CITATION: *Inquest into the death of Ebony Thompson* [2025] NTLC 19

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0177/2023
DELIVERED ON:	24 October 2025
DELIVERED AT:	Darwin
HEARING DATE(s):	18-21 & 27 March 2025
FINDING OF:	Judge Elisabeth Armitage
CATCHWORDS:	**Australian Children's Education and Care Quality Authority (ACEQA); Quality Education and Care Northern Territory (QECNT) Regulation of Child Care Centres; National Quality Framework (NQF); Fencing in child care centres; Supervision Plan and Policies; Adequacy of Supervision for blind spot; Failure to recognise high risk hazard created by loop top fencing**

REPRESENTATION:

Counsel Assisting:	Chrissy McConnel
Counsel for Department of Education & Training:	Tina Tomaszewski
Counsel for Humpty Doo Community & Child Care Centre:	Adam Mason
Counsel for Family:	Luke Officer

Judgment category classification:	B
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0177/2023

In the matter of an Inquest into the death of

EBONY THOMPSON

ON: 2 SEPTEMBER 2023
AT: ROYAL DARWIN HOSPITAL

FINDINGS

Judge Elisabeth Armitage

Family Statement

1. At the commencement of the inquest into the death of Ebony Thompson, this family statement, from parents, Floyd and Jade, and siblings, Cooper and Elsey, was read:

> *In a time of hurt and heartache we would like to take a moment to reflect and remember our beautiful baby girl. Ebony was the sweetest daughter, sister, granddaughter, niece and friend. She truly made all our lives complete. Ebony was known to her family and friends as Puds or Puddy. She got her nickname from being the cutest little pudding.*
>
> *Her chubby cheeks and infectious smile made your day from the moment she woke in the morning. The love and joy she brought into all our lives is something we will forever be grateful for. She touched our hearts in a way we will all cherish forever. We are confident over the coming days so many people will have the pleasure to see the loving and truly special impact she had on the world.*

You, Puddy, made it a brighter place, bringing so much joy, love and happiness to everyone who knew you and had the opportunity to meet you. We are sure you would welcome them all here today with your signature warm welcome "Hey." Puds was the most amazing little girl you could ever imagine. She was everyone's greatest qualities. She was kind and full of light and love. She knew when someone was sad and needs support.

She had this truly unbelievable nature to know when special moments needed her silence or support. She showed compassion and empathy. She was so very cheeky. And for all of this we are forever in awe of her greatness. Her ability to capture a room in one second is something that we are so very proud of. Puddy was so very lucky to be brought up not only by her mum, dad, brother, sister and family, but a community.

She thrived on the love and fun her people shared with her every single day. Puddy loved an adventure, and she lived her life with endless adventures and opportunities to explore new places. Not very many people had a chance to see all the amazing things Puds did in their entire life, and that is something we are so happy to have had the chance to do with her.

We watched Ebony grow and as she did, her intelligence at such a young age made everyone proud. Puddy was always so full of life and walked this earth with such ease and care. Nothing ever worried her. She always held her head high, full of confidence and beauty. Her kind, loving nature was something that came so very easy for her. Standing here today, it's clear that not a moment goes by without feeling the weight of your absence and missing you each and every day feeling this deeply.

We hold together and navigate the best we can, but the pain, the tears, the hurt, that some days are just so tough without you here. You were the glue that made everything so right. It's a clear reflection of what you truly mean to all that loved you. So Puddy, we talk of you every day and we reminisce on all the memories we had the pleasure of making with you. We hold so tight to the love, the memories, the adventures, the buggy rides, the hugs, the nose kisses, the morning snuggles, the laughter and all the special moments we shared knowing that nothing can take that away.

We know you are with us each and every day. We look at the stars and we know they all shine for you. We are confident that everyone who had the privilege of meeting you, knows the special, unique spirit and will forever carry those moments with them, holding them tightly.

We honour her by sharing our love, our sorrow, our commitment to carry her spirit with us every day in everything we do.

As we seek understanding, we're reminded of the preciousness of life. We will continue to honour her by living with the same love, happiness and strength she gave us. We are forever grateful for the time we had, and we will carry her with us always.

Introduction

2. There were no eyewitnesses to the minutes before Ebony was found unresponsive at the Humpty Doo Community & Child Care Centre on 31 August 2023. She received emergency care and was taken to hospital but tragically never regained consciousness. She was only 22 months old when she died in the Intensive Care Unit (ICU) at Royal Darwin Hospital (RDH) at 6.05pm on 2 September 2024. Parents entrust their children to childcare services every day and expect to collect them healthy and well every evening. Ebony's unexpected death invokes fear in all parents of young children and is a tragedy and source of anguish for her family, friends and the wider community.

3. The provisional diagnosis for her death was *severe hypoxic brain injury due to out of hospital cardiac arrest.*[1] An autopsy was conducted by Forensic Pathologist Dr Althea Neblett on 5 September 2023 but how and why Ebony came to suffer this injury was recorded as 'undetermined', noting that pressure to the neck was a possible cause that could not be ruled out. There were no signs of significant injury to her body.[2]

[1] Brief of evidence, Folio 14, Provisional Cause of Death.
[2] Brief of evidence, Folio 15, Postmortem Examination Report for the Coroner, dated 15 December, 2023.

4. Section 34 of the *Coroner's Act* requires a Coroner investigating a death to find, if possible, the cause of death and any relevant circumstances concerning the death. Given the lack of clear evidence as to how and why Ebony passed away it was necessary to hold an inquest in an effort to find the answers.

Establishing the chronology of events on Thursday 31 August 2023

5. At 7.51am, Ebony was signed in at the Humpty Doo Community & Child Care Centre ('the Centre') by her mother Jade. This was a common routine. Ebony's older siblings had attended the Centre and Ebony had been attending since 27 June 2022. On this day Ebony was one of 15 children being cared for by appropriately qualified[3] educators in the 'Green Ants' room.

6. The Centre consisted of rooms for children of different ages from 2.5 to 5 years, named Green Ants, Bull Ants and Fire Ants. The Green Ants room was for children aged 2+ to 3 years but children from 18 months could also be placed in that room.[4] Ebony moved into Green Ants in early August 2023.[5]

7. The rostered educators in Green Ants that day were Miss H, Miss P, Miss K and Miss U, with Miss M assisting as the 'break cover'.[6] All of the rostered staff had childcare qualifications and current First Aid certificates, including first aid training for CPR.[7]

8. Throughout the morning Ebony played with her friends and participated in group activities such as climbing, playdough and 'cereal play'. She was observed throwing sand and biting, developmentally normal behaviours which required some additional supervision, and she appeared happy and engaged.[8]

[3] Brief of evidence, Folio 38.8 – Humpty Doo Community & Child Care Centre.
[4] T169, RM.
[5] Additional documents, Statement of CT, [16].
[6] Brief of evidence, Folio 38.7 – Department of Education & Training.
[7] Brief of evidence, Folio 38.8 - Humpty Doo Community & Child Care Centre.
[8] Brief of evidence, Folio 4, Transcript of Miss H, 4 September 2023.

9. During the morning's activities the chickens in the chickencoop were noisy and some children went to investigate what was going on before being moved away. The chickens were popular with the children, including Ebony.[9]

CCTV

10. The Centre was fitted with CCTV which recorded some areas, including some of the Green Ants playground and the Centre office. The CCTV footage[10] was retained and assisted in piecing together the chronology of the morning's activities. An agreed chronology was prepared and tendered at the end of the inquest setting out the timeline of events captured on the CCTV, with the timings allowing for a 7 minute adjustment[11] as it was accepted by all parties that the timings recorded on the CCTV were 7 minutes slow.

11. The CCTV footage[12] shows that between 11.19am and 11.37am, Miss H, Miss P and Miss U were all in the Green Ants playground area with the children, including Ebony.

12. Miss K was also there for some of the time, supervising near the chickencoop and in a position to see the chickencoop gate. At 11.22am Miss K saw Ebony playing in the sandpit with two other children.[13] This is the last recalled positive sighting of Ebony.

13. Miss K left the playground to get the children's lunch organised at around 11.28am. As she left Miss K recalled telling educators K and P, who were sitting on balls towards the middle of the playground, that she was leaving the playground, though Miss P did not recall the conversation.[14] Neither of the other educators moved to where Miss K had been positioned, so the

[9] T80-T81; T98, Miss H.
[10] Brief of evidence, Folio 38.1 – CCTV.
[11] Brief of evidence, Folio 38.1 – CCTV; Exhibit E17, Aide Memoire – Chronology of CCTV.
[12] Brief of evidence, Folio 38.1 – CCTV.
[13] Brief of evidence, Folio 38.3.5 – AV Statement, KM; T139-140,Miss K. The sandpit is located at the top of the original supervision map, Image 5, which is included later in these Findings.
[14] T11, Miss P.

chickencoop gate was no longer supervised. [15] Miss K said there were no children in that area when she left and it was her view that "there is no point in supervising if there's no children there."[16]

14. According to the CCTV, at 11:28:25am Miss K walked onto the Green Ants veranda with the children's lunches. She saw Miss H and Miss P showing videos to the children in approximately the middle of the playground.[17]

15. A headcount was conducted by Miss P on the 'Xplore Playground'[18] phone application used at the Centre, and she recorded that all children, including Ebony, were present and accounted for at 11.32:30.[19] The educators did not get up and move around to conduct the headcount but Miss P said that when she called Ebony's name Miss H confirmed that she was accounted for and so she was checked off.[20] I have no reason to doubt that Miss H sighted Ebony at this time, and she was correctly checked off, even though Miss H did not recall this headcount in her evidence[21].

16. From 11.37am onwards, the three remaining educators in the playground[22] started the lunchtime routine. They each left the playground with groups of 4 to 5 children to wash hands in preparation for lunch. Miss H left first, followed 30 seconds later by Miss P and Miss U. The CCTV footage shows that some children were following the educators as they left the playground.

17. No further checks of the playground were carried out by the educators to ensure that all of the children were accounted for[23] and it is now known that Ebony did not leave the playground with the other children. As Ebony was

[15] T161, Miss K.
[16] T140, Miss K.
[17] T141, Miss K.
[18] Additional documents 23, Statement of CT, [19].
[19] Brief of evidence, Folio 38.8.3; T70, CT.
[20] Transcript dated 21 March 2025, T17. Miss P.;Coronial brief, Folio 38.8.3 – AV Statement, Miss P.
[21] Miss H immediately and diligently searched for Ebony when she was not present at the next head count.
[22] Miss H, Miss P and Miss U.
[23] T115, Miss H.

known to love her food,[24] that she was not with the children leaving the playground for lunch suggests that she was likely prevented from joining the other children, in other words and in my view, likely already entrapped at that time.

18. After hands were washed, the children moved to the Green Ants veranda for lunch. It was 11.40 or 11.41am when Miss H commenced a lunchtime head count and realised that Ebony was missing.[25]

19. At 11.41:14am, the CCTV records Miss H entering the playground to look for Ebony.

20. At 11.41:18am, the CCTV footage shows Miss H running towards the 'island shed' (so called because it is painted with a bright mural depicting an island). Behind the island shed, and not captured on the CCTV, she found Ebony at the chickencoop gate at the end of the pathway. The chickencoop gate is constructed in the style of many 'loop topped' pool fences but was not as high as a standard pool fence.

