CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 19th day of November, the 3rd and 22nd days of December 2021, the 8th, 14th, 15th, 16th, 17th and 18th days of February, the 2nd, 23rd and 24th days of March 2022 and the 26th day of May 2023, by the Coroner's Court of the said State, constituted of Ian Lansell White, Deputy State Coroner, into the death of Lucas Latouche Mazzei.

The said Court finds that Lucas Latouche Mazzei aged 5 years, late of 57 Gardner Street, Plympton, South Australia died at the Women's and Children's Hospital, 72 King William Road, North Adelaide, South Australia on the 27th day of March 2017 as a result of acute upper airway obstruction. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. On Monday 27 March 2017, thirteen days after his 5th birthday, Lucas Latouche Mazzei was taken to school by his father Miguel Latouche. He attended Henley Beach Primary School[1] at Reception level. As his father described later that day, his son '*...was skipping to his classroom when I dropped him off and he was very happy this morning*'.[2]

[1] HBPS
[2] Exhibit C5, page 3

1.2. That afternoon Lucas was being supervised separately from his seven classmates. This was due to a reasonable decision of not having him engage in the science lesson that afternoon. It was considered he was at risk of ingesting dangerous substances.

1.3. Whilst separated from the class, and under the general supervision of his home room teacher and education support officer,[3] Lucas, without being noticed, obtained a nectarine from within the classroom. Moments later, he silently choked on the nectarine's stone while watching his favourite cartoon character The Gruffalo on the classroom's electronic smartboard.

1.4. He was first noticed to be in trouble when his teacher, Ms Gillian Reddick, returned from a brief visit to the administration area of the school. She enquired with him whether he wished to go to the bathroom. There was nothing to indicate that he was in distress at that time. However, as she described:

> '… when Lucas looked up at me and I noticed that his eyes were glassy … I realised something was wrong. Lucas' behaviour would not have otherwise attracted my attention. He was just sitting still, gazing at the screen.' [4]

Ms Reddick screamed out to the ESO, Ms Denise Hutton for assistance. As Ms Reddick said to South Australia Police[5] that day:

> 'I bent down to take his hand to encourage him to go to the toilet. Then I noticed he appeared to be choking. I got him under his arms and stood him up. I bent him over and started banging his back to clear his airway.' [6]

She assumed and believed that Lucas had not been eating at that time and that the classroom had been cleared and protected against any potential choking items.

1.5. What followed for the next few minutes were understandable heightened reactions by Ms Reddick and Ms Hutton in their attempts to help Lucas. When their efforts failed they contacted the administration area. Mr Shane Misso, the Principal of HBPS responded and rushed to the classroom. Ms Hutton then contacted the SA Ambulance Service.[7] A series of frantic attempts to save Lucas' life continued with guidance over

[3] ESO, also known as Student Support Officer (SSO)
[4] Exhibit C28a, pages 9-10
[5] SAPOL
[6] Exhibit C28, page 2
[7] SAAS

the phone from SAAS. This included at one stage, Mr Misso holding Lucas upside down to try and clear his airway.

1.6. SAAS arrived promptly at HBPS after being alerted. SAAS paramedics took over Mr Misso's CPR efforts and provided further medical treatment by suctioning Lucas' mouth and airway. Intensive care paramedic,[8] Mr Michael Cummings, intubated Lucas. As this emergency was unfolding, Lucas' father arrived at the classroom and assisted SAAS with suctioning Lucas' mouth and airway. He had been contacted by HBPS during this emergency.

1.7. I do not wish to describe Lucas' physical state other than it was a distressing one to see. He was transported by SAAS to the Women's and Children's Hospital[9] with CPR continuing, however he was unresponsive in the ambulance. Despite the best efforts of HBPS staff, SAAS paramedics and the medical staff at the WCH, Lucas was unable to be revived.[10] Lucas' life was declared extinct by WCH at 3:45pm on Monday, 27 March 2017.[11]

1.8. This very distressing attempt to save Lucas' life has had a marked effect on those involved in this heartbreaking and tragic incident at HBPS. Mr Misso agreed at the Inquest that it was the worst day of his professional life.[12]

1.9. Lucas' parents have been '*consumed by grief*'[13] over the death of their precious little son that day.

2. Finding as to cause of death

2.1. Pursuant to my duty under the Act, I must make a formal finding concerning the cause of Lucas' death. As indicated, Lucas died at the WCH on the afternoon of 27 March 2017. A post-mortem examination was conducted by Dr Stephen Wills, forensic pathologist employed at Forensic Science South Australia.[14] This occurred on Wednesday, 29 March 2017 at FSSA.

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[8] ICP
[9] WCH
[10] Exhibit C24. See also Exhibit C11, summary of medical assistance by Investigating Officer Detective Brevet Sergeant Leigh Haring
[11] Exhibit C11, page 11
[12] Transcript, page 512
[13] Exhibit C16a, page 22 and Exhibit C1a
[14] FSSA

2.2. In his detailed post-mortem report, Dr Wills concluded that Lucas' death '*…has most likely resulted from acute upper airway obstruction from the fruit stone*'.[15] Dr Wills further stated that it was likely that the nectarine stone caused Lucas to choke. The stone was found by Dr Wills within the '*nasopharynx and post-nasal space around and just above the level of the soft palate*'[16] and due to '*medical intervention and intubation, its original position could not be confirmed by post-mortem examination*'.[17] Expert evidence was that the stone probably moved to that area during attempts to save Lucas at HBPS. I am prepared to find that this nectarine stone was the cause of Lucas choking based on Dr Wills' report and Mr Misso's actions of holding him upside down which was the most likely way the nectarine stone moved to the nasal area.

2.3. Based on the post-mortem examination report of Dr Wills and other evidence heard at this Inquest, I find that the direct cause of Lucas' death was acute upper airway obstruction.

3. How the Inquest proceeded

3.1. A number of issues arose for consideration and detailed evidence about Lucas' death. I shall set out these issues and a summary of the evidence in the following order, namely:

i) Lucas' personal circumstances including the preparation for attending HBPS in 2017. This will examine preparations by his parents, his teacher Ms Reddick and HBPS in general.[18]

ii) The routine of Lucas' school day.[19]

iii) What happened on 27 March 2017.[20]

iv) First aid issues on 27 March 2017 including the first response by HBPS staff, assistance by SAAS on emergency triple zero calls with HBPS and expert analysis of the response by Professor Anne-Maree Kelly, Senior Emergency Physician.[21]

[15] Exhibit C2a, page 4
[16] Exhibit C2a, page 3
[17] Exhibit C2a, page 4
[18] Paragraphs 6 and 7 of Finding
[19] Paragraph 7 of Finding
[20] Paragraphs 8 – 11 of Finding
[21] Paragraphs 14-15 of Finding

v) Analysis of the evidence concerning how Lucas obtained the nectarine that caused his airway to be blocked, including interrelated issues of his supervision that afternoon.[22]

vi) The aftermath of Lucas' death.[23]

vii) The adequacy of first aid training of teaching staff employed by the Department for Education.[24]

viii) Findings of the Inquest.[25]

ix) Recommendations of the Inquest.[26]

4. Hindsight and outcome bias

4.1. I warn myself concerning two vital considerations in the assessment of the evidence and any potential criticisms of witnesses in this Inquest, namely hindsight bias and outcome bias.

4.2. A description of '*hindsight bias*' is given in the Australasian Coroners Manual, namely as:

> 'The tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact. If it were, there would be far fewer mistakes made. It is an obvious point, but one that nonetheless bears repeating, particularly when Coroners are considering assigning blame or making adverse comments that might damage a person's reputation…
>
> Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. The distinction needs to be understood and rigorously applied.' [27]

4.3. As stated, I am very mindful of this warning when considering evidence of what efforts were made by HBPS staff and SAAS, in particular the SAAS operator who took the emergency call.

4.4. I also am very mindful of outcome bias. That is, the terrible outcome of Lucas' death should not lead me to more harshly assess the evidence of attempts to save him and the further issues, particularly his supervision, that I will identify in this Finding. In other

[22] Paragraph 16
[23] Paragraph 17-18
[24] Paragraph 19. DFE, was also known as the Department for Education and Child Development (DECD) up until 2019
[25] Paragraph 20
[26] Paragraph 21
[27] The Australasian Coroners Manual, page 10

words, the outcome of Lucas' death must not overwhelm or unduly influence my task of assessing the evidence about the issues in this Inquest.

5. Legal basis for Inquest

5.1. Lucas' death was reported to the State Coroner as required under the Coroners Act (SA) 2003.[28] Subsequently the State Coroner decided it was '*necessary or desirable*' to conduct an Inquest to '*ascertain the cause or circumstances*' of Lucas' death.[29] Pursuant to section 3(3) of the Act '*a reference to the circumstances of an event may be taken to include matters relating to or arising out of the event or its aftermath*'.[30]

5.2. There is no definition of '*cause or circumstances*' in the Act. Therefore, it is important to outline guidance from the Supreme Court of South Australia[31] concerning the interpretation of the phrase '*cause or circumstances*'. I refer to the decision of *WRB Transport and Others v Chivell* where Lander J stated:

> 'In my opinion, the jurisdiction given by the Act to the Coroner is quite extensive. It is not limited, as suggested, to a particular inquiry into the direct cause of death of the deceased. The Coroner has a jurisdiction and, indeed, an obligation to inquire into all facts which may have operated to cause the death of the deceased and as well to inquire into the wider circumstances surrounding the death of the deceased.' [32]

He also went on to say with respect to '*cause*':

> 'In determining those events which may be said to give rise to the cause of death, the Coroner is not limited by concepts such as 'direct cause', 'direct or natural cause', 'proximate cause' or the 'real or effective cause'.'

and:

> 'The Coroner, therefore, has to carry out an inquiry into the fact surrounding the death of the deceased to determine what, as a matter of common sense, has been the cause of that person's death. The inquiry will not be limited to those facts which are immediately proximate in time to the deceased's death. Some of the events immediately proximate in time to the death of the deceased will be relevant to determine the cause of death of the deceased. But there will be other facts less proximate in time which will be seen to operate, in some fact situations, as a cause of death of the deceased.'

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[28] the Act
[29] See section 21 of the Act
[30] Came into operation 7 June 2021
[31] the Supreme Court
[32] [1998] SASC 7002

6. Personal circumstances of Lucas

6.1. Lucas was born on 14 March 2012. He was born with a very rare genetic condition known as Succinic Semialdehyde Dehydrogenase Deficiency.[33] Worldwide, this condition only affects approximately 350 people.[34] Following Lucas' diagnosis of SSADH, medical experts discussed with his parents a plan of care and treatment. Mr Latouche summarised this plan in his statement tendered to the Inquest.[35]

6.2. As a result of Lucas' diagnosis of SSADH, he was provided with assistance under the National Disability Insurance Scheme.[36] This enabled him to receive weekly speech pathology and further psychological assistance every three weeks.

