[32] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [8]-[10].
[33] Exhibit D5 – Precis of s 93A interview dated 8 April 2021.
[34] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [11]-[12].
[35] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [13].

The day of the accident

42. On 8 April 2021, at 14:00 hours, Mr La commenced his shift at the residence. He was scheduled to work from 14:00 hours until 22:00 hours. When he started his shift, Mr La received an email advising that the boys had been located by the 13-year-old Child's CSO, Daniel Romero. It was arranged for Mr La to collect the boys from Eagleby Police Beat.[36]

43. At about 14:55 hours, Mr La attended the Eagleby Police Beat to meet with Daniel Romero and collect the boys. After Mr La met the boys, Daniel took the 13-year-old Child to a friend's house to collect clothing and shoes. At the same time, Mr La took the other resident to McDonalds at Beenleigh where they waited for Daniel and the 13-year-old Child.[37]

Decision to attend Cedar Creek Falls

44. After lunch, Mr La drove the boys back to the residence. On the way, Mr La asked the boys what activity they wanted to do for the afternoon. Both boys said that they wanted to go for a swim at the Falls. At the time, the weather was sunny and calm,[38] and Mr La had no reason at that point to believe that the conditions at the Falls were going to be dangerous. The group went back to the residence to collect towels before driving to the Falls.

45. The 13-year-old Child had attended the Falls with Mr La and other carers to swim numerous times, including just the week prior.[39] Mr La knew that the 13-year-old Child had previously been to the Falls to swim and that he was a strong swimmer.[40]

46. The trip to the Falls was not the activity that had originally been intended. It had previously been agreed that the 13-year-old Child would, after meeting with the CSO, return to the residence and go to the local library for the afternoon.[41] However, the 13-year-old Child and the other resident did not want to go to the

[36] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [14]-[15].
[37] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [16]-[20].
[38] Transcript, Day 1: T29: L16-18.
[39] Transcript, Day 1: T14: L1.
[40] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [21]-[25]; Transcript, Day 1: T24: L1.
[41] Exhibit B1 – DCYJMA Report at 4.2 p 71.

library and in the interests of promoting their re-engagement with the placement, Mr La agreed to take them for a swim at the Falls.[42]

Drive to Cedar Creek Falls

47. When Mr La, the 13-year-old Child and the other resident were leaving the house to go to the Falls, the 13-year-old Child said that he was 'going to sit in the front and play music'.[43] Mr La did not let the 13-year-old Child do this because that was 'a privilege and he had left placement'.[44] Mr La said that the 13-year-old Child 'didn't like this' and 'got a bit annoyed' at him, saying 'well stop the car cause I'm going to jump out and take off again'.[45]

48. Mr La encouraged the 13-year-old Child to 'stay in the car'[46] saying that they had 'had McDonalds' and he was 'still taking [the boys] out'.[47] Mr La said that the 13-year-old Child had 'admitted that after taking off' they 'shouldn't even be allowed to go out'.[48] Mr La had said to the 13-year-old Child that they would go check out the water condition at the Falls and if they were not good they would instead go to a public pool.[49]

Arrival at Cedar Creek Falls

49. Around 16:00 to 16:30 hours, Mr La and the boys arrived at the Falls. Mr La parked the car in the car park. The group then walked down a trail to the Falls.[50] Mr La first observed the conditions at the Falls when he reached a lookout point along the trail.[51] Mr La observed that: (a) the water was flowing roughly; (b) the water was quite high; and (c) no one else was swimming. Mr La formed the view that the water was unsafe for swimming.[52]

---

[42] Exhibit B1 – DCYJMA Report at 4.2 p 71.
[43] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [25].
[44] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [25].
[45] Exhibit D4 – Statement of Mr La dated 8 April 2021at [25].
[46] Exhibit D4 – Statement of Mr La dated 8 April 2021at [25].
[47] Exhibit D4 – Statement of Mr La dated 8 April 2021at [25].
[48] Exhibit D4 – Statement of Mr La dated 8 April 2021at [25].
[49] Exhibit B1 – DCYJMA Report at 4.2 p 71.
[50] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [27]-[29].
[51] Transcript, Day 1: T30: L1-5.
[52] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [27]-[29]; Transcript, Day 1: T30: L6-11.

Mr La's conversation with the boys

50. Mr La spoke to the boys and tried to encourage them not to go swimming in the water. Mr La told the boys that the water looked unsafe.[53] The 13-year-old Child said that he had swum in waves before. Mr La took both boys down to the water so they could see the water. Mr La pointed out that no one else was swimming at the Falls. The boys said they were still going in the water. Mr La kept telling the boys not to go in the water.[54]

51. Mr La tried to divert the boys from entering the water multiple times. Mr La told the boys about the safety risks and that it was not good conditions for swimming noting that the water was rough.

52. When they got to the rockpools, Mr La could see the '*water was quite high and even said to the boys that there was no one else even swimming in there*.'[55] Despite this, '*the boys said they were still going in*' and started calling Mr La 'a pussy' when he said he was not going in.[56] Mr La said that he '*told them not to go in the water'* but that they '*didn't listen'* to him and '*just kept walking towards the water*'.[57] Mr La tried to '*encourage them not to go in'* but he said that '*in the mood they were in they didn't listen'*.[58]

53. A photograph of the rock pool taken by the Police later in the afternoon is extracted below. Mr La confirmed in his evidence that the conditions in the photo were similar, if slightly less rough, than what he observed on the day.

Exhibit D1: Image of the swimming area at the time of the incident.

[53] Transcript, Day 1: T30: L13-20.
[54] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [27]-[31].
[55] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [29].
[56] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [30].
[57] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [30].
[58] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [30].

Swimming at the Falls

54. The 13-year-old Child and the other resident entered the water at the Falls. Mr La did not enter the water. He stayed on the edge of the rock pools observing the boys. The boys initially started swimming in the shallow area of the rock pool. The boys then walked to the top section of the rock pool where there is a rockslide which flows down into the rock pool. Mr La told the boys to not go down the rockslide and to walk back down.[59]

55. The 13-year-old Child went down the rockslide into the rock pool. The boys swam across the pool towards the deep section close to the rocks. The other resident swam across first. He got across and held onto a rock. Mr La told the 13-year-old Child not to swim across. However, the 13-year-old Child followed and swam across to the rocks.[60]

56. After swimming across into the deep section, the 13-year-old Child began to struggle to swim and keep his head above the water. Mr La heard the 13-year-old Child say to the other resident, 'hurry up and grab me'. Mr La, who was about 8-10 metres from the boys, thought that the boys were starting to struggle. Mr La observed the 13-year-old Child yank at the other boy's leg, who then then yelled out, 'La, I can't grab him'. Mr La could see the 13-year-old Child bobbing up and down.[61]

57. Mr La ran to the water and jumped in. Before hitting the water, he heard the 13-year-old Child yell, 'help'. Once he reached the boys, Mr La pushed the other boy to the rocks. Mr La then grabbed the 13-year-old Child. However, the 13-year-old Child was struggling to keep himself above the water. The 13-year-old Child was trying to grab onto the rocks, but they were wet and slippery. The water was pushing the 13-year-old Child away from the wall.[62]

58. Mr La attempted to get the 13-year-old Child to safety. He grabbed the 13-year-old Child from his shorts and threw him towards the rocks so he could try and get some air. Mr La got dragged under the water. When he resurfaced, he saw that the 13-year-old Child was still struggling, so again swam towards him. The 13-year-old Child started grabbing onto Mr La's head and pushing him under the water. Mr La again tried to push the 13-year-old Child towards the rocks.[63]

---

[59] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [32]-[34].
[60] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [35]-[36].
[61] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [37]-[40].
[62] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [41]-[43].
[63] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [44]-[45].

59. The 13-year-old Child could not get to the rocks and went under water. The water was very dirty and there was low visibility. Mr La was also pulled under the water again. When he resurfaced, the other boy pointed to where the 13-year-old Child had gone under the water. Mr La called out for help to the people around the rock pool. Another man offered to help and started getting ready to jump in the water.[64]

60. Mr La grabbed the 13-year-old Child's hand and started to pull him up from under the water. The 13-year-old Child grabbed Mr La's Leg. Mr La tried to paddle to keep himself up but could not kick because the 13-year-old Child was holding his legs. Mr La tried to reach down and pull the 13-year-old Child's arms apart from his legs. Mr La grabbed him under the arm and tried to throw him up above the water. This caused Mr La to go back under and swallow more water.[65]

61. After resurfacing, Mr La could not see the 13-year-old Child. Mr La grabbed onto a rock and tried to regain his breath. He then dived back under the water and tried to regain his breath. He then dived back under the water and tried to feel around in search of the 13-year-old Child. He felt something bang against his leg, which he thought was the 13-year-old Child's hand. Mr La dived back under but could not feel anything under the water.[66]

62. By this time, the other man had jumped into the water to help save the 13-year-old Child. The two men worked together to find the 13-year-old Child. Mr La held onto the rocks with one hand and used his other to grip the man's hand. The other man then went under the water looking for the 13-year-old Child before being pulled back up by Mr La. They continued to try this a few times, but they could not find the 13-year-old Child and it was getting too dangerous. Mr La, the other boy, and the other man were then pulled back across the rock pool to the other side by a group of people using a long branch.[67]

63. When Mr La got out of the water, a lady said that she had called the ambulance and the Police. Mr La then called his manager, Mr James Saunders, to notify him of the incident.[68]

---

[64] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [46]-[48].
[65] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [49]-[50].
[66] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [51].
[67] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [52]-[54].
[68] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [55]-[56].

Attendance of emergency services

64. At about 16:54 hours, a female bystander called the QAS and Police, notifying them of the incident.[69] At about 17:01 hours, the QAS and Police arrived at the Falls.[70] When Mr La got to the car park, the Police had already arrived. Mr La took the officers back down to the rock pool to show them where the incident occurred and answer their questions.[71] Mr Saunders arrived and Mr La's regional manager, Mr Morris Savalino, also came to the Falls to check on them.[72]

65. At 17:14 hours, QFES arrived at the scene. The emergency services began a search of the area. The Police were unable to locate the 13-year-old Child.[73] The Police then called in the dive squad to help locate him.[74]

66. At about 21:13 hours, the Police dive squad entered the rock pool and located the 13-year-old Child.[75] He was located at the bottom of the rock pool at the deepest point. The depth was estimated to be between 4 to 5 metres. He was carried to a nearby staging point. The attending QAS officers declared the 13-year-old Child life extinct.[76]

Autopsy

67. On 9 April 2021, the late Dr Alex Olumbe, forensic pathologist, conducted a preliminary examination of the 13-year-old Child's body.[77] Dr Olumbe performed a CT scan and medical examination. The CT scan revealed, relevantly, a marked collection of fluid in the paranasal sinuses, hyperinflated lungs with debris in the air spaces, and an abundant amount of fluid in the trachea and distended stomach. There were no fractures or other significant findings.

68. The cause of death was found to be drowning.

---

[69] Exhibit C2 – Incident Detail Report (QAS).
[70] Exhibit C2 – Incident Detail Report (QAS).
[71] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [56]-[58].
[72] Exhibit D4 – Statement of Mr La dated 8 April 2021 at [61]
[73] Exhibit E2 – QFES Incident Report.
[74] Exhibit A1 – Form 1 – Police report of death to Coroner.
[75] Exhibit E1 – ESCAD Incident Report.
[76] Exhibit A1 – Form 1 – Police report of death to Coroner.
[77] Exhibit A2 – Preliminary Examination Report.