21. Miss H called out to Ebony but Ebony did not respond. She ran to Ebony and noticed that she was blue in the face and was floppy and unresponsive.[26] She grabbed her around the belly pulling her backwards and Miss H said that Ebony's hands, which were holding onto the bars, came away easily.[27] Ebony was loose and limp in her arms.[28]

22. Miss H later described Ebony as being at the middle of the chickencoop gate, facing into the chicken yard, standing upright, with her head tilted to the left on her shoulder. She could not remember if Ebony's feet were touching the

[24] Transcript from 21 March 2023, T19, Miss P.
[25] T64, Miss H.
[26] Coronial Brief, Folio 4 and Folio 4A, Recorded statements, Miss H, 4 & 8 September 2023; T67-69, Miss H.
[27] Coronial Brief, Folio 4 and Folio 4A, Recorded statements, Miss H, 4 & 8 September 2023; T69, 131, Miss H.
[28] Coronial Brief, Folio 4 and Folio 4A, Recorded statements, Miss H, 4 & 8 September 2023; T70, Miss H.

ground. Miss H was firm in her recollection that when she located Ebony, no part of her head or her neck was stuck between the loops in the chickencoop gate.

Image 1. Photo taken on a later date depicting where Ebony was found. The island shed is to the left and Ebony was found upright against the chickencoop gate (the grey loop topped gate at the end of the path). Beyond that gate, to the left behind the island shed and to the right of the chickencoop fence (the fence with green mesh painted with flowers), is the chicken yard. The closer blue gate (depicted opened against the chickencoop fence) was installed immediately after this tragedy and, when closed, would prevent children accessing the chickencoop gate.

23. The chronology establishes that Ebony was last accounted for in a head count conducted at 11.32.30am. She did not leave the playground at about 11.37 with the other children. She was located unconscious at 11.41.18am. She had therefore not been positively accounted for or supervised, for just under 10 minutes.

24. Despite being CPR trained, when she found Ebony Miss H was understandably panicked and ran with her to the main office where the Centre Director (the original Centre Director) was sitting at her desk. The CCTV records her running into the office at 11.42:04 with Ebony in her arms. On the CCTV Ebony appears completely limp and very pale.[29] Believing that Ebony was choking[30] the original Centre Director conducted back blows and then ran out of the office with Ebony in her arms. She handed Ebony to Miss P and the two staff members ran to the Humpty Doo Surgery on Challenor Circuit ('Surgery') directly across the road from the Centre. The time was now 11.42:28.

25. Having heard the evidence of Drs Tiemensma and Barker discussed in greater detail later in these findings, I am not critical of the Centre staff for not immediately commencing CPR. While the preferable response may have been to commence CPR, given the proximity of the surgery and the extent of Ebony's injury, it was understandable and also reasonable to run her across the road where she could be attended to by a doctor.

000 calls and emergency response

26. Another Centre staff member made the first 000 call at 11.44:04am,[31] requesting assistance and alerting Northern Territory Police, St John Ambulance and the Northern Territory Fire and Rescue Service of the emergency.

27. The call log from this first 000 call includes, at 11.45:19am, an event remark; a *"child has been ran over to the clinic across the road."*[32] There was initially some confusion about the nature of the emergency. It was thought that a child was struck by a vehicle (run over)[33] but it was soon clarified that

[29] Brief of evidence, Folio 38.1. Additional documents, Folio 17, Report of Dr Ruth Barker.
[30] T184, RM.
[31] Brief of evidence, Folio 38.6.1 – JESCC Call Recordings.
[32] Brief of evidence, Folio 2, CAD Chronology -P23240338.
[33] Brief of evidence, Folio 24, Affidavit of Sgt Wayne Roomes, dated 12 January 2024, [2].

it was believed to be a choking incident. There is nothing to indicate that this short period of confusion caused any delay in the response of emergency services.

28. Police, Fire and Rescue and St John Ambulance were advised of the emergency at 11.46am. Fire and Rescue officers from the Humpty Doo Fire Station were immediately dispatched and initially incorrectly attended at the Arafura Medical Clinic in the Humpty Doo shopping centre, however, were quickly redirected to the nearby Surgery on Challenor Circuit.

29. A further 000 call was made at 11.47am by a Surgery staff member.[34]

30. Fire and Rescue were first on the scene, followed by Police. An ambulance was dispatched at 11.47:24am[35] and arrived at the surgery at 12.08:56pm.

Humpty Doo Surgery

31. Doctor Khan was the General Practitioner on duty at the Surgery and attending to another patient when he heard that Ebony had been brought in. He immediately went to her. He noted that her face and lips were blue, she was floppy, not breathing and had no heart rate. Dr Khan placed Ebony on a treatment bed, commenced CPR and directed his staff to call an ambulance.[36]

32. While he was conducting CPR, Ebony *seemingly* vomited which he cleared with suction. Dr Khan did not see any foreign item in the vomit that may have caused her to choke.[37] I use the word *seemingly* because Dr Ruth Barker, an emergency paediatrician with over 30 years of clinical experience and Director of the Queensland Injury Surveillance Unit, opined in her evidence that what Dr Khan observed was not active vomiting (which would require a level of consciousness). Instead, she explained this 'vomit' as

[34] Brief of evidence, Folio 38.6.4 – JESCC Call Recordings.
[35] Brief of evidence, Folio 11, St Johns Case Card - D00626537.
[36] Brief of evidence, Folio 6, Statement of Dr Khan, dated 12 September 2023, [3].
[37] Brief of evidence, Folio 6, Statement of Dr Khan, dated 12 September 2023, [4].

'passive regurgitation' arising from the resuscitation efforts.[38] Based on her expertise Dr Barker also clarified that a 'vomit' would not exclude the possibility of a foreign body in the airway, however she further explained that the possibility of choking was excluded by later treatments and at autopsy.[39]

33. CPR continued and when Fire and Rescue members arrived they assisted with the resuscitation efforts. Two St John paramedics and two intensive care paramedics arrived at 12.08:56pm.[40]

34. Prior to the arrival of emergency services, Dr Khan requested that the original Centre Director get a defibrillator from the Centre, which she ran to collect.[41] It was not clear why that happened as the Surgery also had a defibrillator. However, it seems that the Surgery defibrillator was fitted with pads for an adult and was not set up for a child, whereas the Centre machine was.[42] The original Centre Director returned with the Centre defibrillator which Dr Khan used on Ebony and it advised 'no shock'. A Fire and Rescue member realised shortly after his arrival that the pads were not correctly attached to Ebony.[43] This was immediately rectified and 'no shock' was again advised, meaning no pulse was present.[44]

35. Ambulance Paramedics took over the treatment of Ebony, while Fire and Rescue continued CPR. There was no obvious trauma identified. A glucose check was conducted and, due to major concerns of hypoxia, an Endotracheal Tube (ET) was inserted to assist with breathing.[45] When inserting the ET,

[38] T41 21 March 2025, Dr Ruth Barker.
[39] T51 21 March 2025, Dr Ruth Barker.
[40] Brief of evidence, Folio 11, St John Case Card – D00626537; Folio 10, Statement of Intensive Care Paramedic, dated 11 September 2023.
[41] T184, RM.
[42] T227, Dr Khan.
[43] Brief of evidence, Folio 7, Statement synopsis NT Fire Service member, 12 September 2023.
[44] Brief of evidence, Folio 8, NT Fire and Rescue Service Incident Brief.
[45] Brief of evidence, Folio 10, Affidavit of Paramedic, dated 11 September 2023, [15].

the Paramedic had a clear view of Ebony's airway and vocal cords and did not see anything to indicate that choking was a cause for her collapse.[46]

36. An interosseous infusion (IO) was inserted into Ebony's leg for the administration of adrenaline and the Centre's defibrillator was swapped out for a St John machine which showed that there was no heart activity. CPR continued and adrenaline was administered via the IO needle.

37. At about 12.24pm it was observed that Ebony's C02 levels were increasing and there was a return of spontaneous circulation. The Paramedics moved Ebony from the Surgery to the ambulance for transport to hospital while continuing to perform CPR. In the ambulance a pulse check confirmed she had a good pulse and good rhythm and a 12 lead ECG was attached.[47] The ambulance departed the Surgery at 12.26:29pm.[48]

38. Dr Barker explained that the apparent improvement in Ebony's condition was due to blood circulation from the manual 'bagging' and chest 'compressions'. Sadly, Dr Barker also explained that even though Ebony's circulation had improved it was too late for Ebony's brain to recover from the hypoxic injury that had already occurred.[49]

39. Jade was notified of the emergency and arrived at the surgery by 12pm.[50] She waited on the veranda, distraught, while Ebony was receiving emergency care. She travelled in the ambulance with Ebony[51] and a Police officer drove her car to the hospital.[52]

[46] Brief of evidence, Folio 10, Affidavit of Paramedic, dated 11 September 2023, [9].
[47]Brief of evidence, Folio 10, Affidavit of Paramedic, dated 11 September 2023, [10]-[11].
[48] Brief of evidence, Folio 10, Affidavit of Paramedic, dated 11 September 2023,[11].
[49] T43 21 March 2025, Dr Ruth Barker.
[50] Brief of evidence, Folio 9, Event Chronology – F23014712 – NT Fire and Rescue Service.
[51] Brief of evidence, Folio 10, Affidavit of Paramedic, dated 11 September 2023, [11]; Folio 11, St Johns case card.
[52] Brief of evidence, Folio 24, Affidavit of Sergeant Wayne Roomes, dated 12 January 2024, [12].

40. En route to the hospital, Paramedics continued ventilating Ebony with the goal of keeping her C02 at appropriate levels. Fluids were being introduced through the IO. Ebony was checked for bites but none were found.[53]

41. As Ebony appeared semi-stable, an appropriate decision was made to take her to Royal Darwin Hospital (RDH) instead of the Palmerston Regional Hospital (PRH) so that she could receive a greater acuity of care and to avoid a further transfer.[54]

42. The ambulance arrived at RDH at 12.51:14pm. Ebony was admitted to the Emergency Department and soon after transferred to the Intensive Care Unit (ICU) and intubated.[55] Dr Barker explained that this intubation process also excluded the possibility of an airway obstruction from a foreign object.[56]

Sergeant Roomes

43. Sergeant Wayne Roomes, the Officer in Charge of the Humpty Doo Police station, was alerted to the 000 emergency call while he was out getting lunch. Initially, he was advised that there had been a motor vehicle accident and a child had been run over, however, he soon clarified that it was a medical event and the child was at a medical centre in Humpty Doo.[57]

44. Sgt Roomes immediately made his way to the Arafura Medical Clinic in the Humpty Doo shopping centre, was advised that Fire and Rescue had also just been there, and he too was promptly re-directed to the nearby surgery on Challenor Circuit. When he arrived at the Surgery, he observed that Fire and Rescue officers were present and Jade was with another Police officer (the First Policeman) who had responded to an 'any unit call'. The First Policeman briefed Sgt Roomes. Sgt Roomes requested that the First

[53] Brief of evidence, Folio 10, Affidavit of Paramedic, dated 11 September 2023, [12].
[54] Brief of evidence, Folio 10, Affidavit of Paramedic, dated 11 September 2023, [13].
[55] Brief of evidence, Folio 10, Affidavit of Paramedic, dated 11 September 2023, [13]-[14]; Folio 11, St Johns case card; Folio 12, ICU Summary.
[56] T52 21 March 2025, Dr Ruth Barker.
[57] T22, Sgt Roomes.