6.3. In December 2014, Lucas was referred to Dr Nicholas Smith, paediatric neurologist at the WCH. Dr Smith discussed the treatment plan for Lucas with his parents and explained the possible side effects of relevant medications. He also informed them of a trial treatment for SSADH in the United States of America[37] by Dr Philip Pearl.[38] In late January 2015, Lucas' younger brother Alec was born.

6.4. In August 2015, Dr Smith consulted with Mr Latouche and Lucas to further discuss medications and the progress of treatment for SSADH in the USA. Lucas' delayed developmental progress was also raised.

6.5. In July 2016, Dr Smith again consulted with Lucas and his parents. By this time Lucas was on a medication called lamotrigine. It is a medication to prevent seizures and was known as an anticonvulsant drug. Dr Smith noted that '*Lucas was tolerating the lamotrigine without significant side effects and was demonstrating encouraging neurodevelopmental gains since the last consultation*'.[39]

6.6. On 8 February 2017, Dr Smith further consulted with Lucas and his parents. Lucas was still tolerating the use of lamotrigine well. Lucas' parents reported to Dr Smith that Lucas had improved in '*…his social interaction, behavioural ability and language*'.[40]

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[33] SSADH
[34] Exhibit C16a, page 22
[35] Exhibit C5a
[36] NDIS
[37] USA
[38] Exhibit C23
[39] Exhibit C23, page 3
[40] Exhibit C23, page 3

The possibility of Lucas accessing the trial treatment by Dr Pearl in the USA was further discussed. At this time, Lucas was in his second week of school at HBPS.

6.7. This brief background regarding Lucas' development, together with the care from his doctors and experts funded by NDIS, demonstrated he was receiving exemplary support in living with SSADH.

6.8. Dr Smith was of the opinion that Lucas' condition of SSADH would not have affected his ability to clear his airway or make choking more likely for him. This is based on the lack of recorded history concerning Lucas having any swallowing or coughing difficulties.[41] Based on this evidence, I find that SSADH was not a causative factor in his death.

6.9. I now insert a photo supplied to the Inquest by Lucas' parents to illustrate the beautiful nature of Lucas. Lucas' nature matches the description of him in evidence at the Inquest. I note how immaculate and well presented he is in this photo which demonstrates the love and devotion he received from his parents.

[41] Exhibit C23a, page 2

7. Lucas's preparation for school prior to 2017

7.1. Lucas attended preschool up to 2016 at a centre called Precious Cargo. This was one of the preschool centres that routinely had children subsequently attend HBPS. In order to assist the transfer of a child from preschool to school, a written report would be provided to HBPS. This occurred for Lucas.[42] Lucas' documents contained various medical reports from his treating specialists from as early as 2014 through to assessments in 2016. These were all gathered in support of Lucas' application to attend HBPS.

7.2. Part of these documents included what is known as a Teacher Information for Primary Special Options.[43] This document is completed by a teacher or teachers at the preschool centre. This occurred for Lucas.

7.3. The information formally recorded by Precious Cargo on 16 August 2016 was consistent with the behaviour of a child with developmental delay. It showed that Lucas liked animals, books and dinosaurs. He also required a great deal of support. He was described as gentle '*by nature*' but could become frustrated easily. It was noted that he had '*…no regard for his own safety and is an avid climber, climbing furniture and fences*'.[44]

7.4. By letter dated 27 September 2016 from the DECD, in particular the office for Education and Early Childhood Student Support Services at Flinders Park, a placement was offered for Lucas at HBPS in the '*special class*'[45] from Term 1, 2017. An application form was attached to the letter that was completed by Mr Latouche. This offer was accepted by Lucas' parents on 5 October 2016.

7.5. Ms Reddick had met Lucas prior to his arrival at HBPS after his parents had accepted a place for him. Although she had no specific memory of doing so, she believed she went and observed him at Precious Cargo where she learnt and noted information about

[42] Exhibit C16b
[43] Exhibit C16b, pages 21-24. Also known as Teacher Information Pack
[44] Exhibit C16b, pages 23 and 24
[45] The special needs class or SNC

him. Documentary evidence suggest that she must have done so despite her lack of memory.

7.6. In February 2017, Lucas' information was recorded at HBPS. Although Ms Reddick had no specific memory of preparing this information, she acknowledged that it was likely a summary of information from her observations of Lucas, together with highlighted issues detailed in the report from Precious Cargo.[46]

7.7. It was noted in the report that Lucas required '*1-1 support at all times*', was compliant and followed instructions. He had the ability to *'focus for long periods of time to watch a movie*'.[47] It was further noted that with regards to eating, he did not '*recognise when he is full or when mouth is full*'. It also stated he '*tires in the afternoon*'. Lucas never received one-on-one[48] support as recommended, however HBPS did obtain some funding for this to occur on a limited basis. This was approved on 17 March 2017 and was to begin in the second Term of 2017.

7.8. <u>The Special Needs Class</u>

I bear in mind that this was Lucas' first ever term at school. He was one of eight students in the Special Needs Class.[49] The SNC was established by HBPS for students that varied from the normal range of development expected for children of their age. This could involve children with a developmental delay like Lucas, varying degrees of autism, also known as Autism Spectrum Disorder, and other physical and mental conditions that affect the capabilities of children from learning in the standard manner. She confirmed that as at 17 March 2017, Lucas was approved to have five extra hours of supervision on a 1:1 basis.[50] This was due to begin in Term 2, between May and July 2017.

7.9. Ms Reddick gave evidence of what a typical school day involved for the SNC.

7.10. <u>9am</u>

This was the general time when a school day at HBPS commenced in 2017. There was

[46] Transcript, pages 225-227
[47] Exhibit C16b, page 21
[48] 1:1
[49] SNC
[50] Exhibit C16c

some variation for the SNC to allow students from that class to avoid the large crowd and associated noise of mainstream students.[51] During the day some students from the SNC were integrated to mainstream classes where suitable and appropriate.

7.11. 9:45am

The SNC had a '*fruit break*'. This was in the classroom area where each student was required to sit to eat food. Ms Reddick noted that the students would often:

> '…bring their fruit pre-cut in containers. However, we also assist students with peeling and cutting up their fruit if required. The specific needs of each child is communicated by their parents. I specifically recall that Lucas loved fruit and large amounts of fruit were often packed in his lunch box. We would closely supervise Lucas during eating periods, because he did not have the sensation of when he was full. I recall storing portions of Lucas' fruit in the classroom fridge to avoid him eating all of his fruit at once. I cannot recall if his fruit was pre-cut, but I imagine that it was pre-cut because his parents were very thorough.' [52]

Although Ms Reddick had no memory of cutting up Lucas' fruit that day, her evidence was that that was her practice.[53] She agreed that children in her SNC were more prone than the other students to putting objects in their mouth.[54] She accepted she would be careful to take off stickers from fruit.[55] A fruit sticker was found in Lucas' stomach at the post-mortem examination.

7.12. 10:50am – 11:10am, recess

The SNC usually started recess earlier than other students by eating together, supervised in the classroom.

7.13. 11:10am – 12:45pm

This time was dedicated to classroom activities and teaching.

7.14. 12:45pm – 1:30pm, lunch

The SNC had their lunch in the classroom together about 10 to 15 minutes prior to 1pm. At about 1pm the students were released into the play areas for HBPS. SNC students

[51] Exhibit C28a, paragraph 11
[52] Exhibit C28, paragraph 15
[53] Transcript, page 219
[54] Transcript, page 220
[55] Transcript, pages 220-221

were identified outside by wearing a red hat compared with the usual blue hat for mainstream students.[56]

7.15. 1:30pm – 2:20pm

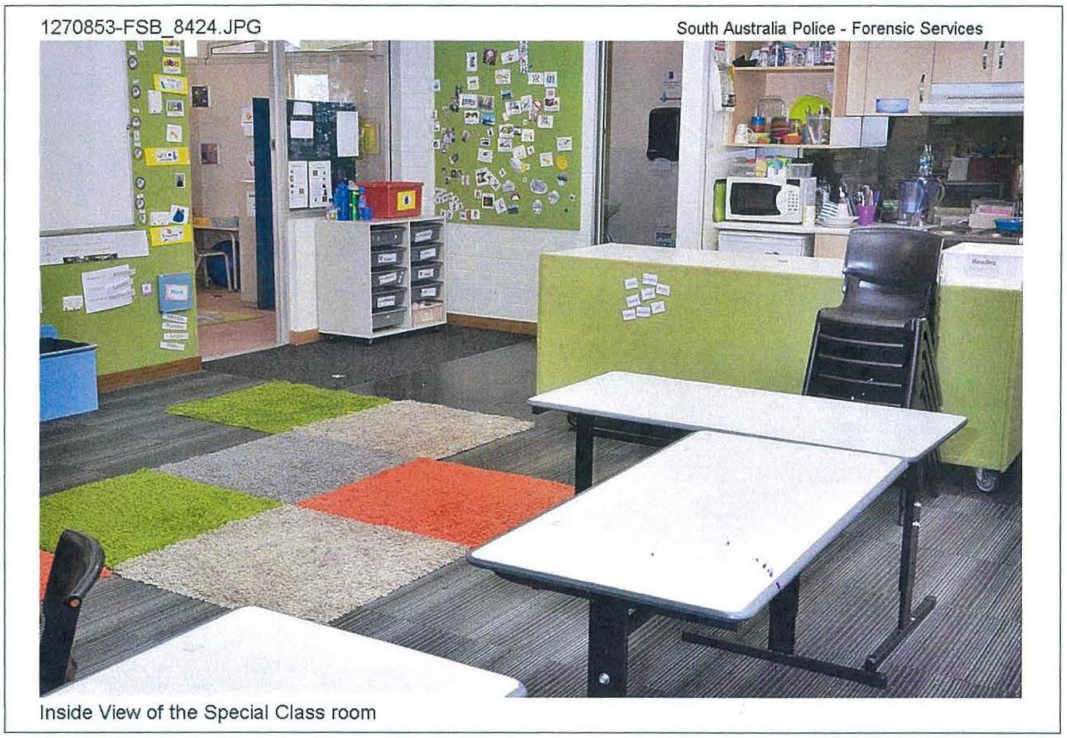
SNC students were allocated to other classrooms for specialist teaching, during which Ms Reddick and Ms Hutton would have student free time to plan future lessons and finish administrative tasks.[57]

7.16. 2:20pm – End of school day

SNC students were subject to informal time including packing up, play and story time.