69. The Forensic Toxicology Laboratory at the QHFSS analysed specimens of blood and urine. No drugs or alcohol were detected in the blood or urine.[78]

Evidence relevant to the standard of care

Mr La La (HSS)

70. On the afternoon the accident, Mr La went to the Jimboomba Police station and provided a statement to Senior Constable Grant McLeod.[79]

71. Mr La gave evidence about his role as a youth worker at HSS. He commenced employment on 20 January 2020. He was working with HSS full-time at the time the accident on 8 April 2021. His role involved looking after young people at the residential placements. This included getting young people ready for school and taking them to other daily activities.[80] In his role, he cared for the 13-year-old Child and had frequent contact with him.[81]

72. Mr La gave evidence about the weekly schedules for the young people at the residence. He stated there was a weekly plan document which set out the activities for the young person for the whole week. This would often include outdoor swimming. The weekly plan would be developed every Sunday before the week starts. The youth worker would sit down with the young person and go through the activities that they enjoy and would like to do for that week. He stated that the 13-year-old Child's favourite activity was swimming, which was a reasonably regular activity for him.[82]

Training

73. Mr La gave evidence about his qualifications and training at HSS. He stated that he had a Cert IV in Youth Work and that he received one week of training when he commenced at HSS. The training was broken down into two sections. The first section was mainly around reporting, such as reporting critical

[78] Exhibit A4 – Certificate of Analysis dated 17 May 2021.
[79] Exhibit D4 – Statement of Mr La dated 8 April 2021.
[80] Transcript, Day 1: T12: L7-40.
[81] Transcript, Day 1: T14: L21-25.
[82] Transcript, Day 1: T13: L4 – T:14: L8.

incidents. The second section was about therapeutic crisis intervention ('TCI') strategies.[83]

74. The TCI training focused on ways to stop an escalation of situations. The training was aimed at dealing with different behaviours and identifying the right tool to effectively manage the behaviour without escalating the situation. He stated that there was a step-by-step process on how to identify the risks of a young person's behaviour, and then how to respond. He stated that he was trained to not use high risk intervention, such as a physical restraint, except in circumstances where there was a risk of serious harm.[84]

75. The training did not include a water safety awareness training course. However, the training did address the identification of risks and hazards, which Mr La said would cover activities in water environments.[85]

The risk assessment procedure

76. Mr La gave evidence about the risk assessment procedure which was in place at the time of accident. When Mr La commenced employment, he was given a youth worker booklet.[86] The booklet was given to him at the training and was also available online. He stated that he was taken through the booklet during the training.[87]

77. He said he received training about how to identify and manage risks of activities. He stated the procedure was to identify the proposed activity and identify the relevant risks. The worker would then notify the case manager and seek their approval for the activity.[88]

78. He stated that activities were discussed in the team meetings which occurred every week or every fortnight. If an activity was proposed on short notice, the youth worker would get in contact with the case manager and seek the approval for the activity. He stated that he had no obligation to inform the Department about activities that might be undertaken with a child. That was the job of the case manager.[89]

---

[83] Transcript, Day 1: T14: L33 – T:15: L17.
[84] Transcript, Day 1: T15: L41 – T:16: L35.
[85] Transcript, Day 1: T17: L11-25.
[86] Exhibit G8.1 – Annexure EJI1 - Youth Worker booklet (two versions as of 2020 and 2022).
[87] Transcript, Day 1: T17: L37 – T:18: L20.
[88] Transcript, Day 1: T18: L22-37.
[89] Transcript, Day 1: T19: L6 – T:19: L6.

79. Mr La could not recall if the training or youth worker booklet provided a step-by-step guide on how to conduct the risk assessment procedure for an activity. When asked about whether the risk assessment is documented, Mr La said he could only think of the team meeting minutes, which recorded some information about the risk of activities.[90] Mr La was aware that the 13-year-old Child had been to the Falls with other youth workers and that it was an activity which often featured in the weekly planner. Mr La did not know whether a risk assessment had been done in relation to the activity.[91]

Risk assessment for swimming at the Falls

80. Mr La gave evidence about assessing high risk activities. He stated that he considers matters like the weather, the environment, the location, and the young person's state of mind. He also considers the level of harm and potential injury. Mr La stated that he did not consider taking the 13-year-old Child for a swim at the Falls was a high-risk activity. He said that this was because the 13-year-old Child had been to the Falls previously and it was a familiar environment. He said that he was confident in the 13-year-old Child's ability to swim.

The day of the accident

81. Mr La's version of events on the day of the accident is set out in his statement to the Police. Mr La also gave evidence about certain aspects of the day of the accident in his oral evidence.

82. At the inquest, Mr La stated that the 13-year-old Child was in an emotional state. Mr La did not consider that the 13-year-old Child's emotional state was a particular risk before heading to the Falls. Mr La stated that the 13-year-old Child's headspace was the same as his baseline on a good day. Mr La's view was that the trip to the Falls had the ability to encourage positive behaviours. The trip was also consistent with the instructions from Mr La's manager not to punish the boys for running away. Mr La also noted that he believed the boys ran off because they were at the house for so long.[92]

[90] Transcript, Day 1: T19: L15-41.
[91] Transcript, Day 1: T24: L1-37.
[92] Transcript, Day 1: T28: L20-46.

83. Mr La gave evidence about the conditions at the Falls on the day of the incident. Mr La said it was a sunny and calm day before heading to the Falls. He said he had no reason to think that the weather would be any different at the Falls.[93] Mr La gave evidence that he realised the conditions at the Falls were more dangerous than normal when he reached the lookout point on the trail down to the Falls. He could see the turbulent conditions at the lookout. This is when Mr La formed the view that swimming in the Falls was unsafe.[94] In cross-examination, Mr La accepted that it occurred to him at that point in time that the activity that the boys were going to engage in was high-risk.[95]

84. Mr La gave evidence that he tried to stop the boys from swimming. He stated that he told them not to swim multiple times. He stated that this direction was constant from the trail all the way down to the rock pool. He said that the boys ignored all the directions.[96]

Utilisation of a physical restraint on the boys

85. Mr La gave evidence about the possible use of a physical restraint on the boys at the Falls. Mr La stated that he did not consider the use of a physical restraint on the boys at the Falls. He said that he did not think a physical restraint would work. He stated that he thought a high-risk intervention would have just made the situation worse.[97]

86. In cross-examination, Mr La was further questioned about the possible use of a physical restraint on the boys at the Falls. Mr La confirmed that he was trained in using force when reasonably necessary.[98] Mr La accepted that the boys were not following his directions, that he knew they were going to enter the water, and that the risk in swimming was high. However, Mr La stated that he did not consider using a physical restraint.[99] Mr La stated that he had never used a physical restraint on a young person before.[100]

---

[93] Transcript, Day 1: T29: L16-31.
[94] Transcript, Day 1: T29: L41 – T:30:11.
[95] Transcript, Day 1: T33: L45-46.
[96] Transcript, Day 1: T30: L10-23.
[97] Transcript, Day 1: T30: L25-32.
[98] Transcript, Day 1: T33: L6-19.
[99] Transcript, Day 1: T33: L40 – T:34: L38.
[100] Transcript, Day 1: T34: L40-45.

Evidence of Mr Eiko Iva (HSS)

87. Mr Iva, a Director and the Quality and Systems General Manager at HSS, stated the following in relation to the use of physical restraints and Mr La's application of the risk assessment process:

    a. HSS youth workers can physically restrain a young person, using what is called a reactive response (see page 29 of the *Youth Worker Booklet*). This is only if the young person is at immediate risk of danger where their safety and/or the safety of others is at immediate risk.
    b. For example, if a young person makes a move to suddenly jump out onto a main road in front of oncoming traffic, that may be deemed an appropriate response.
    c. La applied HSS's relevant risk assessment processes appropriately in the circumstances.

Evidence of Mr Daniel Romero (Child Safety Officer)

88. Mr Romero, a CSO at the Department, gave evidence at the inquest. He was the CSO for the 13-year-old Child at the time of the accident.[101] Mr Romero gave evidence that HSS made no notification to the Department in relation to taking children, including the 13-year-old Child, to the Falls for a swim. He said he was not aware that HSS was taking children out to the Falls for swims.[102] He was not involved in the decision to take the 13-year-old Child to the Falls that day.

Evidence relevant to Departmental policies and procedures regarding participation in recreational activities

89. Three witnesses for the Department were called to give evidence at the inquest: Mr Daniel Romero, Ms Hayley Kruger, and Dr Meegan Crawford. Each witness provided a statement. The witness statements contain information about the Department's relevant policies and procedures and the investigations undertaken following the accident.

[101] Transcript, Day 1: T61: L7-24.
[102] Transcript, Day 1: T69: L32-39.

Mr Daniel Romero (CSO)

Mr Romero's role

90. Mr Romero has been employed at the Department since 2017. He has primarily worked as a CSO. His duties involved supporting young people, particularly children transitioning into care. Mr Romero was the CSO for the 13-year-old Child at the time of the accident.[103]

91. Mr Romero's work with the 13-year-old Child involved the use of crisis driven intervention. A lot of the case work involved locating the 13-year-old Child, checking on him, trying to maintain stability, and trying to link him with the supports that were available.[104]

92. Mr Romero gave evidence about the Department's reliance on service providers. He stated that he had involvement with the staff at HSS.[105] When a young person is in an approved placement, Mr Romero stated that a CSO would have ongoing communications with the young person and also the placement provider.[106] If a child was under a guardianship order, decisions around high-risk activities would be made by the parents.[107]

93. In relation to risk assessments, the general process was that the service provider would provide the Department with a high-risk evaluation form. The form would contain the details for the young person and outline the proposed activity. It would then be Mr Romero's role, as a CSO, to discuss the matter with his team leader or with the young person's parents.[108]

94. Mr Romero stated that, as a CSO, he was very reliant on the accuracy and the quality of the decision being made by the service provider, including the assessment of the nature and degree of risk for an activity.[109] He gave evidence that the Department delegates the care of the day to day activities of the young people to the service provider,[110] and that it is not possible for a CSO to micromanage every activity proposed by a residential service provider.[111]

---

[103] Transcript, Day 1: T61: L7-24.
[104] Transcript, Day 1: T61: L26-31.
[105] Transcript, Day 1: T61: L33-38.
[106] Transcript, Day 1: T62: L5-9.
[107] Transcript, Day 1: T62: L5-11.
[108] Transcript, Day 1: T62: L5-23.
[109] Transcript, Day 1: T63: L35-38.
[110] Transcript, Day 1: T76: L4-8.
[111] Transcript, Day 1: T72: L41-42.