Policeman record everything in his notebook as the Sergeant did not have his Body Worn Video camera or Police issued notebook with him as he was not rostered on active response duties that day.[58]

45. Sgt Roomes assessed the scene in the Surgery including the resuscitation efforts. He learned that the child was Ebony Thompson, he spoke with Jade, and he arranged for a female Police officer (who was a neighbour and close personal friend to Jade) to attend and provide support.

46. Sgt Roomes spoke with Dr Khan who reported that he thought that Ebony had some level of consciousness.[59] Dr Khan was asked about this in the Inquest and said that, on reflection, he was mistaken. He explained that he now believed that what he had previously thought may have been a level of consciousness was more likely a reflexive response to the CPR.[60] By the time of the inquest, he considered that when Ebony was brought into his surgery she was likely "gone" for 10 minutes and "maybe more" because she was completely blue in her face, arms and legs, she did not have a pulse and was not breathing.[61] However, he said that, even so, because she was a child, "we had to try and see if we can revive her."[62]

47. Sgt Roomes spoke to Jade before she left in the ambulance with Ebony. He then told attending Police officers to go to the Centre and speak with staff and he then also crossed the road to the Centre.

48. While Ebony was at the Surgery, Miss K conducted a quick examination of the area where Ebony had been found in an effort to try and work out what had befallen her. She looked for hazards such as snakes and spiders. Miss K saw a red, yellow and blue tricycle *tipped on its side* near the chickencoop

[58] Brief of evidence, Folio 24, Affidavit of Sergeant Wayne Roomes, dated 12 January 2024; T22, Sgt Roomes.
[59]Brief of evidence, Folio 24, Affidavit of Sergeant Wayne Roomes, dated 12 January 2024, [9].
[60] T226, Dr Khan.
[61] T225, Dr Khan.
[62] T226, Dr Khan.

gate where Ebony was found. She picked the tricycle up and checked it for hazards. When she found nothing, she placed it *upright* back on the ground.[63]

49. When Sgt Roomes arrived at the Centre, Miss H showed him where she had found Ebony and provided a description of what had occurred.[64]

50. From the information he received, Sgt Roomes understood that Ebony had been found "standing upright against a waist height (for an adult) fence in an unresponsive state," before being picked up by Miss H and rushed across to the Surgery for assistance.[65] He found it hard to understand how Ebony was upright when found, given that she was unresponsive, not breathing and blue in the face.[66] Sgt Roomes asked Miss H several times to clarify that information and she demonstrated Ebony's position. Miss H remained adamant that Ebony was upright and standing.[67]

51. Sgt Roomes saw the small red, yellow, and blue tricycle close to the loop topped fence and noted that there were no other toys or items nearby. He used the back of his hand to check that the shed wall and fences surrounding the area were not electrified and stepped over the gate and into the chickencoop to search for snakes or other venomous creatures but did not find anything. He took photos of the area where Ebony was found.[68]

[63] Brief of evidence, Folio 38.3.5 – AV Statement, KM.
[64] Brief of evidence, Folio 24, Affidavit of Sergeant Wayne Roomes, dated 12 January 2024.
[65] Brief of evidence, Folio 24, Affidavit of Sergeant Wayne Roomes, dated 12 January 2024, [17].
[66] T23-25, Sgt Roomes.
[67] Brief of evidence, Folio 24, Affidavit of Sergeant Wayne Roomes, dated 12 January 2024 , [17].
[68] Inquest exhibit, E6.

Image 2. Photograph taken by Sgt Roomes of the location Ebony was found.

52. Based on the information received and his assessment of the scene, Sgt Roomes formed the opinion that Ebony was possibly trying to get over the chickencoop gate by standing on the tricycle. He thought the tricycle might have rolled out from under her or tipped over while she was leaning over the gate. He thought this might have caused her to 'drop' and her head or jaw might have become wedged between the chickencoop gate loops. If so, this

may have put pressure on her neck causing Ebony to become unconscious.[69] As it turns out, having heard all the evidence I have come to the same conclusion.

53. When Sgt Roomes was examining the scene, and in light of what he had been told by Dr Khan, he believed that Ebony would survive. It was reasonable for him to conclude that the circumstances of her injury did not warrant a criminal investigation and nor did he suspect that an offence relevant to establishing a crime scene under the *Police Administration Act*[70] had occurred.

The island shed and chickencoop

54. The gate to enter the chickencoop was a loop top style gate. The gate measured 800mm from the ground to the top horizontal bar, 900mm from the ground to the top of the loops and 90mm between each loop.

55. The chickencoop gate was at the end of the pathway behind the island shed. The pathway behind the island shed was a known supervision 'blind spot' in the Green Ants playground.[71] Educators situated in the playground could not see behind the island shed except if they were positioned at the back of the playground not far from the chickencoop.

56. In an effort to establish the island shed's provenance, the Centre records were perused and revealed that it was likely constructed around the end of 1992 but situated at a different location in the Centre. It was moved in about July 2002 but it is unclear where it was placed. A photograph from the Centre files shows that that it was in the location shown in Image 3 (below) by February 2005. The original Centre Director recalled that it was in this same location when she started at the centre in August 2011.[72] At the very least,

[69] Brief of evidence, Folio 24, Affidavit of Sergeant Wayne Roomes, dated 12 January 2024, [19].
[70] Brief of evidence, Folio 24, Affidavit of Sergeant Wayne Roomes, dated 12 January 2024, [20].
[71] T99, T110, Miss H; T145, Miss K; T189, RM.
[72] T185, RM.

the evidence established that it had been in this location for well over 10 years.[73]

Image 3. Green Ants playground with island shed in background. The blind spot is effectively the area in shadow over the path, to the right of the island shed in this image.

57. When she started at the Centre in 2011, the original Centre Director recalled that the chickencoop was in the area marked with a blue line in Image 4 (below), and the chickencoop gate was already in situ, as an entrance into the chickencoop. The position of the island shed relative to the chickencoop gate and the rest of the playground, meant that the chickencoop gate was in the 'blind spot' created by the island shed.[74] That is, the gate could not be seen from most of the playground.

58. The original Centre Director said that the unfenced area in Image 4 (where the boat and raised garden bed are depicted) was a concern for hazards such as snakes, leaf matter and mud. To stop the children accessing that area, in

[73] It was moved again after Ebony passed away. Additional documents, Folio 12, Email HDCCC.
[74] T186; T189, RM.

April 2022[75] the chickencoop fence was moved to follow the red line depicted next to the path. That is, to the location it was in when Ebony passed away. This change in fence line enlarged the chickencoop and decreased the size of the playground. When the fence line was reconfigured, the chicken coop gate remained in situ, as a means of access to the chickencoop.[76]

Image 4. Depicting the locations of the old (blue) and new (red) chicken fence lines

Cause of death

59. On 4 September 2023, an autopsy was conducted by Forensic Pathologist, Dr Althea Neblett. Ebony's height was recorded as 90cm (or 900mm)[77] which is the same height as the chickencoop gate from ground to loop top.

60. Following a full postmortem and ancillary investigations and on the information available to her at that time, the cause of Ebony's death was 'undetermined'. Whilst Dr Neblett could not rule out pressure to the neck as

[75] Additional documents, Folio 28, Invoice from BB; T188, RM.
[76] T185-188, RM.
[77] Brief of evidence, Folio 15, Postmortem Examination Report for the Coroner, dated 15 December 2023, page 7.

a possible cause of death, she reported that on the limited history and circumstances known to her, it was less likely that Ebony died as a result of hanging.[78]

61. Dr Marianne Tiemensma was the Chief Forensic Pathologist in the Northern Territory at that time. She discussed the case with Dr Neblett as part of a peer review and agreed with the conclusion that, based on the information available at that time, the cause of death was 'undetermined'.

62. Given the undetermined finding, an expert opinion was sought from Dr Sarah Parsons, Forensic Pathologist at the Victoria Institute of Forensic Medicine.[79] Following a review by Dr Parsons of the investigation materials and autopsy report she also agreed that the cause of death was 'undetermined'.

63. This was a complicated case and in an effort to understand why Ebony passed away Dr Tiemensma provided further expert forensic evidence at the inquest.

64. As Dr Tiemensma explained, in the autopsy report the term 'undetermined' means that the cause of death could not be determined from the autopsy alone.[80] However, in Ebony's case, the autopsy eliminated several possible causes of death. The autopsy found: no congenital abnormalities; no evidence of cardiac abnormality; no evidence of infection or sepsis; and no signs of trauma, anaphylaxis or snake bite.[81] Via genetic testing, the taking of a family history and considering the circumstances as to her position when found, cardiac arrythmia and seizure activity were also excluded.[82]

65. The possibility of choking was considered by Dr Tiemensma. According to Dr Tiemensma the interventions and treatment provided by the original

[78] Brief of evidence, Folio 15, Postmortem Examination Report for the Coroner, dated 15 December, 2023, page 15.
[79] Additional documents, Folio 2, Report of Dr Sarah Parsons, dated 2 July 2024.
[80] Transcript 21 March 2024, T64, Dr Tiemensma.
[81] Transcript 21 March 2024, T65, Dr Tiemensma.
[82] Transcript 21 March 2024, T65, Dr Tiemensma.

Centre Manger, Dr Khan, St John Ambulance and at the hospital provided evidence that there was no object on which Ebony might have choked; and no potential choking object was found at autopsy. In combination, this evidence satisfied Dr Tiemensma that choking, as a possible cause of death, was excluded.[83]

66. Dr Tiemensma then considered the possibility of a hypoxic injury from pressure to Ebony's neck. That Ebony had been unconscious and in an upright position when she was found was, according to Dr Tiemensma, a very "important clue." Dr Tiemensma explained that as Ebony was unconscious she could not have been standing or supporting her own body weight, so something must have been holding her upright. Dr Tiemensma opined that Ebony must have been "propped up by external forces" causing "pressure to her neck." It was her opinion that Ebony had suffered a hypoxic brain injury caused by pressure to her neck, which included compression of the arteries, veins, baroreceptors and airways.[84]

67. Dr Tiemensma explained that children have small airways and their neck tissues are very soft and pliable. She said that it does not take much pressure to compress structures in a child's neck and a loss of consciousness can occur as rapidly as 10 to 15 seconds. Without oxygen to the brain, irreversible brain damage occurs within three to four minutes.[85]

68. Dr Tiemensma considered Ebony's appearance depicted in the CCTV after she was recovered from the chickencoop gate, particularly when taken to the Centre office. She noted that Ebony was completely unresponsive, grey in colour and there was a complete loss of muscle tone. According to Dr Tiemensma, it was evident that Ebony had suffered a severe injury. Without a pulse, Ebony's prognosis was very poor. Tragically, any children who do

[83] Transcript 21 March 2024, T65, Dr Tiemensma.
[84] Transcript 21 March 2024, T65, 66, Dr Tiemensma.
[85] Transcript 21 March 2024, T66, Dr Tiemensma.

survive a similar but less severe injury are left with irreversible and significant neurological disability.