7.17. Access to food within the SNC classroom by students

I insert a photograph of the SNC classroom taken by SAPOL later that afternoon on 27 March 2017. The children's lunch boxes were kept within the grey trays in the open white cabinet. The entrance door can be seen immediately to the left of the cabinet.



7.18. The lunch boxes were placed by the children in their specific trays labelled with their names. This can be seen in the photo above with their drink bottles on top of the cabinet. Every time food was accessed by the children, they would take the lunch boxes from

[56] Exhibit 28a, paragraph 17
[57] Exhibit C28a, page 6

their trays and then return them after the specified eating time. If a student was seen with food outside of the allocated eating times, he or she would be requested to put it back in their lunch box.[58]

7.19. Kitchen area

The above photo also shows the kitchen area with a bench, small fridge (partially obscured) and a microwave sitting directly above it.

8. Chronology of events, Monday 27 March 2017

8.1. I shall now begin to describe the events of this heartbreaking day. I will give only as much detail as necessary and relevant to my duty under the Act, that is to ensure that the circumstances of Lucas' death are properly ascertained. I will not go into details about Lucas' physical state when he was in distress unless necessary to do so.

8.2. Lucas' arrival at HBPS

As earlier indicated, Lucas was taken to school by his father Miguel. His recess and lunch had been carefully prepared at home. Mr Latouche specifically set out what was in his lunch box, namely carbonara pasta, strawberries, tropical juice, nectarines and muesli.[59] Lucas could not open his lunch box unaided.[60] As described earlier, Lucas happily went to his classroom.

8.3. First lesson to end of lunch break at 1:40pm

The school day for Lucas had been a regular one as described up to this point. This afternoon Lucas was deliberately separated from his class who were attending a science lesson. As earlier stated, this was a reasonable decision as there was a significant safety risk of Lucas putting a range of potentially dangerous substances into his mouth, including common detergent and oil. No one at the Inquest criticised the reasonableness of that decision by Ms Reddick, Ms Hutton and the science teacher.

8.4. As Ms Reddick explained, she thought it was appropriate:

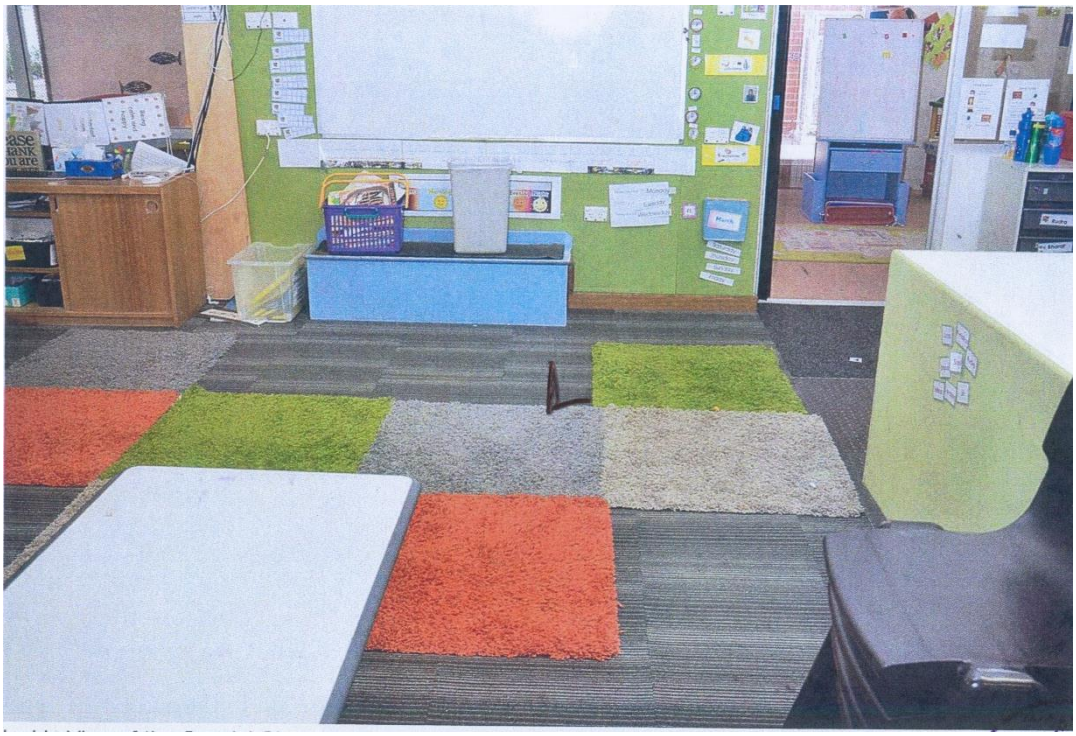
> '…because you can put something in your mouth very quickly and in our experience children sitting beside us can do that when they're right beside us and just to eliminate the threat of that and there's eight of them in there in a bigger environment with big tables, so

[58] Exhibit C28a, paragraphs 19-20
[59] Exhibit C5, page 3
[60] Exhibit 5a, paragraph 9

you can only be in a few spots at once. It was just easier and safer, ironically, to stay back that day.' [61]

8.5. Ms Reddick described that Lucas '*...would have been wondering*' why he was not at science with his classmates given he was happy to be part of the group.[62] She arranged to play his favourite cartoon movie about a gentle, monster like figure called The Gruffalo. He was happy about that. The cartoon was found via access to You Tube on the classroom smartboard.

8.6. I insert a photo below marked by Ms Reddick with an '*L*', indicating Lucas' exact position while watching The Gruffalo.[63] The lunch box trays are visible on the right edge of this photo.



8.7. Ms Reddick remembered staying in the main classroom with Lucas after The Gruffalo had started which she believed was at about 1:50pm. Lucas did not have anything with him. She believed his lunch box was stored away in his tray. Ms Reddick left the classroom and made her way to the general administration area. Ms Hutton was in the internal office,[64] out of sight of this photo on the left. The internal office was separated from the main classroom and had a restricted view of the area shown in the photo. Upon

[61] Transcript, page 191
[62] Transcript, page 193
[63] Exhibit C10aa
[64] Also known as teacher's office area

Ms Reddick's return at about 2:10pm, she approached Lucas in the classroom to see if he wished to go to the bathroom. He looked up and she noticed his '*glassy*' eyes and realised something was terribly wrong. Lucas was silent and seated in the same position as when she left.

8.8. Ms Reddick began immediate efforts to save him. They included standing him up, bending him over and banging his back. In the frantic minutes that followed, she also recalled looking into Lucas' mouth, the arrival of Mr Misso, SAAS being called and their arrival.[65]

8.9. I will now introduce and consider the movements and actions of the SNC teaching staff and Principal, Mr Misso, in the critical minutes after Lucas began watching The Gruffalo that afternoon.

9. Gillian Reddick

9.1. Ms Reddick was a very experienced teacher who had been employed by the DECD since 1995. She had been a special needs teacher at HBPS since 2005. She was able to describe the general routine of her class, both on a daily basis through to the necessary preparations undertaken for a school year. This included visiting the children at their preschool learning environments as she did for Lucas. She also organised visits for the new students to HBPS. This usually occurred in Term 4 of the preceding year.[66]

9.2. The evidence of Ms Reddick tended to suggest that Ms Hutton remained in the internal office the whole time during her absence as she was there when she left and upon her return.

9.3. Ms Reddick found it hard to accept that Ms Hutton would not have been in the main classroom with Lucas at the time she left for the front office.[67] This is despite having no memory of where Ms Hutton was at that time. I find that Ms Reddick was not trying to be difficult or obstructive on this topic. Perhaps she could not comprehend, in hindsight, any chance of Lucas being left out of sight in her absence.

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[65] Exhibit C28 and Exhibit C28a
[66] Transcript, pages 176-178
[67] Transcript, pages 213-214

10. Denise Hutton

10.1. Ms Hutton was an experienced SSO. She had worked at HBPS since 2011 in the SNC. She had extensive work history as an SSO of about 20 years. She actively assisted SAPOL by providing a statement at 6:10pm on 27 March 2017[68] and subsequently in February 2022. Her evidence at the Inquest was consistent with Ms Reddick about the daily routine of the SNC. She did comment that Lucas was '*a good eater*'[69] and '*occasionally he would need to be reminded to slow down and swallow before taking the next bite*'.[70]

10.2. She explained the reason for Lucas missing the science lesson that afternoon was that:

> '…we know that Lucas was very quick with putting things in his mouth, and she[71] was concerned that the experiment we were doing that day involved bark and stones and paper and other objects and she had concerns that he would put them in his mouth.' [72]

10.3. She recalled Ms Reddick setting up The Gruffalo on the whiteboard screen and that Lucas appeared '*transfixed*' by the movie once it began playing.[73] During the time that she was in the internal office of the SNC, she was checking her emails while also preparing visual aids and obtaining images from the internet for future classes.[74] This would involve transferring photos from the internet into a word document, printing the document, cutting the image out and then laminating it. There was no printer nor laminator in the SNC classroom. The printer and laminator were in the administration area.

10.4. She accepted that while she was sitting in the internal office she could not see Lucas on the floor.[75] She could '*clearly*'[76] hear The Gruffalo playing from her office but did not hear Lucas moving around the classroom. Had she seen him she would have '*gone to him*'.[77] She accepted that if Lucas had gone to his tray, she '*wouldn't have noticed…I wouldn't have seen that*'.[78] Ms Hutton was first alerted to Lucas being in distress by Ms Reddick. This is consistent with Ms Reddick's evidence.

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[68] Exhibit C29
[69] Transcript, page 262
[70] Transcript, page 263
[71] The science teacher
[72] Transcript, page 267
[73] Transcript, page 271
[74] Transcript, page 272
[75] Transcript, page 274
[76] Transcript, page 277
[77] Transcript, page 277
[78] Transcript, page 278

10.5. Ms Hutton estimated that Ms Reddick's absence was about 5 minutes. She excluded 10 minutes as a possibility. I make a general comment about estimates of time by witnesses when involved in a crisis or during a crisis, namely time is not in the forefront of most people's minds. Therefore, time estimates are liable to be inaccurate.