95. Mr Romero confirmed that HSS had made no notification to the Department in relation to taking children, including the 13-year-old Child, to the Falls for a swim. He said he was not personally aware that HSS were taking children out to the Falls for a swim.[112]

High risk evaluation form

96. Mr Romero gave evidence about the high-risk evaluation form.[113] In his experience, Mr Romero stated that the service provider would complete the form and submit it to the CSO for approval.[114] This meant that the CSO would not have visibility of the activities that are not considered high to very high risk by the service provider.[115]

The risk assessment process

97. When Mr Romero received a risk assessment form, he would not generally conduct his own risk assessment for the proposed activity.[116] Mr Romero would send the form to a team leader for approval. He was not sure if the senior team leader did their own risk assessment.[117] Mr Romero was asked about how CSO's would document the risk assessment and stated this could be done in various ways including case notes.[118]

98. Mr Romero gave evidence that there was a lack of uniformity as to how the risk assessment procedure was undertaken by service providers. He said that the practice for risk assessments varies between the different service providers. He agreed that it would be quite useful to have a standard approach for the risk assessment forms.[119]

Training

99. Mr Romero gave evidence about the training of CSO's. Mr Romero was asked about what guidance CSO's received to understand the notion of a high-risk activity. Mr Romero was not able to point to any particular guidance. He said

[112] Transcript, Day 1: T69: L32-39.
[113] Exhibit B2.6 – Annexure F – Request for a child or young person to participate in a high-risk activity.
[114] Transcript, Day 1: T63: L18-22.
[115] Transcript, Day 1: T63: L29-33.
[116] Transcript, Day 1: T63: L40-43.
[117] Transcript, Day 1: T64: L1-8.
[118] Transcript, Day 1: T67: L1-8.
[119] Transcript, Day 1: T64: L14-44.

that in his experience the assessment comes down to the activity and a child's ability to actually partake in such activity in that particular situation.[120]

100. Mr Romero stated that he was aware that swimming is not classified as a high-risk activity. He said that assessment was based around experience. He said that he has never received a high-risk activity form based on a swimming activity.[121] Mr Romero said he had not noticed any difference of approach taken in relation to a consideration of whether swimming is a high-risk activity depending on whether the different form of swimming, such as indoor pools, pools at placements, outdoor pools, beaches, creeks or dams.[122]

Ms Hayley Kruger (senior team leader)

101. Ms Kruger has been employed at the Department since December 2010. She has held various roles including CSO and senior team leader. She was a senior leader at the time of the accident.[123]

Risk assessment for swimming

102. In her statement, Ms Kruger stated that the decision to take the 13-year-old Child and his co-resident to swim at the Falls was not one that would usually warrant a referral back to the Child Safety Centre for determination, because swimming is not classified as a high-risk activity.[124]

103. Ms Kruger said it is a common view in child safety work that swimming is classed as a normal, day-to-day activity.[125] Ms Kruger stated she thought part of the reason for that belief is the fact so many people in Queensland grow up near the water and it is normal for young people to learn to swim from a young age.[126]

104. Ms Kruger agreed that in her experience people often talk about swimming without detailing the specific type of swimming.[127] She also agreed that people

[120] Transcript, Day 1: T66: L34-43.
[121] Transcript, Day 1: T68: L1-8.
[122] Transcript, Day 1: T68: L34-39.
[123] Transcript, Day 1: T81: L7-17.
[124] Exhibit B6 – Statement of Ms Hayley Kruger dated 11 August 2023, paragraph [8].
[125] Transcript, Day 1: T81: L41-47.
[126] Transcript, Day 1: T82: L1-3.
[127] Transcript, Day 1: T82: L13-22.

might consider the risks of each type of swimming differently depending on their own life experience.[128]

105. Ms Kruger gave evidence about the Department's reliance on service providers and agreed that the Department delegates its responsibly for the decisions and management of day-to-day activities to service providers. The Department allows those parties to make the decisions about activities with the exception of high-risk activities, where there is an expectation that the decision-making process will be reviewed by the Department.[129]

Risk assessment procedure

106. Ms Kruger was aware of the high-risk assessment form. She stated the form would be sent to the CSO. The CSO would then submit the form to her, as senior team leader, for review and approval.[130] When Ms Kruger receives a form, she stated that she conducts her own inquiries in relation to the proposed activity. This includes speaking with the CSO and/or the service provider about the proposed activity. She may also speak to the child directly about the proposed activity.[131]

107. Ms Kruger stated that she does not believe there is a policy or training direction as to what the process should be at the senior team level.[132] Ms Kruger agreed that service providers are not all using the same risk assessment process and forms,[133] and that there is no standardised approach.[134] In this respect, Mr Iva from HSS also agreed that he could see some benefits in the Department and private service providers all applying the same set of procedure and policies in terms of the specific risk assessment process.[135]

108. In her statement, Ms Kruger stated that it would be usual that, for activities deemed high risk, the form would be self-filled out and sent to the CSSC for review and decision.[136] Ms Kruger accepted that this process meant that she did not see the service provider's decisions for all activities which are not deemed high risk and therefore do not have to go through the process.[137] Ms

[128] Transcript, Day 1: T82: L28-29.
[129] Transcript, Day 1: T82: L31-41.
[130] Transcript, Day 1: T83: L1-4.
[131] Transcript, Day 1: T83: L6-14.
[132] Transcript, Day 1: T83: L16-27.
[133] Transcript, Day 1: T83: L29-35.
[134] Transcript, Day 1: T83: L37-40.
[135] Transcript, Day 2: T11: L45 – T12:L2.
[136] Exhibit B6 – Statement of Ms Hayley Kruger dated 11 August 2023, paragraph [9].
[137] Transcript, Day 1: T84: L16-31.

Kruger agreed that there is a fair risk in the current system that some activities, which could be high risk, are not being reviewed by the Department.

The child information form

109. Ms Kruger also gave evidence about the child information form.[138] The child information form contains important information about the child. This includes the child's ability to swim. That question is near the top of the form under essential information. Ms Kruger accepted that this reflects the fact the Department considers that the capacity of a child to swim is of critical importance.[139] In the case of the 13-year-old Child's form, that information had not been included correctly.

Dr Meegan Crawford (Regional Executive Director)

110. Dr Crawford's role was Regional Executive Director for Brisbane Moreton Bay region at the Department. Dr Crawford's substantive position is the Chief Practitioner for Queensland. In that role, Dr Crawford is responsible for teams including child deaths and serious injury reviews, operational policy and procedure, and also training for CSO's.[140]

Water safety approvals

111. In February 2023, Dr Crawford sent an internal email to teams in the Department about water safety approvals.[141] Dr Crawford stated that the email was a reminder for people in the Department about the need for water safety approvals for high-risk activities, and some of the risk factors that arise in relation to that.[142]

112. Dr Crawford gave evidence about a recent training package for water safety awareness.[143] The training package is part of the Department's system. The training, which is delivered online, started in 2022. It is mandatory for CSO's. However, other staff are also encouraged to do the training.[144]

---

[138] Exhibit B6.2 – Annexure HK2 - Child Information Form.
[139] Transcript, Day 1: T86: L31-42.
[140] Transcript, Day 1: T91:L14-24.
[141] Exhibit B3.7 –Annexure MC7 - Email to all Regional Directors re reminder about water safety awareness and high/very high-risk activities.
[142] Transcript, Day 1: T92: L1-6.
[143] Exhibit B3.3 – Annexure MC3 - Water Safety Awareness Training presentation.
[144] Transcript, Day 1: T92: L25-45.

113. Dr Crawford stated the training is not mandatory for support workers and service providers.[145] Given the considerable overlap in the duties and obligations between support workers in residential placements and CSO's, Dr Crawford accepted that it is reasonable that the training should be mandatory for those workers as well.[146] She also accepted that the training helped improve the decision-making around whether a risk is in fact low, medium, or high, and how nuanced that risk might be in various environments.[147]

114. In relation to training, Mr Iva of HSS also stated that his organisation does not provide water awareness training or a similar program for its support workers. Mr Iva stated that he thought there is some benefit in considering whether support workers should undertake water awareness training.[148]

115. The evidence of Dr Crawford included the data that informed the need for training and the risk assessment procedures for swimming. The training package refers to the fact that young people aged 10 to 17 years are more likely to fatally drown in rural and remote location sites like rivers, creeks and weirs where water is moving or has a strong current.

116. Dr Crawford agreed that the level of risk depends on the circumstances, including environmental hazards, supervision, and the competency level of the swimmer.[149] She accepted that the risk assessment needs to focus on the particular risks in a situation, rather than a more generalised assessment of swimming as a low-risk activity.[150]

117. It was her evidence that the Department looked very carefully at the risk assessment for swimming when reviewing the 13-year-old Child's death. Dr Crawford stated that the Department still took the position that a competent child going swimming under adult supervision was a medium-risk activity, and not a high-risk activity.[151]

118. This was based in part on the need for young people in care to have as normative an experience of childhood as possible. She stated that young people in care often say that their life experience is already regulated to a very

[145] Transcript, Day 1: T93: L1-16.
[146] Transcript, Day 1: T93: L29-33.
[147] Transcript, Day 1: T93: L35-45.
[148] Transcript, Day 2: T12: L15-37.
[149] Transcript, Day 1: T94:L44 – T:95: L4.
[150] Transcript, Day 1: T95: L12-15.
[151] Transcript, Day 1: T95: L34-39.

high level.[152] Dr Crawford stated that the Department has tried to strike the right balance in the risk assessment procedure for swimming.[153]

Placement history and level of supervision exercised by the Department.

The placement history

119. The 13-year-old Child was the third child of his mother and the first child of his father.[154] Much of his history and involvement with the Department is set out in a Systems and Practice Review Report undertaken by the Department after the 13-year-old Child's death ("the DCYJMA Report").

120. The mother had two children to a previous partner (referred to as Step-Father1 in the DCYJMA Report) prior to falling pregnant to the 13-year-old Child's father. After the 13-year-old Child's birth, the mother '*reunited with Step-Father1 and had four more children. After separating from Step-Father1 a second time [the mother] later had another child to Step-Father2*.'[155] A genogram of the composition of the 13-year-old Child's family was produced as part of the DCYJMA Report.

121. In 2016, the 13-year-old Child and his half-siblings entered departmental care due to concerns in relation to '*chronic neglect in [the mother's] household and exposure to Step-Father1's violence towards [the mother] among other concerns*'.[156]

122. The Department applied for custody for a child protection order to grant custody to the Chief Executive for two years for the 13-year-old Child and his half siblings, but during the proceeding, the Childrens Court determined the 13-year-old Child should be placed with his father.[157] It was observed by the Court that '*residential care was not an appropriate placement for* [the 13-year-old Child]'.[158] Family Court Orders were subsequently made in his father's favour with the 13-year-old Child to have contact with his mother once a fortnight.[159]

---

[152] Transcript, Day 1: T96: L1-6.
[153] Transcript, Day 1: T96: L18-28.
[154] Exhibit B1 – DCYJMA Report at 3.3; ODCPL Child Death Case Review Report at Table 1.
[155] Exhibit B1 – DCYJMA Report at 3.3.
[156] Exhibit B1 – DCYJMA Report at 3.3.
[157] Exhibit B1 – DCYJMA Report at 3.3.
[158] Exhibit B1 – DCYJMA Report at 3.3.
[159] Exhibit B1 – DCYJMA Report at 3.3.