69. Dr Tiemensma carefully and sensitively explained to Ebony's family that following compression of her neck, Ebony quickly fell into unconsciousness, likely without noticing. It is unlikely that she would have suffered any significant pain.[86]

70. There was no bruising or injury to Ebony's neck at autopsy. Dr Tiemensma explained that whether an injury may be found is dependent on factors such as the amount of time Ebony was suspended, the nature of the surface, and time for healing while she was in the ICU.[87] That there was no injury was not unusual, Dr Tiemensma said.

71. Doctor Ruth Barker, an emergency paediatrician with over 30 years' clinical experience and the Director of the Queensland Injury Surveillance Unit referred to earlier in these findings, agreed with Dr Tiemensma's opinion as to cause of death.[88] It was Dr Barker's opinion that when Ebony was pulled from the gate, limp and blue, she was unconscious and likely hypotensive. She explained that once a person is unconscious they cannot bear their own weight. Given Ebony's physical state when she was found it was not possible for her to have been standing (bearing her own weight). It was Dr Barker's opinion that the only explanation as to how Ebony could be upright (and giving the appearance of standing), was entrapment and suspension by the neck.[89] Dr Barker opined that it was likely that Ebony got her head stuck between the loops of the chickencoop gate, and through a combination of airway compression and carotid compression, rapidly became unconscious.[90]

[86] Transcript 21 March 2024, T69, Dr Tiemensma.
[87] Transcript 21 March 2024, T65-T66, Dr Tiemensma.
[88] Additional documents, Folio 17, Report of Dr Ruth Barker.
[89] Transcript from 21 March 2023, T36, Dr Barker.
[90] Transcript from 21 March 2023, T36, Dr Barker.

72. Dr Barker was of the opinion that Ebony had been entrapped less than the 10 minutes mentioned by Dr Khan.[91]

73. According to Jade, Ebony was keen on her food and would normally be one of the first to respond for lunch. The CCTV/timeline evidence established that Ebony was last accounted for during the Xplore Playground headcount check at 11:32:30am. The children started washing hands in preparation for lunch at about 11.37am. Ebony did not participate in the preparations for lunch and was found at 11.41:18am. Considering the important information provided by Jade concerning Ebony's usual habits, I am satisfied that Ebony was prevented from responding to the lunch procedure and it is likely she was already entrapped on the chickencoop gate at that time. That means she became entrapped by at least 11.37am. Accordingly, by the time she was found a minimum of four minutes had elapsed since she became entrapped, though it is possible she had been entrapped for a longer period.

74. There was another piece of circumstantial evidence that was significant. During the course of the inquest we learned that the nesting boxes and chicken feeders were located behind the island shed and to the left of the chickencoop gate. When she heard this evidence Jade seemingly understood Ebony's motivation for being at the chickencoop gate and trying to see over it. Jade said:[92]

> "*For weeks beforehand we'd been checking the neighbour's chooks and we'd been collecting the eggs from their baskets. So after they said that, that it was on the back wall, it makes perfect sense. She'd being doing it for weeks and weeks beforehand, because the neighbours had to go down south as an emergency and we were (inaudible) carry the eggs out and every day. It was like – it was her thing every day. So it makes sense that she would have been. I didn't sort of fully understand – I thought she was looking for chooks. But when they said there were baskets on that other side, now I understand.*
> ...

[91] Transcript from 21 March 2023, T41, Dr Barker.
[92] T38 21 March 2025 Jade Thompson (from the body of the court).

You couldn't – you couldn't see the chooks without getting over the fence and looking around the side."

75. Accepting Jade's evidence concerning Ebony's keen interest in the chickens and their eggs, I am satisfied that Ebony tried to look at the chickens and the nesting boxes behind the island shed. To do so she had to look over the chickencoop gate. As she was the same height as the gate, she needed to get higher to look over the gate. To gain the extra height, I am satisfied that she stood on the tricycle which gave her enough height to look over the top of the gate and see behind the shed.

76. The tricycle was originally found on its side. I find it likely that the tricycle rolled away or tipped out from underneath Ebony as she craned over the gate to see the chickens and their nesting boxes. As she lost her footing, Ebony dropped down on to the gate and became suspended by her neck, entrapped in the loops of the chickencoop gate. Whilst I accept that Miss H honestly believed that Ebony was standing, she was mistaken. All the expert medical evidence points to the fact that Ebony must have been entrapped by the neck when she was located at 11:41:18am.

77. Ebony was entrapped for four minutes or more. Accepting the expert evidence of Dr Tiemensma and Dr Barker concerning the speed at which a child would become unconscious due to compression of the neck and thereafter suffer irreversible brain injury, I am satisfied that when she was found (blue, floppy, unconscious and pulseless), her injury was catastrophic and unsurvivable. Immediate CPR would not have saved Ebony.

Formal Findings

78. Pursuant to Section 34 of the *Coroner's Act* I make the following formal findings:

    i. The identity of the deceased is Ebony Jules Thompson, born on 29 October 2021 in Darwin, Northern Territory.

ii. The time of death was 1805hrs on 2 September 2023. The place of death was Royal Darwin Hospital.

iii. The cause of death was hypoxic brain injury caused by pressure to the neck from entrapment on a gate and accidental hanging.

iv. The particulars required to register the death have been provided to the Office of Births, Deaths and Marriages.

Regulation of Child Care Centres in the Northern Territory

The National Quality Framework (NQF)[93]

79. The National Quality Framework (NQF) commenced in 2012, following agreement among all Australian jurisdictions to implement a national approach to regulate and improve the quality of early childhood education and care services.

80. The NQF includes:

    a. *Education and Care Services National Law Act* 2010 (National Law) and *Education and Care Services National Regulations* 2011 (National Regulations);

    b. National Quality Standards (NQS);

    c. Assessment and rating processes;

    d. National approved learning frameworks;

    e. A regulatory authority in each State and Territory responsible for the approval, monitoring and assessment of services in its jurisdiction;

[93] Australian Children's Education & Care Quality Authority: Guide to the National Quality Framework dated January 2025.

f. A national body, the *Australian Children's Education and Care Quality Authority* (ACEQA), which guides the implementation of the NQF and works with regulatory authorities.

Role of the QECNT

81. In the Northern Territory the National Law is applied through *the Education and Care Services (National Uniform Legislation) Act 2011 (NT)*.

82. Quality Education and Care Northern Territory (QECNT) is the regulatory authority in the Northern Territory and its responsibilities include:

    a. **Administration of the NQF**: QECNT monitors and enforces compliance with the National Law and National Regulations through regular inspections, compliance checks and enforcement actions.

    b. **Assessments and Ratings:** QECNT conducts formal assessments and rating visits of education and care services, and evaluates them against the seven quality areas of the National Quality Standards, namely,

    Quality Area 1: Educational program and practice
    Quality Area 2: Children's health and safety
    Quality Area 3: Physical environment
    Quality Area 4: Staffing arrangements
    Quality Area 5: Relationships with children
    Quality Area 6: Collaborative partnerships with families and communities
    Quality Area 7: Governance and leadership.

    c. **Complaints:** QECNT receives and investigates complaints.

    d. **Support and Guidance**: QECNT educates and informs services and the community about the NQF, in collaboration with ACEQA, through resources, learning modules and information sheets.

e. **Continuous Improvement:** QECNT promotes continuous quality improvement in education and care services.

f. **Information collection, review and reporting:** QECNT collects data and reports on the administration of the NQF and the regulation of services.

83. As part of its functions, QECNT conducts regulatory activities on approved services to monitor, assess and support the delivery of education and care services in the NT. These activities include but are not limited to: considering and investigating notifications, incidents and complaints; responding to queries from members of the public; conducting assessments; and amending service approvals. These regulatory activities may involve planned or unannounced site visits to assess service operations and address non-compliance.[94]

84. The assessment and rating process requires an assessment of each quality area against the NQS standard and related sections of the National Law and National Regulations.

Humpty Doo Community & Child Care Centre Inc.

85. The Humpty Doo Community & Child Care Centre Inc. (the Centre) is an incorporated body pursuant to the *Associations Act 2003 (NT)*. The Centre operates as a private, not-for-profit, community managed childcare provider and has been an 'approved provider'[95] under the National Law since 6 March 2012.[96]

[94] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025.
[95] An 'approved provider' is a person or entity that has been authorised by the relevant regulatory authority to operation one or more education and care services in accordance with the NQF.
[96] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025. [50]-[51].

86. The Centre is authorised by QECNT to operate two education and care services in accordance with the NQF. The Humpty Doo Community & Child Care Centre is one of two approved services.[97]

87. Where an approved provider is an organisation, each person with management or control of the education and care service must be deemed a 'fit and proper' person under the National Law and the approved provider must have at least one nominated supervisor.[98]

88. While the approved provider is legally accountable for ensuring that the service meets all regulatory requirements, the nominated supervisor is responsible for the day to day operation of the service and acts on behalf of the approved provider to ensure compliance with the National Law and Regulations including child safety, staffing and educational program delivery. On 31 August 2023, the Centre had four nominated persons responsible for management and control, and three nominated supervisors.[99]

89. Approved provider status is ongoing unless cancelled, suspended or surrendered and the provider must continue to meet the legal and regulatory obligations to retain its status.[100] The Centre attained its approved provider status in 2012 and that status has never been cancelled, suspended or surrendered.[101] When the Centre was granted its approved provider status the island shed and chickencoop gate were already in situ and the playground must have 'passed' any inspection processes.

90. Approved providers are required to apply for 'service approval' for each education and care service they provide. Each application must include key details such as: service type, physical location, maximum capacity and any conditions that must be met under the NQF such as 'ensuring the safety,

[97] The other is Humpty Doo Outside School Hours Care (OSHC) approved on 28 November 2018.
[98] *Education and Care Services National Law Act* 2010 (Vic), Schedule 12 and Schedule 161.
[99] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025, [56], [59].
[100] *Education and Care Services National Law Act* 2010 (Vic), Schedule 17, 30(3).
[101] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025, [50]-[61].

health and wellbeing of the children being educated and cared for by the service'. The National Law enables an approved provider to amend its service approval at any time but requires it to notify the regulatory authority of operational changes. It is also required to make notifications of specified incidents and/or complaints.[102]

91. In 2012, the Centre participated in the accreditation process under the National Quality Framework (NQF) which included a pre-assessment and rating visit by QECNT on 2 November 2012 and on 4 December 2012. Following that assessment the Centre was rated as *Working Towards NQS*. Throughout several assessments in 2015, 2018 and 2020,[103] the *Working Towards NQS* rating continued through to 20 October 2020.

92. However, in October 2020 the Centre was assessed as *Meeting* all seven quality areas under the NQF and the Centre retained this *Meeting* rating as at 31 August 2023.[104] At this time the island shed and chickencoop gate remained in situ.