10.6. Ms Hutton was not aware of the recommendation that Lucas required 1:1 support at all times.[79] She accepted that if she had known Lucas was to have 1:1 supervision she would have tailored some of her activities to have been done in the classroom where she could have seen Lucas and spent less time in the internal office.[80]

10.7. Ms Hutton could not recall whether she stayed in the internal office throughout the entirety of Ms Reddick's absence.[81]

10.8. It was clear Ms Hutton was not concerned about leaving Lucas in the classroom when she was in the internal office and accepted there could have been other times when that happened.[82]

11. Shane Misso, Principal HBPS

11.1. Mr Misso has had a distinguished career with the DECD. He became Principal of HBPS from January 2004 until late June 2020. His earlier career was as a teacher including placements in the country. Whilst working in the country he also became a volunteer for the Country Fire Service and for the State Emergency Service. Mr Misso's description to SAPOL of his attempts to save Lucas are an accurate summary of his expanded evidence. I shall set out his narrative, which in my view is sufficient to describe the rescue attempts. This is what he told SAPOL that afternoon, only hours after Lucas had died:

> 'I was in my office when I was notified that Lucas was choking in his classroom…Denise (Hutton) called me and told me Lucas was choking. I went straight to the classroom and saw Denise and Gill were attempting to clear his airway by slapping his back. It didn't clear his airway so I held him up by his legs to invert him and someone slapped his back to attempt to clear the airway.

[79] Transcript, pages 294-295. See also Exhibit C16b, page 21
[80] Transcript, page 297
[81] Exhibit C29a, paragraph 42
[82] Transcript, pages 336-337

> After about 3 hits, nothing cleared so we put him in a recovery position and we had the ambulance on the line. We had called the ambulance on a land line but they called back on Denise's mobile so we could treat him and remain on line with them for advice.
>
> There is a defibrillator in the office and I called for someone to bring that to the classroom. When he was in the recovery position…he vomited up a huge amount of sputum and blood.
>
> We got the defibrillator on and the ambulance girl on the phone kept offering advice. The defibrillator told us to stand clear for the shock and at that moment the ambulance crew arrived and then shortly after a rapid response car arrived, then an operations truck. We supported the crews and did what they asked.
>
> Lucas' father arrived soon after at about 2:45pm. The ambulance crews worked on him for about 50 minutes giving Lucas drugs via drip and treating him. They broke the news to Lucas' father that it didn't look good…
>
> The ambulance crew then lifted him on a barouche and continued treatment as they left.' [83]

12. What was the best way to provide first aid and attempt to stop Lucas choking?

12.1. Expert evidence from Professor Anne-Maree Kelly, emergency medicine specialist, described emergency first aid situations as:

> '…incredibly stressful. They're incredibly stressful for myself and my colleagues and I've been doing this for 30 years, and we're trained and we practice this. For people who have not had this experience it is really scary and it is really hard to keep all the information being processed in a logical way and keep focused. It's just a terrible situation.' [84]

12.2. Professor Anne-Maree Kelly

Professor Kelly is the director of the Joseph Epstein Centre for Emergency Medicine Research at Western Health Victoria, based at Sunshine Hospital. She has held this position since 2000. She was also Director of Emergency Medicine at Footscray Hospital for 10 years, initially from 1998 to 2006 and then again in 2016 to 2017. Her 28-page curriculum vitae outlines her distinguished career in emergency medicine where she has held numerous important positions in that field and has been involved in, or solely authored, an extensive number of articles and discussions in papers concerning emergency medicine.[85] At the time of giving evidence at the Inquest she was the Senior Emergency Physician at the Western Health Hospital in Footscray, Victoria.[86]

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[83] Exhibit C30, pages 2-3
[84] Transcript, page 65
[85] Exhibit 26
[86] Transcript, page 53

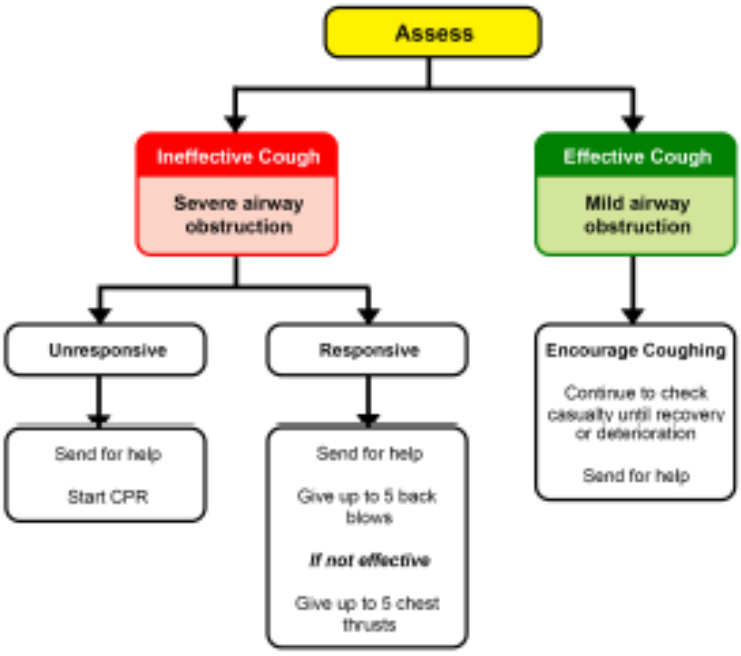
12.3. Prior to the Inquest, Professor Kelly provided a comprehensive report concerning the death of Lucas.[87] She also gave extensive oral evidence at the Inquest.

12.4. In preparation of this report, she was provided with statements taken by SAPOL from the HBPS staff, the triple zero calls and their transcripts, and the addendum affidavit from Dr Smith outlining his opinion whether Lucas' condition of SSADH was a contributing factor to his death in these circumstances.

12.5. Her opinion was divorced from any consideration of the adequacy of Lucas' supervision. It focused on the issues relevant to Lucas' first aid once Ms Reddick discovered he was in distress.

12.6. Professor Kelly specifically acknowledged hindsight bias and outcome bias in her report about Lucas and when she gave evidence at the Inquest. To combat these biases she tries '*…as much as possible to make it… about what was reasonable at the time based on what people knew at the time and who they were and what skills they had and not impose my views about what that should be, knowing what happened*'.[88]

12.7. I set out below a flowchart concerning airway obstructions from the well-recognised and respected '*Australian Resuscitation Council Guidelines*'.[89] Professor Kelly



[87] Exhibit C26a
[88] Transcript, page 59
[89] ARC Guidelines

highlighted this flowchart from the ARC Guidelines as being appropriate for situations of choking.[90]

12.8. The simplicity of the ARC flowchart belies the absolute stress involved in trying to assist someone else who is choking. It does not differentiate between choking by a child compared with an adult. The ARC flowchart emphasises the importance to '*encourage coughing*', if feasible.

12.9. Professor Kelly explained that a cough is '*…the most effective method of removing an obstruction outside of a hospital environment*'.[91] She continued that '*The best outcome is when the person coughs it up themselves. There's good survival when that happens. When that doesn't happen, survival really drops off very, very quickly*'.[92]

12.10. Professor Kelly further explained the significance of back blows and their recommendation due to '*The idea is that increasing the pressure in the chest might pop the foreign body out like a cork*'.[93] She continued that the '*recommended*' order is to perform back blows prior to chest thrusts but that the evidence supporting that recommended sequence is '*weak*'.[94]

12.11. Professor Kelly was asked about the explanation of the nectarine stone being found in Lucas' nasopharynx and post-nasal space just above the level of the soft palate. She believed that when Lucas was held upside down by Mr Misso, it could have dislodged the stone from blocking the airway. She agreed it was not consistent with the '*evidence-based guidelines*'[95] to hold Lucas upside down. In her opinion '*…tipping people upside down can have other adverse effects*'.[96] She further stated that if he had been held upside down at the earlier stages of choking, prior to Mr Misso's attendance:

> 'Lucas would have had relatively firm muscle tone holding the stone in place, but, as he became more unconscious, that muscle tone may have released, and so I can't say at what stage that muscle tone released enough to get him upside down, which might have dislodged anything, so I can't actually answer your question directly.' [97]

[90] ARC flowchart
[91] Transcript, page 73
[92] Transcript, page 73
[93] Transcript, page 73
[94] Transcript, page 73
[95] Transcript, page 153
[96] Transcript, page 153
[97] Transcript, pages 153-154

12.12. Despite those answers, she said it was likely '*on the balance of probabilities*' that the stone was dislodged whilst Lucas was held upside down.[98]

12.13. This issue of providing first aid was a detailed and difficult one during the Inquest. I was greatly assisted by Professor Kelly's evidence on this topic and other aspects concerning emergency first aid.

13. Heimlich manoeuvre

13.1. This method was first published in 1974 by Dr Henry Heimlich, an American thoracic surgeon. It is a phrase and method well-known by most of the public. The manoeuvre involves grabbing the patient from behind with the rescuer's arms linking at the front, below the patient's rib cage and squeezing up. Dr Heimlich argued in his publication that this method was a safer and more effective alternative to back slaps and chest thrusts to dislodge a blockage from the upper airway. Contrary to his beliefs, this manoeuvre is not recommended under the ARC Guidelines. It is not mentioned in the ARC flowchart.

13.2. When asked if it was appropriate to perform a Heimlich manoeuvre on a choking child, Professor Kelly explained:

> 'I personally would not unless I was not at my hospital and I had tried back blows and chest thrusts and they hadn't worked and I was getting desperate. The risk here is that - there's not strong evidence that it works, but there is reasonably strong evidence that it causes damage, particularly in children, such as lacerations of the liver and other things which can be fatal, so I wouldn't be using that technique unless the risk outweighed the benefit, you know, where the benefit outweighed the risk. I think you've got to get to a point. The Americans like the Heimlich manoeuvre and that's fine. The evidence is not particularly strong for any of these individuals.' [99]

13.3. SAAS protocols, in dealing with triple zero calls received concerning a conscious and choking child, allow for the operator to recommend the Heimlich manoeuvre.[100] That inconsistency with the ARC Guidelines did not become relevant for Lucas.

13.4. Professor Kelly postulated that explaining the Heimlich manoeuvre to a '*non-trained lay person*' would be easier to explain than the positioning of contact for a back slap and/or chest thrust.[101] She reasonably pointed out that the triple zero operator at SAAS

[98] Transcript, page 153
[99] Transcript, pages 72-73
[100] Transcript, page 76
[101] Transcript, page 76

must assume '*the lowest level of training and experience*' and does not have the time in an emergency situation to digress to investigate the level of training of the caller and/or rescuer of the person in distress.[102]

14. Analysis of instructions provided by SAAS during the triple zero call with HBPS

14.1. It is now important to concentrate on the two triple zero calls made between Ms Hutton and SAAS from the SNC classroom and the evidence from Professor Kelly who had listened to those calls. I again emphasise the stressful nature of this event in the terms Professor Kelly acknowledged. I will also refer to background matters that hindered these calls.