123. At the start of 2020,[160] the 13-year-old Child was living with his father and '*appeared to have contact with [his mother] for one day on a weekend once a fortnight*.'[161] There is evidence to suggest that the 13-year-old Child did not want to live with his father at this time.[162] Despite efforts, '[the 13-year-old Child] *adamantly refused*' contact with his father, but did want contact with his mother '*as it hurts him when he can't see her*'.[163] An assessment of the 13-year-old Child completed on 1 June 2020 identified that he '*displayed behaviours indicative of emotional harm*' including '*negative attention seeking*', '*difficulty reading social cues and moderating his behaviour*', '*suicidal ideation and self-harm*', '*difficulties with impulse control, reactivity, emotional responses, and reckless behaviours*'.[164]

124. A chronology of departmental involvement was produced as part of the DCYJMA Report, and the history behind it makes plain the high level of instability in the 13-year-old Child's living arrangements, including after his removal into the care of the Department.[165]

The level of supervision

125. Mr Romero, the CSO, gave evidence about the level of supervision by the Department leading up to the accident on 8 April 2021. He stated he was very much reliant on HSS. They were responsible for the management of day-to-day activities. This meant that Mr Romero did not have oversight of most of the activities. The service providers were only required to seek the approval of the Department for high-risk activities.

126. Mr Romero gave evidence that HSS did not notify the Department about taking the 13-year-old Child to the Falls for a swim on the day of the accident or at any other time. He said he was not personally aware that HSS were taking children out to the Falls for a swim.[166] This is because the activity was not deemed a high-risk activity.

---

[160] Exhibit B1 – DCYJMA Report at 3.3. This was the commencement of the review period under the terms of reference of the Review.
[161] Exhibit B1 – DCYJMA Report at 3.3.
[162] Exhibit B1 – DCYJMA Report at 4.2 p17; DCYJMA Report at 4.2 p30.
[163] Exhibit B1 – DCYJMA Report at 4.2 p30.
[164] Exhibit B1 – DCYJMA Report at 4.2 p30.
[165] Exhibit B1 – DCYJMA Report at 4.2.
[166] Transcript, Day 1: T69: L32-39.

Actions taken since the death.

127. The two witnesses from HSS gave evidence about changes to their risk assessment procedure following the accident.

Mr La La (Youth Worker)

128. Mr La stated that there was an amendment to the risk assessment procedure following the incident. This was set out in a new version of the youth worker booklet dated 1 August 2022.[167] He stated that workers also completed another TCI training session for the amended risk assessment procedure.[168]

129. The amended risk assessment procedure is set out in a new section of the booklet dealing with 'managing risk of harm to YP.' There is a subsection dealing with 'Risk management plans for high-risk activities and special events'. The section sets out six steps to consider in the development of an effective risk management plan. Mr La confirms that this process was not in place when he undertook his initial training or at the time of the accident.[169]

130. The new procedure involves the completion of a form for high-risk activities.[170] This form was introduced after April 2021. Mr La received training on the new form for high-risk activities.[171] Mr La stated that there was no change to his communication with the CSO or the Department about high-risk activities following the accident.[172] Mr La did not know whether the form is sent to the Department or a CSO.[173]

Mr Eiko Iva (Quality and Systems Manager)

131. Mr Iva is the quality and systems manager for HSS. He has been employed at HSS since 2014. His duties involve ensuring the business complies with the relevant regulations and standards.[174]

---

[167] Exhibit G8.1 – Annexure EJI1 - Youth Worker booklet (two versions as of 2020 and 2022).
[168] Transcript, Day 1: T21: L3-36.
[169] Transcript, Day 1: T21: L38 – T22:L23.
[170] Exhibit G8.1 – Annexure EJI1 - Youth Worker booklet (two versions as of 2020 and 2022), p. 25.
[171] Transcript, Day 1: T22: L25-47.
[172] Transcript, Day 1: T23: L15-27.
[173] Transcript, Day 1: T23: L44-46.
[174] Transcript, Day 2: T3: L6-35.

Policies and procedures

132. In his statement, Mr Iva detailed the policies and procedures at HSS. He stated that HSS has a Risk Management Policy that incorporates the principles of the International Standard, which provides principles and generic guidelines on risk management. The relevant policies under which risk assessment and management are addressed include:

    a. HOPE Risk Management Framework;
    b. HSS High Risk Activities & Special Events Risk Management Plan;
    c. HSS Policy and Procedures Manual; and
    d. Board Member and Directors Policy Manual.[175]

The risk assessment procedure

133. Mr Iva gave evidence about the risk assessment procedure in place at the time of the incident.[176] Mr Iva accepted that the procedure at section 21 of the booklet which applied in April 2021 deals with managing risk of harm to the young person and contains a brief explanatory statement describing the policy areas.[177]

134. In relation to the booklet, Mr Iva accepted that the degree of detail is a high level coverage of the relevant policy areas in relation to managing risk of harm to young people and does not descend to a step-by-step analysis or standard operating procedures.[178] Mr Iva said that the policy was covered in the training and induction for new employees.[179] Mr Iva accepted that none of the policy areas cover a documented process of risk assessment for risky activities for children.[180]

135. Mr Iva gave evidence about team meetings at HSS. He stated that any activity that the young person is to engage in will go through the team meeting process. He said that the activity is approved as a team via the team meeting process. He said that every activity that goes on the weekly planner is discussed in the team meeting.[181]

[175] Exhibit G8 at [14]-[32].
[176] Exhibit G1 – Youth Worker Booklet – Section 21 Managing Risk of Harm to YP.
[177] Transcript, Day 2: T5: L6-11.
[178] Transcript, Day 2: T5: L13-19.
[179] Transcript, Day 2: T5: L16-26.
[180] Transcript, Day 2: T5: L28-44.
[181] Transcript, Day 2: T6: L1-35.

136. Mr Iva accepted that, in the absence of an identified policy, there is a risk that an activity could fall outside the rigours of the team meeting procedure.[182] However, Mr Iva noted that the attendance at the Falls was on the weekly planner for the 13-year-old Child for the relevant week.[183]

137. Mr Iva also gave evidence about training and the HSS Risk Management Framework.[184] He said there was training about risk analysis during the induction process. The training corresponded with the framework. He said the framework is a general framework for managing risk through all parts of the organisation.[185]

Amendment to the risk assessment procedure

138. In his statement, Mr Iva stated the following regarding the amendments to the risk assessment procedure:

    a. As a response to the incident, HSS has made every effort to continue to strengthen its policies, beyond what licensing required. For example, it strengthened the policy around risk management;
    b. It added a new policy to address risk management, which is contained in section 21 of the *Youth Worker Booklet* (version current as of 2022);
    c. The new policy is that every activity requires a risk analysis to be done each time and for every activity (even it is not deemed a high-risk activity). For example, if risk management had been completed for an activity, it remained valid unless there was a change in circumstances. It now requires all staff to conduct a risk assessment prior to every activity they participate in (even if they have participated in that activity before); and
    d. HSS no longer offer swimming at the Falls as a swimming activity.

139. Mr Iva gave evidence about the amendment to the risk assessment procedure. He was taken to section 21 of the current version of the booklet dated 2022 which deals with managing risk. Mr Iva accepted that section 21.1 contains new material that has been added to the booklet. The new material sets out a specific procedure for risk management of high-risk activities. The procedure involves six steps to go through when assessing the risk.[186]

---

[182] Transcript, Day 2: T7: L1-5.
[183] Transcript, Day 2: T7: L5-13.
[184] Exhibit G8.2 – Annexure EJI2 - Bundle of documents (policies).
[185] Transcript, Day 2: T10: L6-27.
[186] Transcript, Day 2: T7: L30-42.

140. Mr Iva stated that the material was added to the booklet to reinforce and streamline the policy which was in place previously. He stated that a lot of the matters in the new section were discussed in team meetings.[187]

141. Mr Iva stated in relation to the risk management plan for high-risk activity example to the table,[188] that every activity was put through the process. This means every activity that is on the weekly planner for young people is being risk-assessed.[189]

142. Mr Iva was asked whether the six-step process and the risk management plan existed in 2021. He stated that the plan and risk management decisions were documented in minutes of team meetings.[190] It would follow from that evidence that there should be records or minutes detailing the risks assessment for the decision to take the 13-year-old Child to the Falls for a swim.

143. Mr Iva stated that he has not reviewed the records and was not sure whether the risk assessment was in fact done.[191] Mr La had stated in his evidence that he did not know if there was a step by step risk assessment process they were trained in.[192] He also gave evidence that the only template or documented risk assessment process in 2021 was '*probably the only one I know would be our meeting minutes… the risk of the activity any information that's discussed in the team meeting is recorded on our meeting minutes*'.[193]

144. There is no documented evidence of the six-step risk assessment process that was formalised in 2022 being applied to the activity of the 13-year-old Child's swimming at the Falls in April 2021 or prior.

The issues with the previous risk assessment procedure

145. Mr Iva was asked about the difference between the risk assessment procedure between 2020 and 2022. It was put to Mr Iva that the support workers have now been provided with more detailed guidance (including the template, guide, and risk analysis matrix) to help deal with high pressure situations. Mr Iva accepted this to a degree.[194]

---

[187] Transcript, Day 2: T7: L44 – T8: L4.
[188] Exhibit G8.3 – Annexure EJI3 - Risk management plan for high-risk activity example.
[189] Transcript, Day 2: T8: L26 – T9:L11.
[190] Transcript, Day 2: T9: L22-31.
[191] Transcript, Day 2: T9: L33-44.
[192] Transcript, Day 1: T20: L37.
[193] Transcript, Day 1: T20: L31.
[194] Transcript, Day 2: T10: L32-41.

146. Mr Iva accepted that the template and the plan provides the support worker with important guidance in difficult and complex situations. He accepted that the new process takes some of the guesswork and the speculation out of the risk analysis for activities.[195]

147. It was put to Mr Iva that the steps taken since the incident appear to be filling a gap that existed in the documented training and guidance materials for support workers in 2021. Mr Iva did not accept the amendments to the risk procedure were filling a gap. He stated that the amendments were reinforcing policies that already existed.[196] However, Mr Iva accepted that support workers were previously missing the direct guidance about how to implement the risk assessment procedure.[197]

Preventative Recommendations

148. Three witnesses were called from the QPWSP as part of the DES: Mr John Carter, Mr Mark Patenaude, and Mr Benjamin Klaassen.

Mr John Carter (Principal Ranger)

149. Mr Carter is currently retired. Before retiring, he was a principal ranger for the Gold Coast area at the QPWSP. In his role, he had responsibility for the staff and budget of the National Parks in the Gold Coast area. His role involved the management of rangers. He was responsible for the Tamborine National Park, which included the Falls.[198]

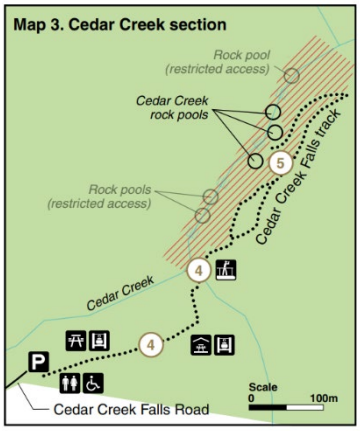
The layout of the Falls

150. Mr Carter gave evidence about the layout and geography of the Falls. He was taken to the information booklet for Tamborine National Park, which included

[195] Transcript, Day 2: T10: L43 – T11:3.
[196] Transcript, Day 2: T11: L5-12.
[197] Transcript, Day 2: T11: L14-17.
[198] Transcript, Day 2: T38: L7-34.

warnings about particular features of the national park directed to visitors who might be coming.[199]

151. Mr Carter was asked about map 3 of the Cedar Creek section contained in the booklet (extracted below).[200] Mr Carter confirmed that the top two and the bottom rock pools depicted in the map in the information booklet are classified as 'restricted access.' Mr Carter confirmed that the three middle rock pools are the Cedar Creek pock pools which are fully accessible by visitors during the day. Mr Carter stated that the relevant rock pool where the accident took place was next to number 5 on the map.[201]



Safety information

152. With respect to any limitations, warning or rules preventing any particular access in or around those rock pools, Mr Carter stated there are warning signs and pictograms about not climbing the rocks.[202] Mr Carter also stated that access to the Cedar Creek section was prohibited at night and that an entry gate that could be closed and locked each evening.[203]

153. Mr Carter gave evidence about the following signage at the Falls from the carpark to the rock pools.

Exhibit F2.2: Metal - Danger (Restricted access area - entry prohibited)

[199] Exhibit F1.7 – Tamborine National Park discovery guide.
[200] Exhibit F1.7 – Tamborine National Park discovery guide, p 8.
[201] Transcript, Day 2: T42: L1-17.
[202] Transcript, Day 2: T40: L8-27.
[203] Transcript, Day 2: T40: L40-46.