93. The *Meeting* rating was obtained following a two day assessment conducted on 19 & 20 October 2020 by a QECNT authorised officer.[105] The evidence supporting the rating included the following findings:

a) In Quality Area 2: Children's health and safety

Standard 2.2 – Each child is protected

"Supervision practices were in place and educators move around the yard strategically ensuring that supervision is maintained. They were observed to check in with others as they moved from indoors to outdoors and changed locations to obtain resources or support children's play. Quality supervision has

[102] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025, [65].
[103] 27 & 28 July 2015; 27 & 28 September 2018, 19 & 20 October 2020; Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025, [67], Annexure LL-16.
[104] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025, [67].
[105] Additional documents, Folio 23, Statement of CT, dated 13 March 2025, Annexure 1.

recently been discussed at a staff meeting and educators reflected on what both quality and poor supervision looked like." [106]

b) In Quality Area 3 - Physical environment

Standard 3.2 – The service environment is inclusive, promotes competence and supports exploration and play-based learning

"…the outdoor spaces including a range of gardens and established trees available for climbing, including gardens sandpits, a chicken coop and various fixed and established climbing structures and bikes…additional resources are kept in various storerooms at the service or within the outdoor shed."[107]

94. There was nothing in the assessment to indicate that QECNT had any concerns around the Centre meeting the criteria for each of the seven quality areas including those for:

a) supervision practices, specifically, the assessment did not identify any concerns about supervision of the blind spot behind the island shed; or

b) physical environment, specifically, the assessment did not identify any concerns about the blind spot created by the island shed or the safety of the chickencoop gate.

Further instances of regulation by the NQF prior to 31 August 2023

95. QECNT conducted two regulatory visits at the Centre in the 12 months prior to 31 August 2023.

96. The first was a 'monitoring and compliance' visit in response to an incident which was reported by the Centre to QECNT on 8 July 2022, in compliance with its notification and reporting obligations under the National Law.[108] The report was about a child who had tripped while running to a water bubbler.

[106] Additional documents, Folio 23, Statement of CT, dated 13 March 2025, Annexure 1, p13.
[107] Additional documents, Folio 23, Statement of CT, dated 13 March 2025, Annexure 1, p16.
[108] *Education and Care Services National Law Act* 2010 (Vic), s174.

The child's mouth hit a concrete step and the child received injuries to 3 front teeth and the upper lip.[109]

97. Following a triage process by QECNT, the incident was deemed priority 3 'low risk'. A monitoring and compliance visit was conducted by QECNT on 4 October 2022 to observe the area where the incident had occurred.

98. This monitoring and compliance visit included a checklist (partially extracted in Image 5) relevant to an assessment of '*Quality Area 3 – Physical Environment*'. In this assessment the Centre's fencing was specifically recorded as 'compliant'.

QUALITY AREA 3 - PHYSICAL ENVIRONMENT	Compliant	Non-compliant	N/A
Regulation 103 - Premises, furniture and equipment to be safe, clean and in good repair • Includes indoor and outdoor furniture of all types • Adequate safety latches, door hinges etc. to protect from finger entrapments and any harm and hazard • Are electrical switches safe and out or reach or include a safety cover/plug? • Has consideration been given to the outdoor environment and fall heights, managing risk, location of play equipment to paths and hard surfaces • Is there adequate sand and soft fall as and where required	☑	☐	☐
Regulation 104 – Fencing • Outdoor space used by children at the premises is enclosed by a fence or barrier that is of a height and design that children preschool age or under cannot go through, over or under it.	☑	☐	☐

Image 5. Part of the 4 October 2022 QECNT checklist.

99. As the primary purpose of this visit was to consider the safety of the bubbler area, it is not known how thorough the fencing inspection was. However, if the entirety of the fencing/barriers were inspected (as is suggested by the checklist), then the NQF assessor must not have identified any risks or concerns about the chickencoop gate, being 900mm high with a looped top.

[109] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025,Annexure LL 17.

100. The second visit was in response to an incident on 21 February 2023. A child at the Centre accessed an open gate during an excursion activity, exited the Centre, and was later located in the Centre carpark. The incident was reported to QECNT as required. The report was triaged by QECNT and deemed to be priority 3 'low risk'. However, it was determined that an investigation into the matter was required.[110]

101. On 8 May 2023, QECNT authorised officers attended the Centre and conducted interviews with relevant staff and viewed the area where the incident occurred. They took photographs limited to the area of the incident. Given the purpose of the visit there was no requirement to conduct further inspections of the Centre.[111]

102. On 5 June 2023,[112] QECNT advised the Centre of the outcome of the investigation. Breaches under the NQF including, inadequate supervision, and a failure to protect children from harm or hazards, were identified.[113] In response to these breaches the Centre was required to take specific actions which included that it:[114]

- reflect on active supervision practices and consider precautions necessary to protect the safety, health and well-being of children.

- implement regular checks of the outdoor area to ensure safety.

103. On 19 June 2023, a nominated supervisor submitted a response to QECNT, attaching documents to demonstrate that the Centre had implemented the required actions.[115] These documents included: an environment checklist, copies of staff newsletters discussing head counts and supervision, a revised

[110] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025, [81].
[111] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025, [82].
[112] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025, Annexure LL-24.
[113] *Education and Care Services National Law Act* 2010 (Vic), Schedule 165(1) and 167(1).
[114] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025, Annexure LL-24.
[115] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025, Annexure LL-25.

supervision policy and procedure (extracted in Image 6 below), and an acknowledgement sheet signed by staff to record that they had read the policy documents. Only two of the educators present on 31 August 2023 had signed the acknowledgement sheet attached to the June 2023 response.[116] However, a later version, completed before 31 August 2023, was produced at the inquest. The later version was signed by all bar one of the educators responsible for Ebony in Green Ants on 31 August 2023. (Miss K did not sign it until 12 October 2023).

104. That the Centre was aware of the importance of supervision is demonstrated by a meeting on 30 August 2022, for Green Ants, Frillies and Possums staff, where the topic of 'Supervision' was on the agenda[117] with the following sub-headings:

- Supervision policy
- Supervision procedure
- Create supervision map

105. The minutes of the meeting on 30 August 2022 contain the following:[118]

II. Supervision

- **Supervision policy**
- All staff read through the Supervision Policy
- **Supervision procedure**
- All educators in Possums, Frillies and GA read through the Supervision Procedure & Active supervision strategies.
- All Educators were happy with the document
- We discussed that the will be displayed in there room.
- **Create supervision map**
- All Possum, Frillies and GA marked best places for educators to be supervising out in the yard and in red they marked high risk area that need to supervised at all times.
-

Image 6. Minutes of meeting 30 August 2022

[116] Miss H on 7/6/2023, Miss P on 7/6/2023.
[117] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025, Annexure LL-31.
[118] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025, Annexure LL-31.

106. The Green Ants supervision map annexed to the minutes of the 30 August 2022 meeting (reproduced in Image 7 and referred to hereafter as the original supervision map) identifies the playground's 'High Risk Areas' (marked by red asterisks). Five locations were marked with a red asterisk, including the long standing blind spot behind the island shed. For each of these locations the 'key' provides that "supervision is always required."[119]

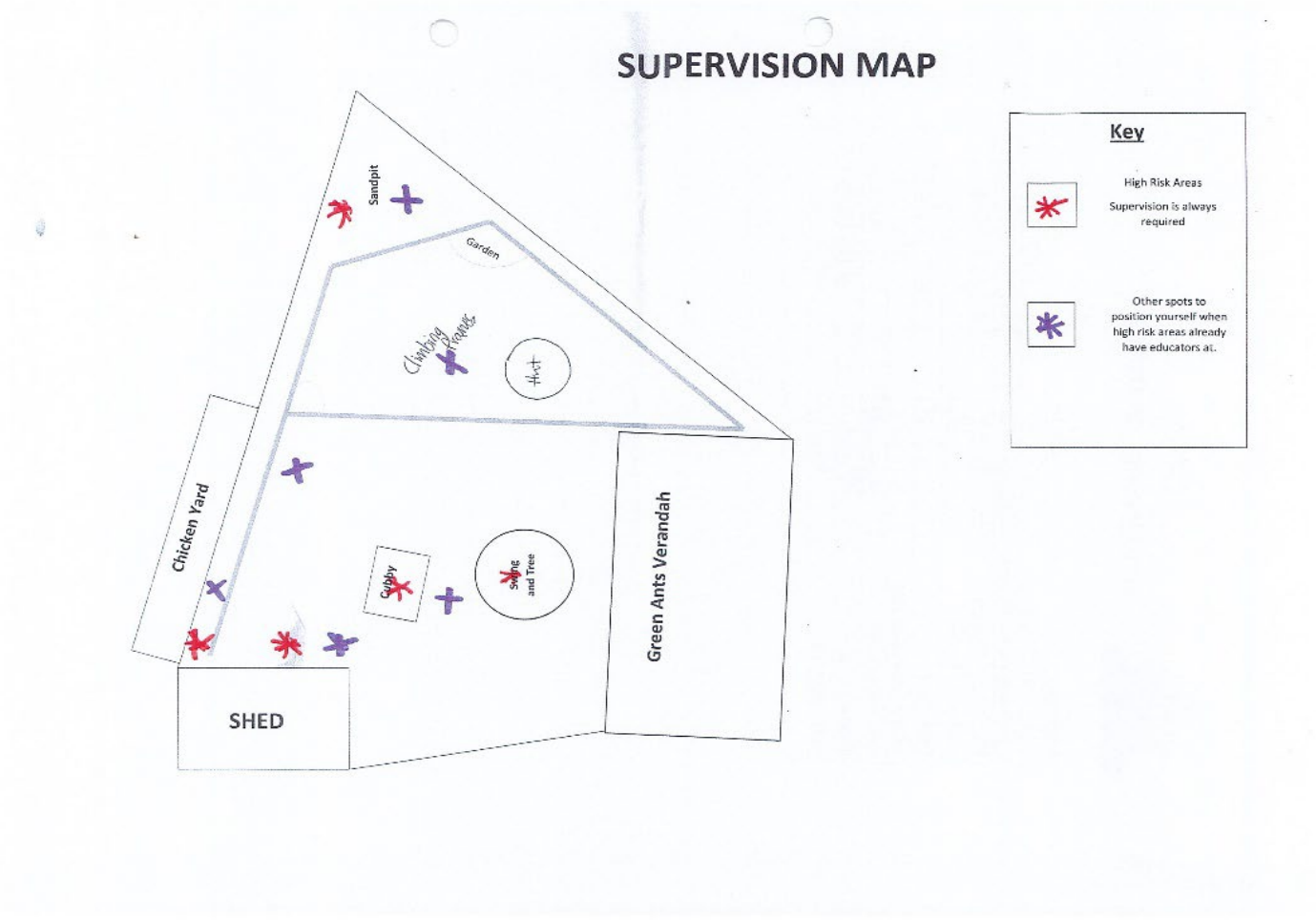

Image 7. Original supervision Map - 30 August 2022

107. I note that the original supervision map is inaccurate in that it does not depict a) the full extent of the chickencoop which extends around the island shed

[119] Inquest exhibit E7.

(referred to as ‘shed’ on the map); nor b) the full extent of the path which continues behind the island shed (as clearly depicted in Image 3).

108. None of the educators who were responsible for Ebony on 31 August 2023 were present at the 30 August 2022 staff meeting when the attending staff identified the high risk areas[120] and there is evidence that not all educators had a clear understanding or appreciation of those high risk areas within the playground.