14.2. First phone call from the SNC classroom to SAAS - '*the first call*'

This was recorded to have been made at 2:16:37pm. It was from the landline phone within the internal office of SNC classroom.[103] It was not a portable phone. I have listened to this call in open court and subsequently in private.[104] The call was made by Ms Hutton. Mr Misso had already been contacted and was present and trying to assist Lucas when the first call was made.

14.3. After the SAAS operator obtained the details of where the call was coming from, namely HBPS, Ms Hutton reported that '*A little boy is choking*' and that he was '*Just*' awake. He was breathing '*…slightly but he's not very well. Actually, I think he has collapsed now…He's alert but he is still choking*'.[105] When it was indicated the landline phone could not reach Mr Misso, SAAS arranged to call Ms Hutton back on her mobile phone.

14.4. Return phone call by SAAS - '*the return call*'

SAAS called Ms Hutton at 2:18:05pm. This call lasted 7 minutes and 13 seconds. The return call was played in open court and I heard it subsequently in private. At the start of the return call, the SAAS operator had to twice ascertain whether Lucas was choking or having a seizure. At the end of the return call, SAAS had arrived to assist and take over from the rescue efforts of Mr Misso.

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[102] Transcript, page 76
[103] Transcript, pages 325-326
[104] Exhibit C6d
[105] Exhibit C6e

14.5. Ms Emily Thorn was the SAAS operator on the first and return call. She provided an affidavit to the Inquest but was not called to give evidence.[106] She explained the '*strict protocols*' followed by SAAS in receiving a triple zero call under the worldwide established use of the Medical Priority Dispatch System.[107] Problems arose with the return call, namely:

i) It was raised that Lucas may have been having a seizure. Understandably, the SAAS operator asked whether it looked like '*he's choking or having a seizure?*'.[108] The answer to that question was '*…definitely not breathing properly…He is bleeding from his mouth…we need an ambulance right now*'.[109] This line of enquiry was repeated again by Ms Thorn as to whether he was choking or having a seizure. Ms Thorn acknowledged that she could '*…hear people panicking there*'.[110] This affected her use of MPDS and her questioning in the return call.

ii) The return call was made to a mobile phone service by SAAS rather than a landline. The reception of a mobile phone service in the SNC classroom was known to be poor. That was due to factors outside of the control of HBPS. It was well known and considered to be a geographically difficult zone to get decent reception for a mobile phone. There was no portable landline phone in the SNC classroom. There is one now.

iii) The return call was placed on loudspeaker to enable Mr Misso to follow instructions provided by SAAS and give responses. This added to the diminishing quality of the reception of the mobile phone in the SNC classroom.

15. <u>How the MPDS works to guide the SAAS operator to provide first aid advice over the telephone</u>

15.1. This issue was thoroughly vented and analysed in the Inquest into the death of the late Ms Virginia Weekes and Mr Craig Files. I refer to the findings of that Inquest for further detail and reference.[111] Based on the information from that Inquest and Ms Thorn's affidavit, I will provide the following brief explanation of how this system works and how it applied to the emergency calls regarding Lucas.

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[106] Exhibit C31
[107] MPDS
[108] Exhibit C6g, page 1
[109] Exhibit C6g, page 1
[110] Exhibit C6g, page 2
[111] Inquest 91/2020 – Finding delivered 26 October 2022

15.2. The MPDS operates on a computer software system called Pro Q/A. This was in use on 27 March 2017. Once an emergency call is connected with SAAS, the SAAS operator will always verify the address, the phone number and then ask the standard question '*okay, tell me exactly what has happened*'.[112] The MPDS is based on the first complaint made[113] and follows a series of computer generated protocol questions from that point to determine the chief complaint. The chief complaint is determined on the basis that the most serious injury or problem will be identified first by the caller. For example, if the caller to SAAS is dealing with a minor cut to the hand and a badly broken leg, the Pro Q/A system assumes the badly broken leg would be mentioned first and designates it as the chief complaint. Here, based on the MPDS, the chief complaint on the first call was clearly identifiable as '*a little boy is choking*'.

15.3. A high priority of SAAS is to ensure that the caller is '*right next to the patient*'.[114] As has been explained for the first call, Ms Hutton could not get the landline phone near Mr Misso. Therefore, the return call was to her mobile phone which was able to be taken right next to Mr Misso.

15.4. <u>What was the chief complaint determined for Lucas</u>

On the SAAS records, Ms Thorn made an entry that the problem was '*choking*'. Consistent with the information she received, she also updated the chief complaint with the report that Lucas '*may have had a seizure*'. Finally, when it was evident to her based on the information that Lucas was not having a seizure, the protocol changed to indicate cardiac arrest. This was deemed by SAAS to be a life threatening emergency and given the highest priority.

15.5. As is evident in the return call, SAAS asked for a defibrillator to be used on Lucas. This caused a further complication as it was not immediately available. It was stored in the administration area. After its retrieval it was used on Lucas, but recorded that '*nil shock advised*'. Ms Thorn then instructed Mr Misso to perform CPR, but SAAS arrived and took over.

15.6. <u>Professor Kelly 's analysis of the triple zero calls</u>

The emergency triple zero calls became more complicated than desirable. Professor Kelly stated that these complications did not change Lucas' fate in her

[112] Exhibit C31, page 4
[113] Also known as '*the chief complaint*'
[114] Exhibit C31, page 5

opinion. Quite correctly, Professor Kelly's view was that '*choking was the problem*' as identified in the first call by Ms Hutton to SAAS. Professor Kelly also believed it was highly likely that during the first call, Lucas was '*beginning to lose consciousness*'[115] and at that stage he had probably been choking for two to three minutes. This would have caused his oxygen levels to '*fall to a critical level*'.[116] She believed it was '*…important to know whether he's breathing…because if he was not breathing then attempts to get oxygen into him are critical*'.[117]

15.7. The return call became complicated when the introduction of a possible seizure occurred, given that both a seizure and choking can cause an alteration in consciousness. Professor Kelly came to the conclusion that the questioning that followed regarding a seizure took '*too long*'[118] rather than concentrating on whether Lucas was breathing.

15.8. In her medical opinion '*…as soon as it was established that he was becoming unresponsive, I would have moved on to CPR. So if he's blue and he's unresponsive…that's CPR*'.[119] However had CPR been commenced earlier, the effect on Lucas' outcome of survival would have been marginal. It would have altered it '*from horrendously terrible to slightly less horrendously terrible*'.[120]

15.9. Based on her summary of the situation, Professor Kelly believed that Lucas '*…unfortunately suffered a complication of choking which is called negative pressure pulmonary oedema*[121] *which inhibited his resuscitation outcomes*'.[122] She explained that NPPO occurs when a build-up of fluid in the lungs[123] is combined with a blocked airway. This produces a situation where attempted clearing of the airway creates a lot of negative pressure in the chest. It also causes a further build-up of fluids into the lungs from blood vessels. Professor Kelly further explained that this would make it '*…almost impossible for any air from a normal breath given mouth to mouth to actually get through that system to get into the bloodstream*'.[124]

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[115] Transcript, pages 80-81
[116] Transcript, page 81
[117] Transcript, page 83
[118] Transcript, page 86
[119] Transcript, page 88
[120] Transcript, page 93
[121] NPPO
[122] Transcript, page 56
[123] Also known as a pulmonary oedema
[124] Transcript, page 57

15.10. Her evidence about NPPO fitted exactly with the eyewitness descriptions of Lucas during his attempted rescue in the classroom. NPPO is a '*rare event*' of which Professor Kelly had only encountered personally twice in her career.[125] Given that background, I will now focus on the issues addressed in Professor Kelly's comprehensive report concerning the death of Lucas. She was asked to provide an opinion concerning five issues, namely:

1) The adequacy of the first aid response provided by the HBPS staff;
2) The appropriate time at which CPR ought to have been commenced on Lucas;
3) The appropriateness of the instructions provided by SAAS to HBPS staff during the triple zero calls whilst Lucas was in extreme distress;
4) Whether Lucas' death was preventable at any point in time prior to his death that day; and
5) If Lucas' death was not preventable at the time he was first observed to be choking, was she able to comment on the duration of time he was likely to have been choking prior to observation.

15.11. <u>Issue 1 - The adequacy of the first aid response provided by the HBPS staff</u>

Professor Kelly stated:

> 'In my opinion, the administration of back blows by school staff was appropriate and consistent with the guidelines.[126] It would appear that chest thrusts were not administered by school staff, which is not consistent with the guideline.' [127]

I refer again to Professor Kelly's evidence that a cough is the most effective method to remove an airway obstruction. I interpreted the overall evidence of Professor Kelly to mean that the failure to perform chest thrusts as recommended, did not change Lucas' chances of survival.

15.12. In other words, HBPS' staff attempts to rescue Lucas were reasonable in the circumstances. They followed SAAS' advice over the phone including informing SAAS when Lucas was unresponsive.

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[125] Transcript, page 125
[126] ARC Guidelines
[127] Exhibit C26a, page 13

15.13. Issue 2 - The appropriate time at which CPR ought to have been commenced on Lucas

Professor Kelly believed:

> '…CPR should have been commenced as soon as Lucas became unresponsive.' [128]

This was consistent with the ARC Guidelines.

15.14. Issue 3 - The appropriateness of the instructions provided by SAAS to HBPS staff during the triple zero calls whilst Lucas was in extreme distress

I have already mentioned the environment in which these calls were made in, including the difficulty with the landline in the first call, the notoriously poor reception for mobile phones in the SNC classroom for the return call and the stress involved which hindered the smooth delivery of the instructions by SAAS. Professor Kelly noted:

> 'Unfortunately, despite her asking about breathing several times, it took more than two minutes to establish that Lucas was not breathing.' [129]

15.15. Professor Kelly's opinion was that as soon as it was established that Lucas was not breathing, the staff should have been instructed to start CPR rather than resort to the defibrillator which was not present. Despite this criticism, she acknowledged that it would have had little impact on the outcome. She was also unaware as to the medical training of the SAAS operator outside of the ability to ask questions as mandated under the MPDS system.

15.16. Issue 4 - Whether Lucas' death was preventable at any point in time prior to his death that day

Professor Kelly's evidence and her report concluded that once Lucas had developed severe airway obstruction, together with the rare but known NPPO and cardiac arrest, his death was not preventable.

15.17. Issue 5 - If Lucas' death was not preventable at the time he was first observed to be choking, are you able to comment on the duration of time he is likely to have been choking prior to observation

Although she was not able to answer this question in her report, she did note earlier that at a certain point in the call it was consistent with when Lucas had choked for about

[128] Exhibit C26a, page 13
[129] Exhibit C26a, page 14

two to three minutes. It is not necessary to develop this given her opinion as to his prospects of survival.