Exhibit F2.3: Metal - Danger (Unauthorised entry prohibited).

Exhibit F2.4: Metal - Warning (Slippery rocks, submerged objects…)

Exhibit F2.5: Metal - Danger (Unauthorised entry prohibited)

Exhibit F2.6: Routed - Warning (Persons climbing and jumping into rock pools…)

Exhibit F2.7: Danger (Unauthorised entry prohibited)

Exhibit F2.8: Metal - Picto and Metal - Danger (Access prohibited beyond this point)

154. Mr Carter stated that the below is located above the first rock pool at the falls.[204]

Risk management approach

155. Mr Carter stated that the Falls is a popular place to visit and was very busy.[205] Mr Carter estimated that 50,000 to 80,000 people visit the falls each year.[206] He stated that rangers patrol the area on a routine basis and would attend the Falls at least two or three times a week.[207]

156. Mr Carter agreed that the Falls were a known and high-traffic area for swimming. He stated that continued swimming by visitors in the restricted access area was an ongoing problem and that the QPWSP did patrolling work to try to ensure people were not trying to jump into the water or explore areas where there could be a potential fall.[208] He agreed that the risk management emphasis from QPWSP was on putting up signs which brought attention to the risks of accessing the different areas. He stated that the webpage also directed people onto the tracks and away from the areas where they did not want people to go.[209]

157. Further, there is visitor information on the website about staying safe while swimming, stating '*be aware of strong currents if swimming in rock pools, even when the surface looks calm*'.[210]

158. Mr Carter was asked about whether there any mechanism or practice to temporarily closing parts of the park that might be dangerous to visitors in April

[204] Transcript, Day 2: T43: L38-47.
[205] Transcript, Day 2: T45: L6-9.
[206] Transcript, Day 2: T45: L11-25.
[207] Transcript, Day 2: T45: L38-45.
[208] Transcript, Day 2: T46: L1-10.
[209] Transcript, Day 2: T47: L28-38.
[210] Exhibit F1.3 – DES Website - 'Visiting Safely' Tamborine National Park.

2021. He stated that there were mechanisms to close sites. He recalled that QPWSP could close the three sites in the Gold Coast under the emergency response policy.[211]

159. He also confirmed that a park alert was in place on 5 October 2022, which published relevant information on the website warning visitors intending to go to the area.[212] He confirmed that the same park alert mechanism was in place in and around April 2021 and that the option to issue the park alert existed at the time of the accident. He agreed it was possible for QPWSP to issue a park alert about the heavy water flow at the Falls on 7 April 2021.[213]

160. Mr Carter confirmed in his evidence that neither in the lead up to or on 8 April 2021, or at any time in the days following, was a park alert issued about swimming conditions at the Falls. Nor was the area of the Falls closed at any time after first responders had left following the recovery of the 13-year-old Child's body.

Risk management and hierarchy of controls

161. Based on Mr Carter's evidence, the hierarchy of controls for risk mitigation that applied to the site consisted of:

    a. High-level warning signage and public information;
    b. A system of published alerts through the website;
    c. A barrier to the entrance of the carpark that was able to be closed; and
    d. Temporary closure of the site.

162. In and around 8 April 2021, Mr Carter agreed that the only control in place was the first one listed above. The remaining controls were available but were not used.[214]

163. In addition, Mr Carter gave evidence that there had been no changes made at all in relation to risk assessment or mitigation at the site at any time following the incident on 8 April 2021,[215] nor did QPWSP undertake any form of substantive review into the incident. [216]

[211] Transcript, Day 2: T47: L40-45.
[212] Exhibit F1.1 – DES Website - Tamborine National Park.
[213] Transcript, Day 2: T48: L23-46.
[214] Transcript, Day 2: T53: L26-40.
[215] Transcript, Day 2: T54: L44-46.
[216] Transcript, Day 2: T54: L22-42.

Mr Mark Patenaude (Senior Ranger)

164. Mr Patenaude is the Senior Ranger for the Gold Coast Lowlands area for the QPWSP. He has been in the role since January 2022. Prior to that, he worked in the management unit for Tamborine National Park. He reports to a Principal Ranger.[217]

165. Mr Patenaude gave evidence about the operational policy for visitor management.[218] He was taken to paragraph 9 of the policy and agreed with the proposition that there was a an organisational view that the QPWSP is there to manage the parks, and if there are naturally occurring risks, then people should be warned of them, but otherwise they have to exercise their own judgment if they are going to avoid injury or harm.[219]

166. Mr Patenaude also accepted that in relation to some risks the QPWSP has an obligation to go further and take steps to reduce or mitigate a potential harm to visitors.

167. Mr Patenaude gave evidence about how rangers would assess the conditions in areas of the park. There was no specific system or mechanism for rangers to report hazardous conditions that they see on patrols to supervisors, or particular thresholds of risk that would trigger rangers to take certain actions or report local conditions to their supervisors.[220]

168. Mr Patenaude expected that if a ranger had visited that day and seen the conditions, they would have reported the conditions through either a toolbox talk the next morning or during operations that day. They should have spoken to a supervisor and could have recommended a closure of the site based on the description of the water flow.[221]

169. There were rangers at the Falls earlier in the day on 8 April 2021, undertaking water sampling and also attending after another person suffered an injury at the site requiring a medical evacuation.[222] There is no evidence that any report was made to a supervisor or other relevant person at that time about conditions

[217] Transcript, Day 2: T80: L7-33.
[218] Exhibit F1.13 – Visitor Safety Policy.
[219] Transcript, Day 2: T83: L26-36.
[220] Transcript, Day 2: T85: L1-3.
[221] Transcript, Day 2: T85: L1-19.
[222] Ibid, at [20].

at the Falls[223], nor is there any evidence that particular action was taken to mitigate the relevant risks.

170. Mr Patenaude agreed that there is lack of clarity about the relevant trigger event or process for closing a site. He said the assessment of conditions is '*very subjective*'. He said that there is turnover of staff and that rangers new to the environment may think that a small water flow is extreme, whereas experienced rangers might have some complacency and may not issue any alert for the same conditions. He stated, *'So without an actual tool or implementation or measurement of some sort, then it is difficult for everyone to agree as to when the button should be pushed, so to speak.'*[224] Mr Patenaude agreed that there is a gap in the work method to the individual ranger to assess and report risks at the site.[225]

171. When Mr Klaassen later gave evidence, he agreed there was no documented procedure for making a risk assessment of the situation. He somewhat agreed with the conclusion that the lack of a procedure contributed to the decision not to report the water conditions to supervisors.[226]

172. Paragraph 24 of the Visitor Safety Policy states.[227]

> '*Relevant risk warnings are conveyed via the QPWS&P Park Alert Page, park web pages, conditions reports where relevant to a particular area, Department of Environment and Queensland National Parks social media channels, SMS and email notifications (National Parks Booking Service) and via media and onsite signage*.'

173. Mr Patenaude accepted that none of the warnings mentioned in paragraph 24 of the policy were made on 8 April 2021 in relation to the conditions on the day at the Falls. He also agreed that unless there is clarity about when the safety mechanisms are to be engaged, they are functionally useless.[228]

---

[223] This is contested in submissions on behalf of QPWSP.
[224] Transcript, Day 2: T85: L25-37.
[225] Transcript, Day 2: T86: L1-10.
[226] Transcript, Day 3: T8.
[227] Exhibit F1.13 – Visitor Safety Policy.
[228] Transcript, Day 2: T86: L19-32.

Mr Benjamin Klaassen (Deputy Director-General)

174. Mr Klaassen is the Deputy Director-General of QPWSP, which is part of the DES. He has been in this role for nine and a half years. In the role, he is responsible for the leadership and management of national parks and conservation parks.[229]

175. Mr Klaassen stated that QPWSP officers and others have undertaken risk assessments/safety plans at the Falls in 2004, 2016 and 2023.[230] QPWSP have introduced control measures at the site to mitigate risks in accordance with the Visitor Safety Operational Policy.[231]

176. The controls focused on the known highest risk activities of swimming in the more dangerous rock pool associated submerged rocks or shallow waters.[232] The control included the establishment of restricted access area, chain barriers to restrict access to some pools, and a network of on-site signs alerting visitors to the risks.[233]

177. Mr Klaassen stated that the QPWSP has no record of a visitor, prior to 8 April 2021, being injured or drowning as a result of the water way becoming flooded with strong currents or eddies. The risk assessments prior to 2021 did not identify that occurrence as a high likelihood given the controls were focused on other risks.[234]

178. Mr Klaassen set out the procedure if a risk is identified. He stated that rangers have the power under the relevant legislation to direct people to leave a park in dangerous circumstances.[235] He stated that the closures are communicated to park visitors through QPWSP's park alert system and supported by on-site signs and barriers where needed.[236] Rangers can exercise their powers immediately.[237] They make their decisions based on their own knowledge and understanding of park conditions, known hazards and high risk locations. The

[229] Exhibit F8 – Statement of Benjamin Klaassen dated 6 October 2022, at [1].
[230] Ibid, at [6]; Exhibits F1.11, F2.18, and F7.
[231] Ibid, at [6]; Exhibit F1.13.
[232] Ibid, at [6].
[233] Ibid, at [7].
[234] Ibid, at [10].
[235] Ibid, at [11].
[236] Ibid, at [12].
[237] Ibid, at [13].

closures are most commonly enacted where there is a known and foreseeable risk such severe weather events.

179. In the 2022-23 financial year, QPWSP issues 540 park alert notifications of park closures, partial or facility closures or access restrictions due to weather events.[238]

Warning triggers for specific sites

180. Mr Klaassen stated that QPWSP has established site safety management protocols where it has identified and knows of foreseeable risks. For example, Mr Klaassen notes that the Burleigh Head track automatically closes when rainfall events over 50mm occur. This is achieved through a gate closure.[239] He also referred to a similar automatic closure at Purling Brook Fall.[240]

181. He stated that QPWSP is currently seeking to establish a site management safety protocol for Cedar Creek Falls, similar to those established for Burleigh Heads and Purling Brook Falls. Two rangers have tasked with drafting the safety protocol. This protocol will seek to establish triggers (conditions) and control measures (actions) to be implemented when changes in site conditions occur (including rises in water levels).[241] Moreover, site specific water level warning systems have been put in place in other national parks in Queensland such as Josephine Falls.[242]

182. Mr Klaassen states the protocols will direct and enable rangers to carry out actions, including closures, with confidence and without the requirement of obtaining further approval. The protocols will include:

    a. Environmental and weather triggers to enact pre-determined control actions;
    b. List required control actions including site closure arrangements and methods where appropriate;
    c. Supporting communication and notification requirements, including pre-determined text to simplify the process; and
    d. Assessment and reopening checklist and procedures.[243]

[238] Ibid, at [15].
[239] Ibid, at [26].
[240] Ibid, at [27].
[241] Ibid, at [28].
[242] Ibid, at [37]; Exhibit BK-9.
[243] Ibid, at [28].