109. Concerning the Green Ants original supervision map for example, Miss H said she was familiar with a ‘supervision map’ but she was not able to confidently say that she had seen the original supervision map depicted in Image 7, before Ebony passed away.[121] Miss H said that none of the areas marked by red asterisks were ever specifically pointed out to her as being high risk areas where supervision was always required, including the area behind the island shed,[122] but she agreed that it was common sense that behind the island shed was a blind spot that could only be supervised from limited locations in the playground.[123]

110. Miss U did not recall ever seeing the original supervision map and was not aware of any high risk areas in the playground.[124]

111. Miss K and Miss P both confirmed that the high risk area behind the chickencoop was known to them.[125]

112. Miss K understood that educators were expected to position themselves so that one of them could see the areas identified as high risk. She said that when an educator left such a position, they were to communicate that to

[120] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025LL-31; Miss H was not working in Green Ants at that time, T123, Miss H.
[121] T48-T49, Miss H.
[122] T 79, Miss H.
[123] T99-T100. Miss H.
[124] T257, Miss U.
[125] T145, Miss K and Transcript 20 March 2023, T9, Miss P.

another educator who was to take up the location.[126] However, she agreed that did not occur when she left the playground the day Ebony was injured and nor did she think it necessary on that day as there were no children behind the island shed when she left.[127]

113. A copy of an updated 'Supervision Map - Frillies and Green Ants' was received in evidence during the inquest.[128] I note that the inaccuracies concerning the location of the chickencoop and path continued on this version (depicted below in Image 8, hereinafter referred to as the updated supervision map). The dates on the updated supervision map indicate that it was reviewed and updated twice since the 30 August 2022 meeting. The dates noted on the document are:

Created	30/08/2022
Updated	02/10/2023
Updated	12/02/2024
Reviewed	10/12/2024
Reviewed	29/01/2025

114. As the first update is recorded as occurring on 2 October 2023, after Ebony had passed away, this means that on the day of the incident the original supervision map was in place.

[126] T138, Miss K.
[127] See also [13] of these Findings.
[128] Exhibit E7.

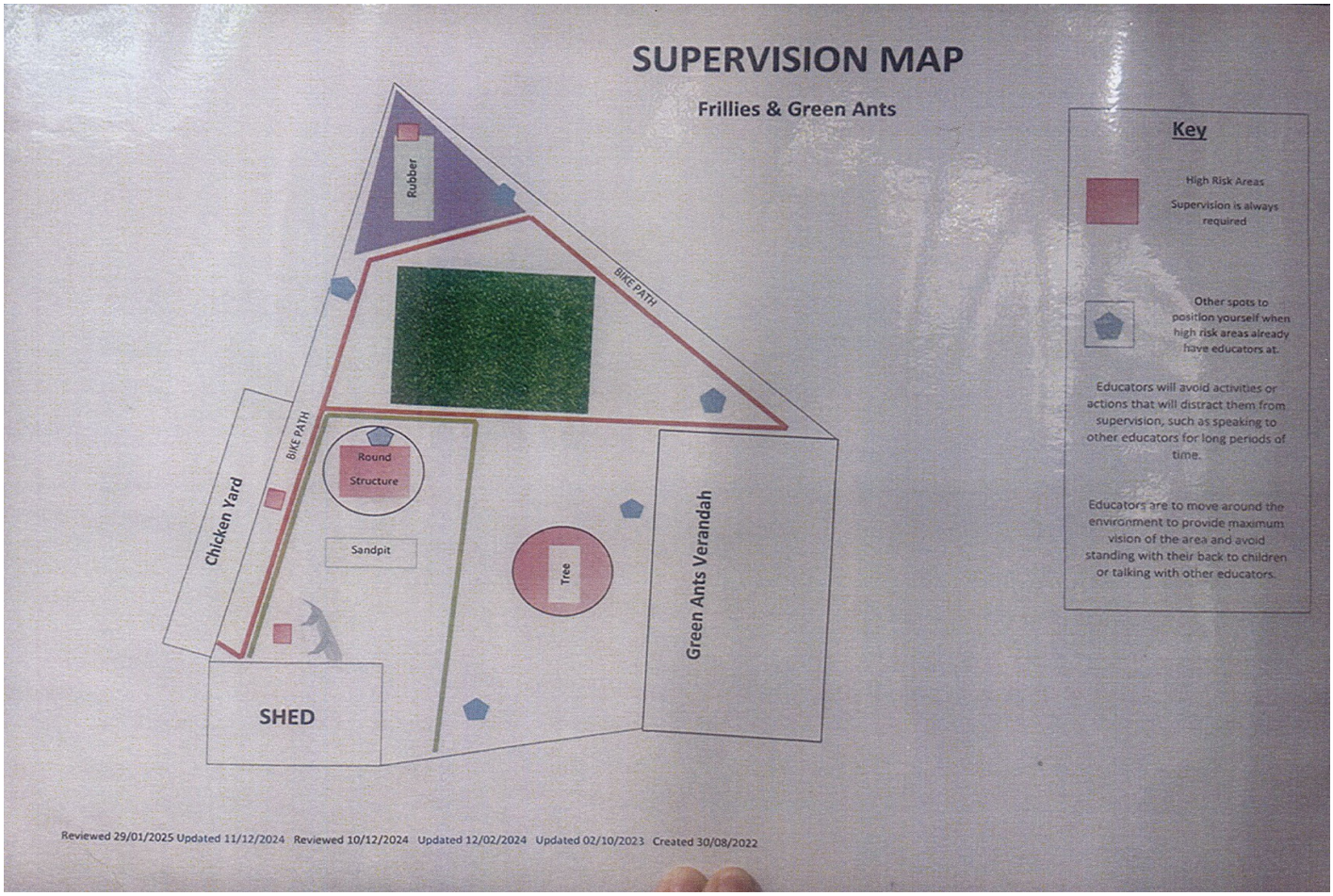

Image 8. Updated supervision map as at 29 January 2025

115. It is unclear from any versions of the map as to what a 'high risk area' is, and whether the map indicated that staff were required to be positioned at each of, or alternatively, in view of, the locations marked with a red asterisk. As there were 5 asterisks on the original supervision map and only 3 or 4 educators in the playground (or required to be present for staff to child ratio purposes), it was impossible for staff to be located at each asterisk.

116. The location where Ebony was found is marked with a red asterisk on the original supervision map. It is unclear from the evidence whether it was marked as high risk due to it being a blind spot, or because a risk associated with the chickencoop gate had been identified, or because some other risk had been identified. However, none of the educators on duty gave evidence that they considered that the chickencoop gate posed a risk to the children and in

those circumstances I suspect it was marked because it was a known blind spot.

117. The inadequate supervision at the Centre which was identified by QECNT as a result of their investigation in May 2023 indicated that the supervision strategies in place at that time were either insufficient, not understood or not followed, resulting in an unsupervised child gaining access to a carpark. There was clearly a lapse of supervision during which time this escape occurred and the outcome could have been far more serious if the child had not been located and promptly returned to the Centre. Whilst this incident required a response from the Centre which included an education session with staff regarding supervision and a revised Supervision Procedure (Image 9 below), the fact that Ebony was not positively accounted for over a ten minute period demonstrates that in spite of those efforts, there was another occasion of inadequate supervision, this time with tragic results.

SUPERVISION PROCEDURE

Effective supervision is integral to creating environments that are safe and responsive to children's needs and interests. Identifying potential risks and hazards allows educators to determine the level of supervision required for different situations and environments, whilst promoting children's agency, exploration and development.

Education and Care Services National Law or Regulations (R.101, 115, 120, 121, 122, 123, 126, 132, 133, 134, 166, 168, 176, 264) NQS QA 2: Element 2.2.1 and 2.2.2 Health practices and procedures
Related Policy: Supervision Policy

	SUPERVISION PROCEDURE
1	The Approved Provider, Nominated Supervisor and educators will review and update the Service's *Supervision Policy* each year
2	Educators are to be aware of where all children are at all times and monitor their environment closely
3	Educators are to be able to respond to any situation immediately, particular when a child is distressed or in a hazardous situation
4	The Nominated Supervisor/responsible person will develop and maintain rosters that ensure continuity of care and adequate supervision at all times when children are being cared for and educated at the Service and on excursions.
5	The Nominated Supervisor/responsible person is to adopt accepted best practice; ensuring no staff member is left alone with a child to support child protection protocols.
6	Educators will have a sound understanding of their duty of care and responsibilities in ensuring children are within a safe environment at all times
7	Educators will implement vigilant supervision strategies for hygiene requirements including: • regular handwashing • toileting (whilst maintaining children's privacy and dignity) • cough and sneeze routines- using disposable tissues and handwashing
8	The Nominated Supervisor/Responsible person will inform new and relief educators about supervision arrangements, outlining their supervision responsibilities
9	Educators will ensure that hazardous equipment and chemicals are inaccessible to children
10	Educators will ensure adequate supervision is provided when children are transported in a vehicle at all times (see *Safe Transportation Policy* and *Road Safety Policy*)

11	Educators will ensure a second staff member or nominated supervisor accounts for and supervises children as they get in or out of the vehicle.

ACTIVE SUPERVISION STRATEGIES

	ACTIVE SUPERVISION STRATEGIES
1	Educators are to communicate and collaborate with others to ensure the effective supervision of children within the Service.
2	Educators will avoid activities or actions that will distract them from supervision, such as speaking to other educators for long periods of time, taking personal phone calls, checking mobile phones or administrative tasks.
3	Educators are to position themselves to allow them to observe the maximum area possible
4	Educators are to move around the environment to provide maximum vision of the area and avoid standing with their back to children or talking with other educators.
5	Educators will alert other colleagues if they need to leave an area for a particular reason to ensure continuous supervision of children (e.g.: to obtain resources, visit the bathroom) another educator is to replace them, ensuring ratios are maintained at all times
6	Educators will actively engage with children to support their learning whilst actively supervising and observing children
7	Educators will ensure that all children are in sight and hearing of educators at all times
8	Educators will ensure that no child is left alone while eating or at nappy change and toileting times
9	Educators are to adequately supervise children during rest time in accordance with the Sleep and Rest Policy and relevant legislative requirements
10	Educators will scan the environment during interactions with individuals or small groups
11	Educators will listen closely to children whilst supervising areas that may not be in a direct line of sight noticing changes in volume or tone of voice
12	Educators will plan for a mixture of activities to allow for appropriate supervision of groups of children
13	Conversations with parents are to be kept under 5 minutes, please arrange a meeting with the parent if it is to talk in depth about their child.
14	Only one staff member is needed to talk to a parent at one time and be mindful to maintain supervision while talking to parents.

Image 9. Supervision procedure in force on 19 June 2023

118. Dr Barker considered the Centre's revised Supervision Procedure and the Active Supervision Strategies. Addressing Point 2 in the Supervision Procedure, it was Dr Barker's view that this was unrealistic. She said that it was not possible for every educator to 'be aware of where all children are at all times'. She explained that despite policies, training, best efforts and

intentions, educators will always be confronted with competing demands for their attention, and so it is impossible to eliminate all supervision lapses.