15.18. Professor Kelly acknowledged in her report that the rescue efforts were '*…no doubt very traumatic for the school staff and the SAAS triple zero operator involved. In my opinion, all tried very hard to save Lucas*'.[130]

16. How did Lucas obtain the nectarine?

16.1. This leads back to the issue of supervision and how did Lucas find an opportunity to attempt to eat a nectarine with a stone that afternoon, outside of the designated eating schedule. I refer back to the crucial time period after lunch that day when Lucas was by himself in the SNC classroom.

16.2. The important aspects involved in this issue are:

i) Where was the nectarine that Lucas obtained?

ii) When did Lucas obtain the nectarine?

iii) What supervision was Lucas under that afternoon in the SNC classroom?

16.3. The evidence on these aspects of the issue was extensive. Understandably, Ms Reddick and Ms Hutton were questioned about these critical time periods. They gave their best estimates accordingly. I note again that estimation of time is one of the most difficult tasks a witness can be asked to do. In my experience, estimates or reconstructions about time are notoriously inaccurate because most witnesses do not consider time when they are part of ordinary events. This is also true for people witnessing or being part of extraordinary and very stressful events. I take those considerations into account when assessing the evidence of time estimates.

[130] Exhibit C26a, page 15

16.4. In the detailed submissions of Lucas' parents, it was submitted that Lucas was unsupervised for a significant period of time as he watched The Gruffalo. Although it cannot be established definitively, the most likely time period when he obtained the nectarine was when Ms Reddick went to the administration area, leaving Ms Hutton in the internal office. The photograph below shows the internal office behind the window.

16.5. At the time Ms Reddick left, Ms Hutton was within this area. The internal office has a restricted view of the SNC classroom and, in particular, where Lucas was sitting, the lunch trays and the kitchen area including the small fridge.

16.6. It seemed that despite Lucas remaining in the SNC classroom, Ms Reddick and Ms Hutton treated this as pupil free or non-interactional time.[131] Whether it is arguable that Lucas was not being taught and therefore Ms Reddick and Ms Hutton were in NIT was not relevant. Lucas was in their direct care that afternoon.

16.7. Ms Hutton considered that it was Ms Reddick's NIT that afternoon and therefore '*…she had things that she had to do, to plan further lessons, and so I was staying back with Lucas*'.[132]

[131] Also known as NIT
[132] Transcript, page 268

16.8. It is clear that Ms Reddick set up the video of The Gruffalo whilst Ms Hutton was in the internal office checking emails. Ms Hutton was seated at the bench furthest from the main classroom. As mentioned, her view was restricted.[133] Ms Hutton could not see the entrance area of the classroom, including the trays, bathroom area and kitchen.[134]

16.9. Shortly after the video began, Ms Reddick went to the internal office where Ms Hutton was for a short time before she '*needed to go to the office*'.[135] She promptly went to the administration area.

16.10. Ms Hutton knew Ms Reddick had left the classroom. Their practice in that situation was that they would '*acknowledge each other*'.[136] Ms Reddick explained further '*…that if one goes in or out and often we don't even say anything because we just see each other do it or we just, you know, we'd look up, we had just worked together for so long that we just – we're just like one almost*'.[137]

16.11. This explanation suggested that they were an experienced team who instinctively knew by gestures as well as words, when one was leaving the other in a tacit acknowledgement that the person remaining behind would be the sole supervisor. I believe Ms Hutton assumed Ms Reddick would not be absent for long and during that time Lucas would do no more than sit in the same spot and watch The Gruffalo.

16.12. Ms Reddick believed that she was out of the classroom for 5 to 10 minutes, '*no longer*'.[138] She agreed that it was possible that Lucas, by his own initiative, could have gone to the fridge or his lunch box. She also agreed it was easier for Lucas to go to the fridge as he did not have to negotiate his lunch box zip.[139] Ms Hutton also agreed to these propositions.[140] Ms Hutton had seen Lucas open the fridge before.[141]

16.13. The evidence does not allow me to definitively find <u>where</u> Lucas got the nectarine with the stone. Had the nectarine been pre-cut, I believe a stone would not have been present. Equally, I believe it is highly unlikely Lucas would have gone to the bin where the stone may have been discarded in the classroom, retrieved it and put it in his mouth.

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[133] Transcript, page 274
[134] Transcript, page 278
[135] Transcript, page 193
[136] Transcript, page 207
[137] Transcript, page 207
[138] Transcript, page 197
[139] Transcript, page 244
[140] Transcript, pages 286-287
[141] Transcript, page 361

16.14. I find it likely that Lucas obtained the nectarine whole, with the small sticker attached to the skin. He then returned to his sitting position to eat the nectarine. I find he would have done this during the absence of Ms Reddick as described, and whilst Ms Hutton was in the internal office. This finding was acknowledged by Ms Hutton to be a likely event.[142] The obvious places where the nectarine must have been were in the fridge or in his partially or fully unzipped lunch box. It is possible it may have come from another child's tray, but that is unlikely in my opinion, particularly given that a nectarine had been placed in Lucas' lunch box that day.

16.15. Before leaving this topic, I wish to note that Mr Misso was informed in a meeting with Ms Reddick, and possibly Ms Hutton, after Lucas' death that he had previously tried to eat food outside of the designated times by going to his tray.

16.16. Lucas' pattern of over-filling his mouth and trying to eat everything were well-known by Ms Reddick and Ms Hutton.[143] Lucas wore a sensory rubber necklace every day to '*chew it as a substitute for putting foreign objects in his mouth*'.[144]

17. Aftermath of Lucas' death

17.1. The aftermath of Lucas' death is a relevant consideration into the duty of the Court to investigate the circumstances of his death. It is specifically referred to in section 3(3) of the Act as already set out in paragraph 5.1. Aftermath is not defined in the Act but according to the Oxford Dictionary means:

> 'consequences, results' [145]

17.2. The aftermath of Lucas' death concerns the following people and/or entities, namely:

1) Lucas' parents, Miguel Latouche and Daniela Mazzei;
2) DECD;
3) The staff of HBPS;
4) First aid training for teachers, ESOs and carers.

17.3. The grief of Lucas' parents has already been described, albeit very briefly. Despite their grief they diligently pursued contact with the DECD. This was based on their

[142] Transcript, page 353
[143] Ms Reddick, transcript, pages 185-186, 233; Ms Hutton, transcript, page 259; Mr Misso, transcript, pages 480, 482
[144] Exhibit C5a, paragraph 10
[145] 5th Edition

wishes to '*…understand what happened and to ensure that no other parent might have to go through the pain we still endure*'.[146] Part of their suffering was caused by the initial description of events concerning Lucas' death described in the HBPS newsletter dated 5 April 2017. It stated he had:

> '…passed away… from complications after an isolated medical episode related to his condition.' [147]

This description was wholly inaccurate. It caused added distress to Lucas' parents. Additionally, HBPS placed a modest blue plaque in the area just outside the SNC classroom acknowledging Lucas' death as a HBPS student. The plaque stated:

> 'Lucas Latouche Mazzei 14/03/2012 to 27/03/2017
> A life filled with Love and Happiness
> "The boy with the beautiful smile" '

Unfortunately, Lucas' parents were not consulted regarding the plaque. They found out about it via the school newsletter on 6 December 2017.[148] By letter dated 23 February 2019, Mr Rick Persse, Chief Executive Officer of DECD addressed this issue with Lucas' parents explaining that Mr Misso:

> '…understood that the placement of a small plaque in the garden accorded with your wishes and that this should be managed quietly and respectfully. He further understood your wish to not be part of any commemorative process and that you would chose to visit the plaque at a time appropriate to yourselves. Please know it was never the intention of the principal or staff to cause offence or distress and I am deeply sorry to hear that the school's communication has caused you these concerns.'[149]

17.4. Further, Lucas' parents highlighted the DECD's lack of investigation and follow-up concerning this serious incident despite indicating to them otherwise. The policy document to report and investigate serious incidents within the DECD was tendered at the Inquest.[150]

17.5. It was the expectation of Lucas' parents that an investigation was being conducted pursuant to the DECD's own policies under the Incident Response Management System.[151] They powerfully argued at the Inquest that an investigation was mandated

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[146] Exhibit C16a, page 22
[147] Exhibit C16a, page 22
[148] Exhibit C16a, pages 22-23
[149] Exhibit C16a, page 26. See also Exhibit C1a, annexure DMD2
[150] Exhibit C16i
[151] IRMS

under the IRMS under the guidance of the Incident Management Directorate[152] monitored by the Critical Incident Coordination Committee.[153] They argued Lucas' death should have been classified as an '*incident of extreme severity*'[154] under the IRMS based on policy and procedure documents dated 24 June 2016, tendered at the Inquest.[155]

17.6. Lucas' parents understandably argued that the scope of the DECD investigation applied to the '*Death of child/young person, from any cause occurring in, or related to, DECD education sites/care settings or services*'.[156] The only exclusions under the IRMS applied to incidents of extreme severity in '*Families SA care sites/settings*'.[157]

17.7. The reporting of such incidents involved immediate notification to the Chief Executive, Minister for Education and Child Development where the '*Chief Executive and Minister are provided with all available information*'.[158] The CICC were to '*regularly´* monitor the follow-up from an incident at least once per week.[159]

17.8. Mr Misso reported Lucas' death within 24 hours to the Chief Executive of DECD, both by phone call and through the electronic IRMS. SafeWork SA were also notified.[160] This was in accordance with instructions of the policy.

17.9. On 29 March 2017 it was noted that Mr Misso had counselling support provided to staff and students of HBPS.[161] Detective Brevet Sergeant Neil Dunn from Port Adelaide CIB called Mr Misso on 31 March 2017 advising that he was preparing a report for the Coroner.

17.10. On Friday 8 March 2019, a significant meeting was held between the DECD and Lucas' parents. This meeting was subject of a formal record.[162] The outcome of this meeting was that the DECD advised that they did not independently investigate Lucas' death at

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[152] IMD
[153] CICC
[154] Also described in the policy as '*extreme seriousness*' where it appears these terms are used interchangeably. See Exhibit C16, pages 1 and 4-6. It seems to be unnecessary to interchange these words
[155] Exhibit C16i, page 1
[156] Exhibit C16i, page 4
[157] Exhibit C16i, page 5
[158] Exhibit C16i, page 5
[159] Exhibit C16i, page 5
[160] Exhibit C16e, page 12
[161] Exhibit C16e, page 14
[162] Exhibit C1a, annexure DMD3. See also Exhibit C16a, pages 27-28

HBPS. The simple fact was that Lucas' parents and Mr Misso himself had expected an independent investigation by the DECD into Lucas' death.[163]

17.11. In conclusion, the relationship between the DECD and Lucas' parents was affected by the inaccurate information being provided by the DECD, particularly after the 8 March 2019 meeting, that an investigative conclusion would be reached rather than the fact that none ever started. I accept that this caused further distress to Lucas' parents in the years following Lucas' death.