Royal Life Saving Society Australia safety and risk assessment report

183. Mr Klaassen confirmed that the QPWSP have not conducted a review into the accident. He stated that the QPWSP had extremely limited detail on the circumstances surrounding the incident,[244] as such information was not routinely shared by Police or other investigating authorities.[245]

184. The QPWSP had engaged RLSSA to undertake a risk assessment and recommend controls for the QPWSP's consideration at the Falls.[246] However, this review was scheduled as part of the overall visitor strategy and was not a specific response to the incidents on 8 April 2021. Mr Klaassen indicated that QPWSP intends to accept the recent report, consider the findings and risk ratings and enact the recommendations (control measures) where practicable.[247]

185. Mr Houston was one of the authors of the report and is the General Manager – Capability & Industry of RLSSA. RLSSA were commissioned to undertake the report on 17 April 2023, and the review was completed on 9 October 2023.

186. At section 5.1, the report made the following recommendations:

    a. It is recommended that monitoring and review activities including integration with other organisational frameworks and processes is conducted by the QPWSP;
    b. It is recommended that the QPWSP review the non-conformances as part of the safety assessment and Risk Register and Treatment Tables and determine the suitability of risk treatment measures;
    c. It is recommended that swimming areas are acknowledged as such and signage is included to inform users of the risk of entering the waterway;
    d. It is recommended that arrangements regarding ranger patrols be documented in the risk management documentation;
    e. It is recommended that the consumption of alcohol and drugs are expressly prohibited at the venue;
    f. Conditions in the waterway should be monitored;
    g. Consideration should be given to the development of and distribution of community education and awareness programs (safety campaign);

[244] Ibid, at [30].
[245] Ibid, at [31].
[246] Ibid, at [33].
[247] Ibid, at [34].

h. Consideration should be given to the installation of an emergency communication device at the venue, noting that there is only suitable mobile phone coverage at the carpark;
i. It is noted that signage is present, however, signs are generally targeted at the individual level and are not consistent with Australian Standards or water safety guidelines. Updating signage to comply with industry standards is recommended;
j. Consideration should be given to the provision of suitable public rescue equipment; and
k. A warning system is recommended to be developed. This could be low-tech like indicator signage or high tech like an alert system. It is critical that some form of warning system is installed at the waterway to warn users of increased flow.

Determination and Recommendations

187. I acknowledge the comprehensive submissions given by Counsel Assisting and the parties' representatives following the Inquest; the last of which was received on 8 December 2023.

188. On an analysis of the available evidence, I make the following findings in respect of the Coronial Issues.

Issue 1

The findings required by section 45(2) of the CA; namely the identity of the deceased, when where and how he died and what caused this death.

Identity of the deceased

189. The 13-year-old Child, born 30 October 2007.

How he died

190. The 13-year-old Child died while swimming in a rock pool at Cedar Creek Falls. He had been taken to the Falls for a swim by a youth worker, Mr La, along with another boy from his residential placement. The water at the Falls at the time was turbulent, and visibility in the water was very poor.

191. The 13-year-old Child swam in the rock pool for a short period of time, under the supervision of Mr La. He then swam into a deeper area of the rock pool where, out of his depth, he could no longer swim in the turbulent conditions. Despite the efforts of Mr La and a bystander, the 13-year-old Child drowned at the Falls.

Place of death

192. The death occurred at Cedar Creek Falls, Tamborine Mountain, Queensland.

Date of death

193. The death occurred on 8 April 2021.

Cause of death

194. The cause of death was drowning. [248]

Issue 2

The circumstances surrounding the death and, in particular, the chain of decision-making in the lead up to it by relevant individuals from the Department and the service provider responsible for the custody and care of the 13-year-old Child.

195. I accept the submissions of Counsel Assisting that on the basis of the evidence before the Court, the death of the 13-year-old Child was a tragic accident.

196. Mr La gave frank and detailed oral evidence that was consistent with the account he gave in his statement to Police. I accept his factual account of events. On the sum of the evidence, the actions Mr La took at each relevant point while the 13-year-old Child was in his care on 8 April 2021 were reasonable given his training and the information available to him at the time.

197. It is clear from the evidence that Mr La's efforts to prevent what occurred were clear, strenuous and persistent, and his actions and efforts in entering the water to save the boys were admirable, and in so doing he put his own life at risk. Once they arrived at the site and observed the conditions, Mr La was faced with a very difficult series of decisions to try and ensure the welfare of children who were refusing to follow his directions. The evidence does not suggest that

[248] Ex A2 – Preliminary Examination Report.

any of those decisions, in balancing the competing considerations, were the cause of, or directly contributed to, the 13-year-old Child's death.

198. In particular, Mr La's decision to take the 13-year-old Child to the Falls was reasonable having regard to the following factors:

a. The 13-year-old Child requested to the swim at the Falls as his afternoon activity on 8 April 2021[249];
b. Mr La knew that the 13-year-old Child was a competent swimmer, and had been swimming at the Falls on previous occasions;
c. Mr La observed that the weather was calm and sunny and had no reason beforehand to believe that the conditions at the Falls were dangerous; and
d. Mr La considered that the activity would have a positive impact on the 13-year-old Child after the period of absence from the residence.

199. Once at the Falls, Mr La first observed the dangerous conditions at the lookout on the trail down to the rock pools. This is when Mr La determined that swimming at the Falls posed a high risk to the 13-year-old Child and other child resident. Mr La's updated risk assessment was, by that stage, functionally too late. Mr La made continued efforts to stop the 13-year-old Child and other child from swimming but was unable to do so.

200. One of the options open to Mr La, which he did not use, was to restrain physically one or both of the boys to prevent them from entering the pools. I find that Mr La's decision not to use physical restraint on the 13-year-old Child was reasonable having regard to the following factors:

a. Mr La had been trained to use a physical restraint only as a last resort;
b. Mr La had never previously used a physical restraint on a young person in his care; and
c. The use of a physical restraint presented significant other risks to the 13-year-old Child given the circumstances, and it is reasonable to consider there must have been some doubt about whether the attempt given the presence of both boys would have been practically possible or likely to be successful.

[249] It was an activity that had been planned the previous day but not undertaken due to absence from placement.

201. In reaching this conclusion, I have considered the submissions of the 13-year-old Child's mother and father which combined, in effect, are summarised as follows:

a. The training given to Mr La by HSS was inadequate in respect of the assessment of risk.
b. Mr La's actions were not reasonable and that the 13-year-old Child should have been physically restrained and that this was a contributing factor to his death; and
c. That a reasonable use of force was an appropriate response to the emergency situation that confronted Mr La and one which was permissible. Such use of force outweighed any other risks.

202. I do not accept those submissions on the following grounds:

a. Whilst I accept that no formal risk assessment had been carried out of the 13-year-old Child's activity of swimming at the Falls prior to 8 April 2021, I do not accept that this equates to no risk assessment having been undertaken for this activity. The 13-year-old Child had successfully participated in swimming activity before, at the Falls and in other aquatic environments with no issue. He was assessed as a competent swimmer. It was his favourite activity and an ideal way to attempt to positively reengage with him after being absent from placement. Establishing normalcy for traumatised children in care is integral. These recreational activities are ordinarily enjoyed by children in an intact family. For the reasons that appear below, I do not accept that the unique situation at the Falls that day was foreseeable.
b. There was sufficient evidence that the training given to staff by HSS was of an acceptable standard. By its own initiative, HSS has nevertheless revisited its policies and procedures in an effort to ensure so far as possible, that such a tragedy would not occur again. Mr Iva gave evidence that HSS has strengthened its policies beyond what is required by licensing.
c. I do not accept that it was reasonable to physically restrain the 13-year-old Child in the circumstances. Physical restraint presented very real risks in the dynamic and unexpected situation that unfolded, which were highlighted in evidence[250]. Leaving aside the 13-year-old Child's human

[250] For example, Transcript, Day 1: T100: L21-41.

rights[251], and whilst not in any way minimising the tragic death that occurred, physical restraint had the very real prospect of escalating the situation to a point where the outcome could have been much worse. In my view, Mr La did the best he could have done in the circumstances. Mr La's actions were heroic, and he has personally suffered as a consequence in the aftermath of the accident.

Issue 3

The adequacy of policies and procedures of the Department governing issues around notice, consent and supervision with respect to children in the custody and care of the Department undertaking potentially risky recreational activities.

203. The Department, through its officers, gave comprehensive evidence at the Inquest about the systems in place[252] to keep safe children in care whilst permitting them the joy of participating in recreational activities such as swimming, like other children not in care enjoy. I accept Dr Crawford's evidence of the fine balancing act that the Department adopts in this respect.

204. Whilst the day-to-day decisions of a child in care is delegated to the service provider, the Department acknowledges the oversight role it plays in this respect.

205. I accept the submissions of Counsel Assisting that the sum of the evidence does not suggest that any acts or omissions by Departmental staff directly caused or contributed to the death of the 13-year-old Child. In practical terms, this is because the risk assessment was a question of timing. Once the conditions at the Falls became plain to Mr La, and his assessment of the level of risk posed by the swimming changed, he was not able to prevent the boys from undertaking the activity. At that point, the risk assessment practices of the Department were functionally irrelevant.

206. However, the issue of risk assessment raised by the circumstances does place focus on the system through which the Department is informed by service providers about the potentially high-risk activities the children in their care may be undertaking. The key issue is the evidence of a lack of standardisation and

[251] Decisions by public entities are to be made compatible with human rights, with consideration of factors including whether there are any less restrictive and reasonably available ways to achieve the purpose: Ss 4(b), 58(1) and 13(2) *Human Rights Act* 2019.
[252] Through policies, manuals and training.

guidelines around the risk assessment mechanism to be used by service providers in reporting high-risk activities to the Department.

207. That lack of consistency in practice and uniformity in process means the Department is not able to assure itself that service providers are properly assessing and advising of high-risk activities being undertaken by young people. That degree of variation is a risk in itself and contributes to a potential gap in which high-risk activities are not being assessed by such as the Department and are not being approved accordingly.

208. The Department acknowledges this and states that the below recommendations will be incorporated into the relevant practices and procedures by the Department as soon as reasonably possible[253].

209. The Department does however, state that the recommendation may require some further examination because the issue requiring consideration is not just water awareness training but training to identify circumstances where that would normally be a low-risk activity becomes a high-risk activity due to external forces and what steps should or could be taken to determine if the category of risk had changed. This case has identified that factors such as weather conditions and any inclement weather played a role in changing the risk.