119. It was Dr Barker's view that there was (and is) an over-reliance on direct supervision for child safety when a more effective concomitant approach should include identifying and eliminating hazards.[129] Dr Barker explained that "supervision, despite best intentions, can vary. Therefore, environmental modifications, provided they are well designed and maintained, are the more reliable way to prevent most injury."[130]

120. I note that the updated supervision map no longer identifies the blind spot behind the island shed as high risk. This is because immediately after the incident involving Ebony, a new blue gate was fitted minimising the possibility of children accessing the blind spot or the chickencoop gate (the new blue gate is depicted in its open position in Image 1)[131,] and later the island shed and chickencoop gate were removed, thereby eliminating both environmental hazards.[132] That is, these changes to the physical environment reflect Dr Barker's recommended approach of eliminating environmental hazards to prevent injury. Tragically, this simple fix was too late for Ebony.

The Centre failed to notify QECNT of the change to the chickencoop fence.

121. Approved providers have reporting obligations under the National Law which include notifying the regulatory authority (QECNT) of any proposed change to premises[133] within 7 days.[134] Failure to comply with these obligations may result in financial penalty.[135]

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[129] Transcript from 21 March 2023, T33-34, Dr Barker.
[130] Additional documents, Folio 16, Kidsafe report of Dr Ruth Barker, p18.
[131] Additional documents, Folio 8, Affidavit Laura Lymer dated 25 February 2025 at [86.5], the new gate was fitted on 1 September 2023.
[132] Even though the island shed is still shown on the updated supervision map.
[133] *Education and Care Services National Law Act* 2010 (Vic), s174; s173(3)(c).
[134] Australian Children's Education & Care Authority, Guide to the National Quality Framework dated January 2025, p499.
[135] *Education and Care Services National Law Act* 2010 (Vic), s174(2), Penalty: $4,500 in the case of an individual; $22,900, in any other case.

122. In 2017, the original Centre Director notified QECNT of a change to the premises, namely, the removal of an internal fence to increase playground space. QECNT assessed the notification and decided that no further action needed to be taken.[136]

123. However, in 2022, inconsistent with its reporting obligations, the Centre Director did not notify QECNT of the change to the chickencoop fence, which reduced the available Green Ants playground space.

124. I heard evidence that if QECNT had been notified of the change to the chickencoop fence, then a QECNT authorised officer would have assessed the notification and determined what, if any, further action was required. That assessment may have included a phone call to the Centre to clarify the nature and extent of the work and/or the viewing of photos/diagrams of the proposed work and/or the Centre may have been asked to provide a risk assessment in circumstances where the proposed change affected site capacity.[137]

125. A risk assessment would have provided a targeted opportunity for any risks posed by the blind spot and/or the chickencoop gate to be identified by the Centre and QECNT. If the risk was identified then this should have resulted in steps being taken to eliminate or minimise the risk (for example by preventing children accessing the blind spot and gate).

126. Additionally, if QECNT had been notified of the change to the chickencoop fence it would have been recorded in their system as a site change which would likely have been inspected when the Centre was next visited by a QECNT authorised officer.[138] This would have provided yet another opportunity for any risks posed by the blind spot and gate to have been identified and addressed.

[136] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 18 February 2025, [98].
[137] T77, K Brennan.
[138] T77, K Brennan.

127. While it is by no means certain, and perhaps even unlikely, that the risks would have been recognised and/or identified, the failure of the Centre to notify QECNT of the change to the chickencoop fence was a missed opportunity by the Centre and QECNT to conduct a risk assessment, potentially identify the blind spot and chickencoop gate as risks and respond to them appropriately.

The regulation of fencing/barriers in childcare centres

128. Under the NQF, fencing in childcare centres must comply with National Regulation 104 which specifies that outdoor spaces used by children at the premises are to be enclosed by a fence or barrier that is of a height and design that children of preschool age or under 'cannot go through, over or under'. I consider that in this regulation the terms fence or barrier encompasses a gate. National Regulation 104 provides as follows:

104 Fencing

(1) The approved provider of an education and care service must ensure that any outdoor space used by children at the education and care service premises is enclosed by a fence or barrier that is of a height and design that children preschool age or under cannot go through, over or under it.

Penalty: $2000.

(2) This regulation does not apply to a centre-based service that primarily provides education and care to children over preschool age.

(3) This regulation does not apply in respect of a family day care residence or a family day care venue if all the children being educated and cared for at that residence or venue as part of a family day care service are over preschool age.

Image 10. National Regulation 104

129. Dr Barker, in her capacity as the President of Kidsafe Queensland, provided an instructive report setting out the risks associated with playground fencing (and equipment) in childcare centres.[139]

[139] Additional documents, Folio 16, Kidsafe report of Dr Ruth Barker.

130. These risks include entrapment and strangulation. Dr Barker explained that entrapment of a body part is a well-recognised mechanism of paediatric injury, and head entrapment is a known, time-critical, high risk hazard. Entrapment can result in fatal injury if there is hanging (the child is suspended by the neck) or there is sufficient pressure to obstruct air intake (airway compression) or vascular flow (arterial or venous compression).[140]

131. Dr Barker opines that *National Regulation 104* is inadequate. Firstly, it fails to address the risk to children of entrapment or strangulation posed by fencing and barriers. Second, it provides no guidance as to heights or design which might meet the standard of ensuring that 'children preschool age or under cannot go through, over or under it'. To illustrate this point, Dr Barker showed me videos of young children who could breach well- constructed and designed pool fencing with speed and agility. Unlike pool fencing regulations, *National Regulation 104* does not regulate the size of gaps, specify a minimum height, or provide examples of appropriate design. Nor does it consider or address entrapment risks. Dr Barker explained that *National Regulation 104* is less rigorous than the Australian Standards (AS) for playground fencing or the National Construction Code (NCC).

132. The National Construction Code (NCC) specifies that for Education and Care services (early childhood centres Class 9b buildings), fencing of outdoor play spaces including multistorey outdoor play spaces must comply with AS 1926.1. AS 1926.1 (updated in 2024) is the Australian standard which applies to Safety Barriers for Swimming Pools. It includes detailed diagrams and specifications for non-climbable zones, fence height, gaps, footholds, gates, automatic closing and latches etc. The standard also has a probe test, designed to ensure that no opening exceeds 100mm, to preclude a child getting their head through the barrier.

[140] Additional documents, Folio 16, Kidsafe report of Dr Ruth Barker, p2.

133. However, although the dangers of entrapment and hanging are identified and in Australian Standards applicable to playground equipment (AS 4685), AS 1926.1 contains no design requirement that addresses snag or neck entrapment/hanging hazards for fencing. While loop-topped fencing has been prevalent over the years and is a common sight, this style of fencing is now recognised by Kidsafe as creating an entrapment/strangulation risk. Kidsafe produces Fact Sheets explaining the risk and recommending 'flat top rails' for playground fencing and these Fact Sheets include photos of appropriate styles of fencing.

Top Rail Profile: A flat top rail is recommended. Loop top or rod top may potentially create a hanging point for a child's head between the pickets protruding above the top rail. For existing fences with protruding loops or rods at the top, ensure that climbing access to the top of the fence is not provided.

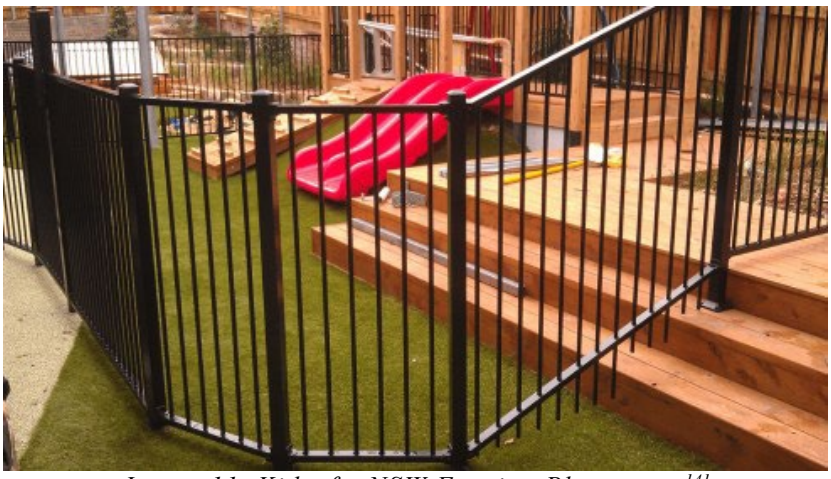

Image 11. Kidsafe NSW Fencing Playspaces[141]

[141] Additional Documents Folio 4 p2 and https://www.kidsafensw.org/imagesDB/documents/FencingPlayspaces2020_2.pdf.

134. That the risk of strangulation was not identified by the Centre or QECNT was tragic for Ebony but sadly did not surprise Dr Barker who frankly acknowledged,[142]

> *"This fencing entrapment and snag hazard is something that many early childcare providers are not aware of. It does not seem to be always picked during the development or compliance certification process and many rating and assessment officers (from regulatory bodies) licensing early childcare services are not always aware of it either."*

135. Following Ebony's death this lack of awareness must change. Kidsafe is doing what it can to raise awareness of this risk. I consider that the currently applicable fencing/barrier *National Regulation 104*, is inadequate. The Regulation is silent on the risks of entrapment and its minimal terms effectively authorised the presence of the lethal loop-topped chickencoop gate.

136. Dr Barker said that the NQF safety requirements for fencing/barriers should be upgraded to reflect the current Australian Standards and building codes relevant to fencing spaces for children, which in turn should be amended to incorporate standards for playground equipment in order to address and mitigate the risk of entrapment. Given that childcare centres cater for very young and vulnerable children, Dr Barker's opinions are persuasive and accord with commonsense. I will make a recommendation to support this reform.

137. This case exemplifies the need for expert oversight to assist with identifying and mitigating risks to children attending childcare services. Kidsafe entities throughout Australia provide playground inspection and risk assessment services. The Centre requested a Kidsafe playground inspection on 11 October

[142] Additional documents, Folio 16, Kidsafe report of Dr Ruth Barker, p13.

2023 and multiple risks of varying severity were identified including items that could pose a strangulation risk. Dr Barker opines that best practice in childcare provision should include regular playground certification and thorough all-of-service risk assessments by suitably qualified independent professionals.[143] I will make a recommendation with a view to encouraging service providers to undertake expert playground risk assessments.

Institutional response

138. Ms Lara Lymer, Acting Executive Director, Quality Standards and regulation in the Department of Education and Training, provided an affidavit dated 25 February 2025 outlining the institutional response to this tragedy.[144] QECNT immediately satisfied itself that access to the location was precluded by the installation of the new blue gate.[145] In those circumstances QECNT and the Department waited until police investigations were completed and then conducted:

    a. a Compliance and Monitoring review of the Centre on 5 October 2023 which resulted in the service of a Non-Compliance Notice and which identified actions in rectification to be undertaken,
    b. a QECNT Assessment and Rating review of the Centre on 12-13 November 2024 in which the Centre's rating was downgraded from *Meeting* to *Working Towards* the NQS and maximum capacity was reduced from 116 to 72 children, and
    c. an unannounced spot check on 10 January 2025 with further non-compliance issues identified.