18. Andrew Wells – Director, Incident Management Directorate at DECD/DFE

18.1. Mr Wells provided an affidavit dated 17 February 2022 outlining the DFE's[164] response to Lucas' death and the follow-up investigations by other Departments. Lucas' death was reported and monitored on the IRMS. As stated earlier, Mr Misso made entries on the IRMS on the day of Lucas' death at 4:28pm.[165]

18.2. The IRMS report was '*regularly updated*' from March through to October 2017, again in February, March, May and August of 2018 and in July 2019.

18.3. Mr Wells confirmed that the DFE '*…did not conduct its own investigations in relation*' to Lucas' death.[166] He explained that it was:

> '…normal practice to await the outcome of those investigations before undertaking any internal investigation so as not to interfere with or jeopardise those investigations, or take any action that may be inconsistent with the outcome of ongoing investigations.' [167]

The investigations he was referring to were from SafeWork SA and the State Coroner.

18.4. The Coroner made a finding as to the cause of Lucas' death on 13 June 2018. The State Coroner considered Lucas' death further, and found it was necessary or desirable to conduct an Inquest.

18.5. However, on 5 February 2019, the DFE received confirmation from the Coroner's office that a Finding had been made in regard to Lucas' death and that it would not be

[163] Transcript, pages 485-500
[164] Department for Education
[165] Exhibit C34, paragraph 21
[166] Exhibit C34, paragraph 23
[167] Exhibit C34, paragraph 23

holding an Inquest.[168] This was also discussed with counsel at the beginning of the Inquest.[169]

18.6. SafeWork SA concluded their investigation on 5 September 2017, having notified the State Coroner that their preliminary investigation found no breaches of the Work Health and Safety Act 2012.[170] However, it appears that the DFE were not advised about the SafeWork SA decision.[171]

18.7. Lucas' parents were not aware of the details as outlined above, and therefore were only aware of the state of investigations when Mr Wells' affidavit was produced and tendered. They felt aggrieved that they were promised to be informed of any developments from 8 March 2019 concerning their son's death.

18.8. Mr Wells' evidence was that the reporting procedures did occur as mandated to the Chief Executive of the DFE and the Minister[172] as an immediate response.

18.9. Response by Lucas' parents to Mr Wells' affidavit

It was submitted that Lucas' parents were left with the incorrect belief that the DFE was conducting an independent investigation. They based their belief on the detailed records they kept of their contact with the DFE.[173]

18.10. Whilst acknowledging that the initial part of the reporting and monitoring to the DFE occurred as mandated, it was suggested that little else happened. It was also suggested that Mr Wells in claiming that the procedure as described only required '*…notification of a death of a child where it occurs at an Out of School Hours Care (OSHC), Preschools, Long Day Care or a Family Day Care*'[174] is plainly incorrect. If that is what was meant to be conveyed by Mr Wells, then I agree it is an incorrect interpretation.

18.11. I believe a DFE investigation should have been completed. The complicated state of affairs as set out above could have been managed more efficiently. I do not criticise the DFE for waiting until the outcome of other investigations, but I believe the DFE

[168] Exhibit C34, annexure AJW8
[169] Transcript, pages 8-11
[170] Exhibit C18a
[171] Exhibit C34, paragraph 31
[172] Exhibit C34, paragraph 17
[173] Exhibit C1a, DMD5
[174] Exhibit C34, paragraph 20

would have benefited from their own investigation to see whether improvements could be made to the DFE issues, such as those advocated for by Lucas' parents.

19. Adequacy of first aid training and requirements for teachers and classroom staff employed by DECD

19.1. I refer again to Mr Misso's evidence and his high level of first aid training. He explained in his evidence that as part of his training:

> 'Chest thrusts were reserved for CPR, that's my memory, and back thrusts were the preferred option for choking and there was always the stipulation don't follow what you see on American TV and do the reverse grab and pull (DEMONSTRATES) because of the damage that can cause to internal organs.' [175]

19.2. After Lucas died he arranged for the DECD to grant his staff members, including himself, to complete a more advanced training course called '*Provide an emergency first aid response in an education and care setting*'.[176] This advanced course concerned primary school aged children with emphasis on a higher level of CPR skills.[177] The course involved six hours of practical application of the skills from adult through to infant sized mannequins.

19.3. His view was that any[178] teacher in any classroom would benefit from training undertaken on that occasion. His evidence on this topic was supported by Professor Kelly.[179]

19.4. The Court received an affidavit from the Australian Red Cross Society[180] which emphasised the higher level of training provided in first aid in an education and care setting as compared to a basic first aid course.[181]

19.5. The Inquest also received evidence via affidavit from the Principal of St Patricks Special School[182] at Dulwich. St Patricks is a school that specialises in students with particular special needs that require intensive support. Principal Cathy Sires outlined

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[175] Transcript, page 459
[176] Transcript, pages 454-455
[177] Transcript, pages 454-455
[178] My emphasis
[179] Transcript, page 66-67
[180] Red Cross. Exhibit C22
[181] Exhibit C22
[182] St Patricks

the first aid practices at St Patricks.[183] She described the following requirements, namely:

1 All staff are required to hold their qualification in Basic Emergency Life Support training which is conducted every three years.

2 At least three staff are trained in senior first aid with a minimum of one who must be present on site at all times.

3 Specialised training for all staff for specific students with particular care needs which would involve attending locations such as the WCH.

4 St Patricks employs a full-time speech pathologist and an occupational therapist who will liaise with students and medical professionals concerning consistency of care and educational needs. This includes oral eating and drinking plans.

5 Staff always inspect lunch boxes to ensure items packed by children's parents and carers are safe for consumption in order to minimise the risk of choking.

6 Safe eating is taught as part of the curriculum.

7 First aid guidelines are taken from Catholic Education of South Australia.

St Patrick's is a school exclusively dedicated for students with special needs. Therefore, issues such as safe eating and drinking apply to every student. I was impressed by the standards of care implemented by St Patricks as highlighted above.

19.6. In contrast the first aid requirements for DECD teaching staff in 2017 were minimal in that:

i) Permanent teachers were not required to hold a current first aid qualification.

ii) Ancillary workers and support staff were not required to hold a first aid qualification.

iii) '*Site leaders*' were left to manage first aid training requirements.

This policy from 2017 is currently in force.[184]

[183] Exhibit C20
[184] Exhibit C16

19.7. Further, DECD guidelines for a choking emergency failed to address and advise a first responder what to do if a person who is choking becomes unresponsive, namely to commence CPR immediately.[185]

20. Findings relevant to the cause and circumstances of Lucas' death

20.1. The findings will be set out in accordance with the issues identified in paragraph 3.1 of this Finding.

20.2. The below findings are made on the basis that I was comfortably satisfied each of them were established on the evidence, including the opinion evidence of Professor Kelly, Dr Wills and Dr Smith.

20.3. Several of these findings are adverse to some of the witnesses. In reaching the decision to do so, I was mindful of the potential adverse consequences for the persons concerned, including the potential for damage to their respective reputations.

20.4. I am very mindful of the need to be satisfied that such a finding should only be made based on the relevant evidence presented being reliable and compelling.

20.5. I have applied the principles expressed by the High Court of Australia in '*Briginshaw v Briginshaw*'[186] and also of the recent Supreme Court decision of '*SJ Berry Pty Ltd v McEntee*'.[187]

20.6. Finding concerning the cause of Lucas' death

I find based on the guidance of Dr Wills and Dr Smith that Lucas' cause of death was acute upper airway obstruction.

20.7. Findings concerning the circumstances of Lucas' death

Lucas Latouche Mazzei was a well-loved and cared for 5-year-old boy who happily attended HBPS in 2017 as a Reception student. He was placed in the SNC due to developmental delays associated with the rare condition he was born with known as SSADH.

[185] Exhibit C26h, Professor Kelly analysing DECD guidelines in Exhibit C16
[186] (1938) 60 CLR 336 in particular Dixon J at 362
[187] [2022] SASCA 133

20.8. In 2016 Lucas had attended Precious Cargo, a pre-school centre where many students progressed to attend HBPS. Precious Cargo produced a comprehensive written document concerning Lucas' behaviours and needs which was attached as part of the application for Lucas to attend HBPS. It stated Lucas needed 1:1 supervision at all times.

20.9. A very experienced primary school teacher, Ms Reddick, was in charge of the SNC in 2017. Her class had eight students. She was assisted by SSO, Ms Hutton.

20.10. In preparation for the academic year 2017, Ms Reddick physically observed Lucas at Precious Cargo in 2016. She had met with his parents. Ms Reddick compiled her own information dossier and was prepared as much as possible for Lucas to be in the SNC in 2017. These efforts showed Ms Reddick acted professionally in preparing to teach Lucas in 2017.

20.11. Lucas was unable to get 1:1 supervision prior to the commencement of the 2017 school year. This was due to the funding application for additional assistance not being able to be lodged until Lucas had officially commenced at HBPS.[188]

20.12. <u>27 March 2017</u>

Lucas attended school on time. His father had properly prepared his food for the day. In his lunch box was carbonara pasta, strawberries, tropical juice, nectarines and muesli.[189] At least one of the nectarines, if not all, were uncut. That is the only logical conclusion I can make given that a nectarine stone was swallowed by Lucas and that the small plastic sticker was found in his stomach contents by Dr Wills at post-mortem. I find it is most likely that Lucas gained access to a whole nectarine that afternoon whilst separated from his class who were attending a science lesson.

20.13. For reasons already discussed, I find this decision by his teachers was appropriate.

20.14. From that point Lucas was under the care and responsibility of Ms Reddick and Ms Hutton. While it was officially NIT for Ms Reddick, and designated time for Ms Hutton for preparation of future classes, that did not lessen their duty of care for Lucas who was with them in the SNC classroom.

[188] Transcript, page 393-395. Exhibit C16
[189] Exhibit C5, page 3

20.15. I find it was appropriate to play The Gruffalo for Lucas as a comforting measure in order to deal with his expected reaction of being upset due to separation from his class. The plan to care for him that afternoon was well made.