210. In so far as HSS is concerned, I observe that it sees the benefit in formal water safety training for its staff and support the recommendations.[254]

211. I note that the 13-year-old Child's parents support the following recommendations. They further submit that I should find that the systems in place at the Department and HSS were deficient. I decline to do so. The issue identified during the course of the hearing relates to the standardisation of guidelines around the risk mechanism used by a service provider in the reporting of activities to the Department, which in turn gives the Department assurance about the appropriateness of the assessment of risk undertaken by the service providers. In my view, this is better categorised as a quality improvement opportunity for the Department after a procedure framework gap had been identified during this process. Such a gap did not cause or contribute to the 13-year-old Child's death.

[253] Subject to funding, particularly with respect to water awareness training.
[254] Transcript, Day 2: T12: L27-32.

212. For similar reasons, I decline to make the further recommendation sought by the 13-year-old Child's mother on the Department conducting audits to ensure that:

    a. Internal policies of care providers are in alignment with the policies of the Department; and
    b. Youth workers employed by care providers have been adequately instructed in risk assessment and the use of physical restraint.

213. I am satisfied from these proceedings that the Department has taken this incident seriously both in the quality of the evidence it gave through its staff and in the subsequent actions it has taken, and will ensure as part of its continuous quality improvement, that its oversight obligations in this respect are honoured to the extent it is reasonably able to do so.

Recommendations

214. I recommend that the Department take steps to standardise, through a guideline or documented risk assessment procedure, the process by which service providers are to assess and report to the Department on high-risk activities.

215. I also recommend the Department consider making it mandatory for out of home care service providers to provide water awareness safety training to their frontline staff.

Issue 4

The placement history of the 13-year-old Child and the level of supervision, both generally and in the days leading to the death, exercised by the Department in relation to his daily care and activities.

216. I accept the submissions of Counsel Assisting on this issue. The evidence on the matters relevant to Issue 4 does not point to any substantive direct or causal factors in the death of the 13-year-old Child. This is particularly so given the delegation of responsibilities for day-to-day care by the Department to HSS, and the fact that the decision to take the 13-year-old Child to the Falls was neither made by, nor advised to, a Departmental officer[255]. Accepting the

[255] At least not highlighted directly. In this respect, I accept HHS's submission that it was not the case that the Department was never aware that children, including the 13-year-old Child,

oversight role exercised by the Department over service providers and to the extent systemic issues arise in relation to risk assessments made by the Department and the service provider, I am satisfied these are satisfactorily dealt with in the findings and recommendations relating to Issues 3 and 6.

Issue 5

What actions have been taken since this death to prevent deaths from happening in similar circumstances in the future.

217. The evidence suggests that Mr La received relevant training in risk assessment and responses from HSS before commencing his duties. However, there is no evidence to suggest that the specific step-by-step risk assessment guidance documented in the booklet in 2022 was relevantly applied in or before April 2021 to the activity of swimming at the Falls. Notwithstanding what training may have been provided, the written policy that was in place at the relevant time was sub-optimal in terms of guidance to workers about proper risk assessment processes. The amendments to the booklet made in 2022 were required to fill a material documentation gap in HSS's risk assessment policy. I note these amendments were made and implemented spontaneously by HSS, well before the criticism surrounding this issue crystallized during these proceedings.

218. Whether or not the specific six step process was applied in team meetings at or before April 2021 is in one sense irrelevant, as it can be inferred from the records available that the reasonable assumption made in those meetings was that the Falls were generally not a high-risk place to swim. The truly relevant risk assessment was the one Mr La had to make on the new information available to him once they arrived at the Falls; the risk of which he did in fact identify based on his training and policies in place at HHS at the time. Nevertheless, it is in this context that documented risk assessment procedures and responses are important, as it provides the clear and accessible training and guidance workers need when making decisions in difficult or fast-moving circumstances. I find that HSS should have had that system in place prior to its introduction in 2022 after the death of the 13-year-old Child.

---

were being taken to Cedar Creek Falls to swim. The evidence of Mr Romero was that this was evident in the weekly progress reports, monthly tailored support plan and weekly planners.

219. The steps taken by HSS in their review after the incident seems to have recognised that reality, and the reformed policies appropriately address these issues. However, I agree that given the training provided to Mr La and the appropriateness of his actions as the incident unfolded, the evidence does not suggest that anything done or not done by HSS directly caused or directly contributed to the death of the 13-year-old Child.

Issue 6

Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the CA.

220. Counsel Assisting submits that a number of concerning features about the risk mitigation strategies applicable by QPWSP to the Falls, and how they were applied, arise on the evidence. In summary:

    a. Rangers attending the Falls on the morning of the incident, and who were present when an injury to another person occurred, made no report at all of the conditions to a supervisor or made any recommendations about risk controls that should be applied in the circumstances;
    b. QPWSP had no documented or conventional process or procedure by which such reports should be made, or triggers or thresholds that would warrant further controls being put in place;
    c. Of all the available controls able to be applied to prevent visitors swimming in the dangerous conditions, the existing and generalised signage was the only warning or prevention control in use;
    d. The Falls were not closed at any time before or after the incident, except when emergency services, QAS and Police were in attendance;
    e. No substantive review was undertaken in the wake of the incident to understand what had occurred or what might be done to prevent further deaths;
    f. No request was made by QPWSP in the period following the incident to obtain further information from investigators or first responders so as to inform any review or assessment of what occurred; and
    g. At the time of the commencement of the inquest, over two years since the incident occurred, no changes have been made to the risk assessment or control process used by QPWSP over the site.

221. Counsel Assisting acknowledges that the relevant risks would have been at least somewhat obvious to visitors attending the park on that day, by virtue of both the warning signage and the conditions themselves. The risk was plainly clear to Mr La, who attempted stop the boys from entering the water at the Falls. For that reason, it is submitted that it could not be reasonably concluded that the failure to warn of the relevant risk was an operative factor in the death of the 13-year-old Child. Tragically, if the warnings on the signage or of Mr La had been heeded, the death could have been avoided.

222. However, Counsel Assisting submits that the default position of the QPWSP at the time in terms of risk management seems largely to have been a policy of '*visitor beware*'. While that may be justifiable, and a practical necessity, in remote and inaccessible areas of the QPWSP estate, it is reasonable to distinguish the position with respect to a popular, accessible and high-traffic area such as Falls, with up to 80,000 people visiting annually. Moreover, the QPWSP has done just that in other areas of the national parks already. Those same considerations should urgently be brought to bear on the conditions at the Falls.

223. Pursuant to s 46(1) of the CA, given the evidence set out above, it is submitted by Counsel Assisting that it is open to the Court to consider making recommendations that will improve public health or safety and that may prevent deaths from happening in similar circumstances in the future.

224. It is submitted that those recommendations open to the Court (in addition to those identified at [214] and [215] above) include:

    a. QPWSP consider and action all accepted recommendations of the RLSSA report as soon as practicable, and include an oversight mechanism by which the QPWSP must monitor and evaluate the effectiveness of the implemented recommendations;
    b. QPWSP enter into a memorandum of understanding or other information sharing agreement with Police in order to formalise the disclosure of information relevant to deaths or serious injuries occurring in national parks; and
    c. QPWSP introduce and implement a work method statement for rangers detailing the circumstances in which potentially risk conditions in relevant park sites should be reported to a supervisor, and the relevant

actions that are to be undertaken if clear and identifiable risk thresholds are met.

225. Extensive submissions were made on behalf of QPWSP; which are helpfully summarised in its submissions as follows:

a. QPWSP takes an active approach to risk management. Respectfully, '*visitor beware*' oversimplifies the approach taken by QPWSP both generally and specifically, at the Falls. In summary:

i. QPWSP legislated cardinal management principle is to provide, to the greatest possible extent, for the preservation of an area's natural condition. This necessarily reduces certain architectural /infrastructure controls to risk. A creek in a national park is not an artificial environment like a public pool;

ii. QPWSP legislated management principles include providing for opportunities for recreational activities and ecotourism. More restrictive approaches to managing risk, such as the prohibition of access to/swimming at the Falls, would not be welcomed;

iii. QPWSP manages an estate comprising of approximately 7.5% of Queensland. Managing such an estate, with just 780 rangers, necessarily influences how it can reasonably manage risk within national parks;

iv. Given the size of QPWSP estate, in a natural environment, they have a huge variance in the risks they manage, including bushfires, weather events, swimming, wildlife, falling branches, and more. With such variance in risks and hazards, in the context of an unpredictable natural environment which can change rapidly, this again influences the approach QPWSP must take to risk management;

v. QPWSP, as part of DES, has a broad level risk management policy which provides a framework of how risk will be managed, mitigated, or eliminated. This demonstrates there is oversight in terms of how risk is managed;

vi. QPWSP, as part of DES, has a Risk Universe which broadly outlines themes of risk that have been identified within DES.

This demonstrates DES proactively tries to identify relevant risks;

vii. QPWSP, in their Enterprise Risk Management System, has identified visitor safety as a specific risk to which controls and treatments apply. This demonstrates QPWSP taking an active approach in monitoring and improving visitor safety;

viii. QPWSP has developed a Visitor Safety Policy, which outlines its approach to meeting its duty of care to visitors. This policy outlines specific measures that can be taken in relation to managing risks on its estate;

ix. QPWSP has a Parks Site and Facilities Design Manual, providing guidance on site planning and user safety. This demonstrates that foresight and planning does occur into the safe development of its locations;

x. QPWSP do issue park alerts, which convey relevant warnings via the DES website. This is actively used, as shown from the 699 park alerts issued in the 2022-2023 financial year;

xi. In terms of signage, QPWSP have developed the Parks Sign Manual. This demonstrates that planning and effort is put into developing appropriate signage to convey risk warnings;

xii. In terms of signage, QPWSP commissioned an academic article to examine their use of signage. This shows QPWSP taking an active approach in trying to improve their signage to appropriately convey risk warnings.

xiii. QPWSP has six different regional emergency plans. These plans contain objective trigger points/thresholds which are both specific and general to various estates. When a trigger point is met, the plan outlines what action is required to be taken, e.g. closing a park. These emergency plans show that QPWSP have actively identified risks and outlined specific steps to be taken once a threshold has been met;

xiv. QPWSP do not promote or advertise swimming at Cedar Creek Falls;

xv. In terms of Cedar Creek Falls:

I. In 2004, a risk assessment identified most incidents were associated with people diving off rocky cliffs. A such, it was proposed to enact Restricted Access Area's (RAA's) to help visitor safety;

II. In 2006, an infrastructure plan assessed the implementation of the RAA's, and outlined different signage to be installed;

III. In 2016, a Safety Sign Plan, again, identified most incidents were associated with people in the RAA's, and made recommendations for signage improvement. This was against the background of a 2014 coronial recommendation to review signage and information in relation to the Daintree National Park[256]; and

IV. In 2023, a risk assessment was completed. QPWSP identified the need for this assessment in their 2022 Tamborine Visitor Strategy, along with the updating of the emergency response plan for severe weather events.[257]Given the two incidents on 8 April 2021, QPWSP engaged a subject matter expert, being RLSSA, to complete the risk assessment. As, prior to 8 April 2021, QPWSP did not have any record of a visitor being injured or drowning as a result of the water becoming flooded with strong currents.

xvi. In terms of the Falls, QPWSP has a comprehensive network of warning signage. Given the history of incidents at the Falls, these mainly provide warnings in relation to the RAA's. Nonetheless, there is signage providing warnings about the risks of swimming at the Falls.