139. Across the sector as a whole QECNT advises that it has increased its activities in respect of all service providers with the goal of ensuring high

[143] Additional documents, Folio 16, Kidsafe report of Dr Ruth Barker, p20.
[144] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 25 February 2025.
[145] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 25 February 2025 at [86.5].

standards of safety and quality are maintained in education and care services, including by:

a. offering educational sessions on request,
b. engaging in at least monthly communication on sector obligations through emails, letters and updates,
c. providing daily education support through a dedicated phone line and email ensuring approved providers can access regulatory guidance,
d. holding quarterly meetings with large approved-providers (operating 5 or more Centres),
e. requiring new providers to complete ACECQA learning modules, and
f. requiring new applicants to complete the National Law Provider Knowledge Assessment,
g. ensuring its authorised officers improve their knowledge and skills to regulate the sector, by engaging in dedicated training days, induction programs and professional development.

140. QECNT advised that commencing in February 2025 it would conduct a supervision audit across all approved services in the NT which includes:

a. a review of service providers' premises and environments,
b. the identification of blind spots and a consideration as to how each service manages these,
c. a consideration of each service's general risk management strategies,
d. a review of how each provider ensures children in its care receives adequate supervision at all times,[146]
e. support for service providers to understand their obligation with respect to adequate supervision at all times,
f. education on self-reporting obligations, and
g. an emphasis on the importance of timely reporting in maintaining compliance and ensuring child safety.

[146] Additional documents, Folio 8, Affidavit of Laura Lymer, dated 25 February 2025, [117]-[119].

141. As at the date of the inquest, all service providers had been requested to identify and document, including with photographs, any blind spots at their service locations, including as to how they are managed. This task in and of itself raises awareness and includes risk assessments by each service provider overseen by QECNT. I am advised that most service providers do have blind spots on premises. And I accept that whether and to what extent a blind spot creates a risk, and how that should be managed, is to be assessed case by case. Small blind spots, for example a tree trunk, may be less risky than larger blind spots, such as that created by the island shed. Blind spots in playgrounds for older children might be less risky than blind spots in playgrounds used by younger children. What is hidden by the blind spot might increase or decrease risk. I accept that it is the intention of this audit to identify and reduce any risks associated with blind spots.

142. Concerning the provision of photographs, Ms Katy Brennan, the Director of QECNT, explained that any fencing depicted in the photographs would also be reviewed for safety concerns given that fencing (and anything else hidden in a blind spot) gives rise to greater safety concerns over fencing that everyone can see. Ms Brennan further advised that authorised officers are now required to take photographs of fencing at every centre they visit so that QECNT has a comprehensive understanding of every fence at every service "so that they we can make some really clear distinctions around active supervision, [and] also around fencing."[147] However, Ms Brennan explained that as fencing standards are regulated by the National Framework, any change to those standards (such as recommended by Dr Barker) would have to be adopted nationally. The NT could not act unilaterally.

143. Concerning supervision, Ms Brennan initially considered that the policy, strategy and map used by the Centre were adequate documents but said there

[147] T p81 21 March 2025

was a failure to actively supervise on the day of the tragedy. In particular she pointed to a failure by the educators to do a yard check when the children transitioned to lunch. It was then identified that a yard check was not specifically provided for in the active supervision strategies (see Image 8). Ms Brennan agreed that the strategy could be improved by including a requirement that, when children are transitioning from one location to another, an educator is required to check the space they are departing to ensure no child is left behind; and also agreed that this had not been previously identified as a shortfall by QECNT in any of their reviews of the Centre.[148]

144. On reflection, it is difficult to understand how a yard check, or more broadly speaking a departure check, was not included as part of the active supervision strategy. Service providers and QECNT must be acutely aware of occasions when children have been left behind in childcare centres, on buses, on excursions or in public swimming pools, sometimes with tragic results. Head counts are one level of protection, a final sweep of the space being exited (a departure check) is a second line of defence that should have been part of the active supervision strategy. In my view, this was a systemic failure on the part of the Centre and QECNT.

Family Submissions

145. Ebony's family do not want any other family to suffer as they do. In response to her death and the identified shortfalls in supervision and environmental safety at the Centre, they proposed the following recommendations:

> *Recommendation 1 – "Ebony's Law"* -recommendation to the Attorney General (AG) to urgently implement legislation regulating the use of fencing in NT which has entrapment risks, including prohibition on the use of loop style pool fencing, and rectification of existing loop style pool fencing; Further, that the NT AG inform all AG's in Australia of the risks and that a

[148] T p84 and p99 21 March 2025

uniform approach should be adopted with respect to reviewing and modernising *Regulation 104*.

Recommendation 2 - "Supervision audits" - recommendation that the Department of Education and QECNT develop and introduce mandatory 6 monthly supervision audits across all childcare centres in NT, that include penalties for failure to do so, and penalties for failure to rectify identified issues in a timely manner;

Recommendation 3 - "High risk hazards" - recommendation that the Department for education and QECNT develop and introduce a standardised strategy and policy that requires childcare centres to identify high risks (and blind spots) and report those to QECNT for assessment as to best eliminate or minimise the risk, including by way of supervision.

Recommendation 4 - "Compliance checks" - recommendation that the AG NT implement legislation that mandates safety and compliance checks at CCC in the NT on an annual basis.

Recommendation 5 - "Ratios" - recommendation that the Department of Education and QECNT reduce the educator to child ratios from 1-4 to 1-3 for children under 2 years old, and ensuring all staff are required under the ratio policy to directly and actively supervise.

Recommendation 6 - "Supervision strategies" - recommendation that HDCCC and Department of Education adopt a mandatory policy that 'spot checks' are conducted in areas after all children transition;

Recommendation 7 - "Sanitary areas" - recommendation that HDCCC and with the imprimatur of the Department of Education and QECNT, all CCC in NT, have a sanitary area that is separate from the outdoor and indoor areas so that all children are accounted for during that process;

Recommendation 8 - "3 strikes rule" - recommendation that Department of Education develop and introduce a mandatory regime that any CCC in NT found to breach a supervision obligation on 3 or more occasions be immediately temporarily closed pending assessment and rectification of the supervision issue/s, and/or infringements are issued as authorised in law and regulation.

Recommendation 9 - "Playground app" - recommendation that the Department of Education develop and introduce a policy and strategy that provides much more structure and routine to head counts on the playground app as opposed to its present ad hoc use e.g. less frequent indoors, but for example, every 10 minutes outdoors and mandatory when transitioning.

Recommendation 10 - "SafeWork NT" – (NT WorkSafe) recommendation that the safety authority play a more active role in oversight and safety compliance of high risk areas, blind spots and hazard elimination, within childcare centres in the NT.

Recommendation 11 - "Collaboration" - QECNT collaborate with HDCCC to review all supervision procedures and policies are read and understood by educators and staff.

Recommendation 12 - "Policy review" - QECNT review HDCCC policies and practices to ensure they effectively influence educators.

146. It is understandable that Ebony's family to want to see sweeping changes given the magnitude of their loss. However, I consider that some of these recommendations fall beyond the scope of the limited evidence available to me through this one inquest alone. The more limited recommendations I make also take into account the steps already undertaken by QECNT in response to this tragedy. While my recommendations are not as comprehensive as those submitted by the family, each of the family's recommendations is worthy of

close consideration by the NT Government, and I have repeated all of them in full so that can occur.

Conclusion

147. Ebony's death was a preventable death and her family is devastated. Her death rightly shocked the broader public. Her family and the wider public deserve to be reassured that the cause of Ebony's death has been established and that steps have been taken to ensure a tragedy like this does not occur to another child, to another family, in this or any other childcare centre.

148. Ebony died because her neck became entrapped in between the loops of a loop-topped style gate. Her neck was compressed which restricted her breathing and the flow of blood to her brain. Without sufficient blood and oxygen travelling to her brain, she suffered irreversible brain damage and passed away from that brain damage.

149. The main factors that contributed to her death were:

    a. The presence of the low, loop-top style gate in the childcare centre playground. This style of fencing is permitted by the fencing regulations applicable to childcare centres even though Kidsafe has identified and published findings that this fencing poses entrapment and strangulation risks. Despite Kidsafe's efforts to alert relevant providers and authorities to these risks it seems they are still not well understood. The potential risks posed by this gate were not identified by the Centre, the educators on duty, or QECNT prior to this tragedy.

    b. The gate was located in a supervision blind spot. The gate could only be observed by educators standing reasonably close to it but otherwise could not be seen from most of the playground. Although some level of risk created by the blind spot was recognised by the Centre, the extent of the risk created by the gate was not appreciated, and the risk

as a whole was not adequately addressed or managed by the Centre or QECNT.

c. The active supervision strategies in place at the Centre failed. The evidence indicated that Ebony was unaccounted for for about 10 minutes which meant that:

    (i) There was inadequate active supervision of the children in the playground. This provided an opportunity for Ebony to enter and remain in the blind spot without it being noticed by any of the educators on duty.

    (ii) When the children transitioned from the playground to lunch there was no yard/playground/departure check to ensure that no child was left behind. Yard/departure checks were missing from the Centre's active supervision strategies and that this was lacking was not identified by the Centre or QECNT.

150. I extend my sincere condolences to Ebony's family.

Recommendations

151. **The NT Department of Education and Training** with QECNT will take all necessary steps to advocate for a strengthening of the fencing standard in the National Quality Framework so that fencing standards throughout childcare centres (not just perimeter fencing) are upgraded to reflect Kidsafe recommendations for child safe fencing including for entrapment and strangulation risks.

152. **The NT Department of Education and Training** with QECNT will ensure that its authorised officers are aware of entrapment and strangulation risks arising from fencing (and playground equipment) and require its authorised officers to take active steps to identify those risks and ensure they are addressed when carrying out their functions.

153. **The NT Department of Education and Training** with QECNT will put in place processes to: obtain and consider all Kidsafe Facts Sheets and or other Kidsafe notifications relevant to early childhood safety; ensure that its authorised officers are aware of any such notifications; and ensure that such notifications are shared with all childcare service providers.

154. **The NT Department of Education and Training** with QECNT will ensure that site visit documentation completed by its authorised officers includes a requirement to conduct fencing/barrier and blind spot inspections at regular intervals as determined as appropriate by QECNT and QECNT will maintain and retain current photos of inspected fences/barriers and blind spots.

155. **The NT Department of Education and Training** with QECNT will educate providers as to the benefits of engaging in Kidsafe (or similarly expert) playground inspections and service risk assessments. If playground (or other) safety concerns are identified by an authorised officer, where deemed appropriate, QECNT will require the service to engage in a Kidsafe (or similar) playground/risk assessment inspection.

156. **The NT Department of Education and Training** with QECNT will develop and conduct a supervision audit across all childcare centres in the NT. Penalties for any service that fails to fully participate in the audit and for any failures to rectify identified issues in a timely manner will be specified and should be applied. QECNT will conduct similar audits at a frequency determined by QECNT as considered necessary to ensure supervision standards are maintained.

157. **The NT Government** will undertake a public awareness campaign to alert the general public to the entrapment and strangulation risks of loop and rod topped fencing. If Ebony's family consents, the campaign might be called 'Ebony's Message' (or similar) in the future.