xvii. In terms of the Falls, QPWSP have two webpages specifically for the location which provides warnings about swimming in the creek. It has a third webpage which provides more generic information about the risks of swimming in creeks. It also links

[256] Inquest into the death of Che-Wei Su, Cairns, 14 July 2014.
[257] Exhibit F2.11, p6.

to a fourth webpage which provides information about the risks of swimming in creeks.[258]

b. The evidence demonstrates QPWSP proactively manages risks. The characterisation of '*visitor beware'*, respectfully, undermines the amount of work done by QPWSP in terms of risk management, and does not properly contextualise the unique challenges faced by QPWSP in managing risk in a natural environment, with inherent danger, prone to rapid changes, and covering an expansive estate;

c. The inquest has, properly and thankfully, noted areas for QPWSP to improve. However, the mere existence of these areas to improve should not be relied on to criticise QPWSP. The events on 8 April 2021, at the Falls, were unique. It is immensely easy to look back and find areas for improvement. However, given what was known as of 8 April 2021, it could not be concluded that QPWSP could have reasonably foreseen the incident. In summary:

    i. Cedar Creek Falls receives a huge number of visitors each year. Despite the huge number of visitors there have been relatively few incidents – indicative of QPWSP's proactive approach to managing risk at the Falls;

    ii. Compared to other inquests, e.g. Josephine Falls and Mossman Gorge, there had been fewer incidents at Cedar Creek Falls;

    iii. Prior to 8 April 2021, QPWSP did not have a record of a visitor being injured or drowned at Cedar Creek Falls as the result of the water becoming flooded with strong currents. As such, it was entirely appropriate for QPWSP to focus on the known, more significant risks, which were associated with use of the RAA's;

    iv. While QPWSP have introduced water level warning systems at other locations, e.g., Josephine Falls, it is clear that Josephine Falls had a large number of incidents requiring the attendance of the Swift Water Rescue crews[259]. This can be contrasted to Cedar Creek Falls – it is unsurprising there was no water level warning system at Cedar Creek Falls;

[258] There are unfortunately, other websites not attributable to QPWSP, which promote swimming at Cedar Creek Falls.
[259] Inquest into the deaths of Thomas Hunt and Youngeun Kim, Cairns, 18 October 2019.

v. Cedar Creek Falls is much more than a swimming location – as noted QPWSP do not advertise or promote it as a swimming location. There are various utilities and activities available at Cedar Creek Falls. The evidence suggests that the majority of people go to Cedar Creek Falls to do an activity other than swimming – for example to recreate beside the water. A knee jerk reaction of simply closing a park whenever any injury occurs is overly simplistic;

vi. Cedar Creek Falls is not a controlled environment. It is not a pool. It is not patrolled by life savers. There are inherent dangers associated with swimming in a creek. It is also prone to sudden change due to rapid environmental changes. Not all naturally occurring events can be predicted;

vii. There is a causeway leading to the Cedar Creek Falls entrance. The flooding of this causeway restricts entry during more severe rainfall events. The circumstances on 8 April 2021 were unique, in that the rainfall was not so severe to have flooded the causeway, but yet the water was still turbulent;

viii. While there was an earlier incident on 8 April 2021, it is easy with the benefit of hindsight to suggest some sort of decision should have been made following that incident. Given the historical context of Cedar Creek Falls, it is understandable why some sort of procedure was not in place providing further guidance as to what should be done in relation to fast flowing water at Cedar Creek Falls; and

ix. Rangers are responsible for a large number of different national parks, and visitor nodes within these national parks. The suggestion of having rangers stand guard is impractical.

d. In terms of areas for improvement, it is submitted that QPWSP has made changes, are in the process of making changes, or changes could be addressed by the proposed recommendations which it accepts is appropriate:

i. QPWSP have already implemented a notification system for the escalating of emergencies;

ii. QPWSP are currently considering the implementation of objective triggers in relation to Cedar Creek Falls, including the implementation of a water level warning system;

iii. Recommendation three (risk work method statement) proposed by Counsel Assisting would appropriately ensure that there is clear guidance about risk;

iv. QPWSP have now received the completed RLSSA report, and a working group is considering the implementation of those recommendations;

v. While there was no immediate review, it is noted that QPWSP did engage a subject matter expert as a result of the incidents on 8 April 2021; and

vi. The recommendation of Counsel Assisting, regarding a memorandum of understanding, would appropriately deal with the issues previously faced by QPWSP, being a difficulty to obtain precise information about incidents, which would properly arm them to consider incidents when they occur. However, given Police were not a party to these proceedings and were not provided with an opportunity to make submissions about this recommendation, it is submitted that the wording be amended, that 'QPWSP *attempt* to enter into a memorandum of understanding or other information sharing agreement with QPS'.

226. I am mindful that QPWSP came into these proceedings late and although issues arose during the hearing touching upon the role played by QPWSP and its staff, it must be borne in mind that its involvement was limited to the sixth coronial issue, namely recommendations. Consequently, the focus of QPWSP was on overarching policies and risk management, not individual decision making on the day of the incident. As such, evidence on the latter was not explored in evidence.

227. Ultimately, after carefully considering the evidence and the parties' submissions, I am persuaded by and accept the submissions made on behalf of QPWSP. I find as follows:

a. Natural environments like Cedar Creek Falls are not controlled environments like a pool. They carry inherent risks which are diverse and subject to rapid change often associated with weather events. Visitors accept a level of risk when accessing these unpredictable environments, which is part of the attraction of pristine wilderness. The park in question is used for diverse activities, the majority of which does not relate to swimming;

b. QPWSP reasonably managed risk at the Falls within the context of its legislated and geographical remit;

c. The circumstances that confronted Mr La on 8 April 2021 were unique and not reasonably foreseeable by QPWSP. Unlike the Inquest involving Josephine Falls[260] where there had been 12 incidents reported over an approximate 3-year period, there have been relatively few at the Falls and none of those incidents involved large rainfall events or fast flowing water.[261] On the afternoon Mr La took the boys to the Falls it was sunny and calm. He accessed the site via an unflooded causeway[262]. He could not and did not appreciate the conditions until after arriving on site and observing the water flow from the track. In that context, it is unsurprising that there were no procedures in place by QPWSP to respond to the rainfall at the Falls;

d. Although both incidents on 8 April 2021 involved fast flowing water, they were different. The incident earlier in the day at the Falls was in the context of a woman sustaining injury close to the edge of a RAA, after having a slip and fall and being washed over the edge. The fatal incident involving the 13-year-old Child was in the context of swimming in a deep pool and being held under by turbulent water;

e. I accept the uncontested evidence that the rangers did not witness the initial incident. They arrived on site after the initial incident occurred, an incident was logged in the incident management system, and it was reported to a supervisor. The rangers relied on third party accounts as to what happened. In this context, and in the absence of evidence

[260] Inquest into the death of Che-Wei Su, Cairns, 14 July 2014.
[261] The incidents involved trauma from people jumping and falling off rocks. Prior to 8 April 2021, QPWSP did not have a record of a visitor being injured or drowned at Cedar Creek Falls as the result of water becoming flooded with strong currents.
[262] A flooded causeway by reason of high rainfall presents a natural barrier to accessing Cedar Creek Falls.

during these proceedings exploring the individual decisions made by the rangers on the day, I do not accept submissions that the park should have been closed or other risk measures put in place;

f. It is nevertheless acknowledged by QPWSP that the initial incident did not result in any additional controls being put in place. Having regard to the history of incidents at Cedar Creek Falls, this is not surprising. However, in the interests of improving risk management, QPWSP is addressing this including the development of a notification system for the escalation of emergencies;

g. Against that background, there were no actions or inactions of QPWSP which contributed to the death of the 13-year-old Child;

h. Since the incident, QPWSP have made various improvements and engaged a subject matter expert in the field of water safety (RLSSA) which produced a comprehensive report. That report is now under consideration for the implementation of the recommendations arising therefrom as soon as practically possible, to improve the safety of visitors; and

i. I note that in May 2023, RLSSA produced a Drowning Report with a 10-year analysis of drowning deaths in Southeast Queensland. This was published and was the subject of deliberation at the Southeast Queensland Water Safety Forum held on the Gold Coast on 15 and 16 May 2023, which I attended. Relevantly, of the 366 people that have drowned in the region in the last 10 years, 30% of these occurred in rivers and creeks. A Southeast Queensland Water Safety Strategy 2023-2027 has since been developed and makes recommendations on drowning prevention strategies through targeted campaigns, education of communities about risk and prevention strategies.

228. It was submitted on behalf of the 13-year-old Child's father that an additional recommendation be made in respect of the implementation by QPWSP of a procedure for investigation and assessment of a QPWSP managed site after a serious incident or fatality. That recommendation holds some attraction in view of the evidence that transpired during the hearing.

229. The QPWSP endorses such a recommendation but proposes different wording to allow greater flexibility in the implementation of such process, having regard to funding, staffing resources and information sharing, noting that the DES

already has in place a policy in relation to work related incidents (not involving a visitor). I accept that such an adjusted recommendation be made as proposed by QPWSP.

230. I make the following recommendations, noting that QPWSP have already progressed in part:

a. QPWSP consider and action all accepted recommendations of the RLSSA report as soon as practicable, and include an oversight mechanism by which the QPWSP must monitor and evaluate the effectiveness of the implemented recommendations;

b. QPWSP attempt to enter into a memorandum of understanding or other information sharing agreement with Police in order to formalise the disclosure of information relevant to deaths or serious injuries occurring in national parks;

c. QPWSP introduce and implement a work method statement for rangers detailing the circumstances in which potentially risk conditions in relevant park sites should be reported to a supervisor, and the relevant actions that are to be undertaken if clear and identifiable risk thresholds are met; and

d. The DES form a working group to consider the implementation or amendment of polices, to create a process of discovering potential problems and identifying appropriate solutions, in relation to serious incidents or deaths involving visitors on QPWSP estates.

Conclusion

231. This is a tragic accident which resulted in the death of a child in care, whilst engaging in swimming activity at a national park. His death has had an impact on many people who cared for him, including his father and mother.

232. At the conclusion of the evidence at the Inquest, I invited the 13-year-old Child's parents to read out family statements they wish to give about their son. The father prepared a statement. This was read out in full by his legal advisor. Suffice to say that the statement was heartfelt and sincere.

233. I express my sincere condolences for the loss suffered by the 13-year-old Child's family. It is hoped that the coronial process and these findings will assist those persons affected by his death to make some sense of the tragedy.

Findings required by s. 45

Identity of the deceased: The 13-year-old Child

How he died: The 13-year-old Child died while swimming in a rock pool at Cedar Creek Falls. He had been taken to the Falls for a swim by a youth worker, Mr La, along with another boy from his residential placement. The water at the Falls at the time was turbulent, and visibility in the water was very poor.

The 13-year-old Child swam in the rock pool for a short period of time, under the supervision of Mr La. He then swam into a deeper area of the rock pool where, out of his depth, he could no longer swim in the turbulent conditions. Despite the efforts of Mr La and a bystander, the 13-year-old Child drowned at the Falls.

Place of death: Cedar Creek Falls
TAMBORINE MOUNTAIN QLD 4272
AUSTRALIA

Date of death: 08 April 2021

Cause of death: 1(a) Drowning

I close the inquest.

Carol Lee
Coroner
SOUTHPORT