20.16. At about 1:50pm, Ms Reddick decided to be absent from the SNC classroom in order to make a brief visit to the administration area, a short distance away. I find Ms Hutton was aware, either by words or gestures or both, that Ms Reddick was leaving the SNC classroom. During this time The Gruffalo was being played for Lucas.

20.17. Lucas had no visible food or items with him at this time and was simply sitting in front of the whiteboard screen. He appeared engrossed by The Gruffalo. Ms Hutton remained in the internal office in the absence of Ms Reddick. Her view of the area Lucas was sitting in was very restricted. There is no direct evidence of where Lucas obtained the nectarine from. Lucas, at some point, must have left his spot and either gone to the classroom fridge or to his lunch box within his tray, and obtained the whole nectarine.

20.18. Lucas' fine motor skills would have made it more difficult for him to totally unzip his lunch box compared with simply obtaining the nectarine from the classroom fridge. This leaves the option that his lunch box was not fully zipped, or the unlikely situation he got the nectarine from another student's tray. I note Mr Latouche had said Lucas could not independently open his lunch box. The obtaining of the nectarine must have been during the absence of Ms Reddick and whilst Ms Hutton was in the internal office.

20.19. The other alternative is that the nectarine was hidden on him but he had not eaten it. Given his history concerning food, and in particular overeating, I find that to be quite an unlikely situation. I prefer the very strong inference that he obtained it from within the SNC classroom unobserved while The Gruffalo was playing.

20.20. It is highly likely Lucas ate the nectarine whilst sitting and watching The Gruffalo. It would have been extremely difficult for him to move around once he got into difficulty with his airway being blocked. There was no obvious sign that he was in distress when his airway was blocked at the time Ms Reddick returned.

20.21. Immediately upon her return, Ms Reddick went to Lucas and made a routine enquiry about whether he needed to go to the bathroom. There was nothing noticeable about the obvious danger and distress he was under at the time of her enquiry. It is likely that

there were no visible or audible signs of distress made by Lucas until approached by Ms Reddick upon her return. At the time of speaking to him, Ms Reddick reacted to Lucas' silent distress. I do note Ms Hutton was not watching him in Ms Reddick's absence.

20.22. What followed was a series of complicated and highly stressful events of unsuccessfully administering first aid by Ms Reddick and Mr Misso before SAAS arrived. I confirm my earlier descriptions of what happened in those frantic minutes as being a suitable description of the findings regarding first aid assistance given to Lucas in the SNC classroom.

20.23. In particular, I find that the following matters have been established on the evidence, namely:

i) The attempted efforts by Ms Reddick were consistent with first aid training, namely back slaps and looking for the obstruction within Lucas' mouth.

ii) Mr Misso's attempts were also within ARC Guidelines, save for holding Lucas upside down while someone slapped his back.

Although this is not a recognised nor recommended manoeuvre in such a situation, I do not criticise Mr Misso for trying something he believed might work to attempt to clear Lucas' airway. Mr Misso knew Lucas was in extreme distress when he tried that unconventional method.

iii) It is likely the stone was dislodged from Lucas' airway and moved to his nasal area due to being held upside down. It is likely that the muscles and tissue had relaxed due to the unconscious state Lucas was in at that point. This finding is based on the evidence of Professor Kelly.

20.24. Lucas' life was not salvageable after suffering NPPO. I accept Professor Kelly's opinion that the circumstances of the physical reaction of Lucas meant he suffered this rare but known medical event due to his airway being obstructed.

20.25. The calls to SAAS were made in less than ideal circumstances to obtain clear communication due to reception problems in the SNC classroom for mobile phones and the inability of the landline phone in the internal office to be used effectively.

20.26. The advice given by SAAS was hampered with difficulties involved in the introduction of the possibility of a seizure, rather than purely choking as reported in the first call.[190] This led to the advice to aid Lucas not being as effective as it should have been.

20.27. The introduction of a seizure as the cause of his distress diverted attention away from the issue of whether Lucas was breathing. In the return call by SAAS to Ms Hutton it was unfortunate that this topic caused the questioning to become too long. Ideally, the focus and advice from SAAS should have been based on Lucas being unresponsive, with CPR commencing immediately. Even if CPR commenced immediately, I accept Professor Kelly's evidence that Lucas' survival was still highly improbable from that point.

20.28. I rely significantly on the expert evidence of Professor Kelly to make the following findings concerning the adequacy of the response provided by HBPS staff on the following issues, namely:

i) Back blows administered by Ms Reddick were appropriate, however chest thrusts were not administered as recommended by the ARC Guidelines.[191]

ii) I accept the opinion of Professor Kelly that the effect of chest thrusts would have been negligible.

iii) CPR should have been commenced as soon as Lucas was not responding to the back blows.[192]

iv) The landline phone from the internal office of the SNC classroom could not be taken near Lucas. The advice from SAAS was hampered by physical factors such as the poor mobile phone reception in the SNC classroom, the extreme stress at this time on Ms Reddick, Ms Hutton and Mr Misso and finally the issue of Lucas choking or having a seizure having to be identified and dealt with by SAAS under the MPDS system. This resulted in SAAS taking longer than desirable to establish Lucas was not breathing.

[190] Exhibit C6e, see also paragraph 15.3 of Finding
[191] Exhibit C26a, page 13.
[192] Exhibit C26a and ARC Guidelines

20.29. Despite all of the issues about first aid for Lucas above, I find that his death was not preventable at the point he was discovered in distress.

20.30. Was Lucas adequately supervised that afternoon?

I have already dealt extensively with the issue of Lucas' eating habits and the recommended '*one-to-one*' supervision level for him at all times. I find Ms Hutton must have made an assumption that Lucas would not move from his spot whilst watching The Gruffalo as she remained in the internal office during the brief absence of Ms Reddick. It was an assumption she should not have made in the absence of Ms Reddick.

20.31. This was the critical time for Lucas' wellbeing as events transpired. As said, in this time period Ms Hutton falsely believed that he would not move while watching The Gruffalo and that he was safe. It also must have been assumed by Ms Reddick that Ms Hutton would make sure that Lucas was in her sight at all times in her absence. I believe this is most likely what she thought when she left the classroom. In the alternative, Ms Reddick must have assumed that, like Ms Hutton, Lucas would not move from his spot. What is clear from the circumstances is that neither assumed Lucas would access food.

20.32. Although Ms Reddick's absence was brief, I find it resulted in Lucas being able to obtain the nectarine unsupervised and unobserved.

20.33. In the circumstances, Lucas was left unsupervised for an unacceptable period of time. This error involving his extremely dedicated and compassionate teacher and SSO was a direct cause or link to Lucas obtaining the nectarine and attempting to eat it uncut in a background of his tendency to overeat or overfill his mouth. This finding is made having considered hindsight and outcome bias.

20.34. If this was Lucas' nectarine, the routine was not followed that day of Lucas' fruit being cut up by Ms Reddick or Ms Hutton, thus removing the dangerous stone and potentially harmful sticker.

20.35. In light of the above findings, I find that Lucas' death would have been prevented that afternoon if Ms Reddick and/or Ms Hutton had remained in the SNC classroom at all times whilst he watched The Gruffalo.

20.36. Adequacy of staff training for first aid

Based on the extensive evidence on this topic, I find that first aid training for the DECD teaching staff was not adequate at that time. The evidence seen from Mr Misso was that in the aftermath of Lucas' death he organised further first aid training for HBPS staff after his own internal review.[193] I accept the evidence from the Red Cross and Professor Kelly that ongoing training of a practical nature was essential to be effective. I make a finding accordingly.

20.37. I was impressed by St Patrick's regime of first aid training and the requirements of staff to be trained to a high level for this important safety issue. I find the evidence on first aid training of the DECD has significant scope for improvement as there is currently no requirement that teachers permanently employed under the DECD have up-to-date first aid qualifications. I was concerned by the evidence that first aid training requirements for DECD staff are now less than at 2017.

20.38. Lucas' treatment at WCH and by SAAS paramedics

WCH staff did everything they could to maintain and preserve Lucas' life. There is no criticism of their care of Lucas. This also applies to the ICP Mr Cummings and the other SAAS paramedics who attended at HBPS and took over the personal care of Lucas until he arrived at the WCH.

20.39. DECD relationship with Lucas' parents after his death

This became problematical. The initial announcement of his cause of death to the HBPS community by newsletter was misleading and caused further distress to Lucas' parents. They were not consulted about his plaque at the school. They believed all along that the DECD were conducting an independent investigation. Lucas' parents

[193] Transcript, pages 453-454

were diligent and caring in pursuing issues with the DECD to ensure that such a situation could never happen again as did to their son.

20.40. Despite the evidence of Mr Wells from the DFE, I believe that Lucas' death should have been investigated as an incident of '*extreme severity*' and followed the protocols set out in the procedure document entitled '*Incident coordination: managing incidents of extreme severity*'.[194]

20.41. I acknowledge that the DECD was entitled to take into account the fact that Lucas' death was reported to the State Coroner under the Act, thus a coronial investigation was ongoing. However, that did not alleviate the need for adherence to that procedure as set out for an incident of extreme severity occurring within the DECD.

20.42. Issues concerning SAAS – Is the SAAS protocol for advice about choking satisfactory? Professor Kelly gave evidence about the MPDS used by SAAS to triage triple zero calls. At the time of the Inquest, Mr Keith Driscoll was the acting Executive Director of Rescue and Retrieval Services at SAAS. He provided an affidavit which set out the process that a triple zero call taker must follow, as guided by the software version of the MPDS and Pro Q/A.[195] Ms Thorn, the triple zero operator who spoke with Ms Hutton, also provided an affidavit.[196]

20.43. Ms Thorn did not ask questions about back slaps or chest thrusts as this was not directed by the protocol.

20.44. I find Ms Thorn followed the protocol, that SAAS call takers are required to strictly follow the Pro Q/A questions. The protocol outlines all questions to be asked and answered. She determined and selected the most appropriate '*chief complaint*' and entered it into the system. The system then provided her specific questions to ask. She then clicked on the answer set out in the system that corresponded with the information provided by the caller.

[194] Exhibit C34, AJW-1
[195] Exhibit C27
[196] Exhibit C31

20.45. Mr Driscoll from SAAS confirmed that the protocol does not recommend applying back slaps in the event of a choking emergency. He explained that it is too difficult to properly instruct the performance of back slaps over the telephone.

20.46. Professor Kelly's comments on the choking protocol of the MPDS system used by SAAS

Professor Kelly stated that she would prefer the protocol to include an instruction to perform back slaps on a choking and responsive child.[197] Professor Kelly disagreed with the order of the system's instructions provided to the SAAS call taker. She believed the instructions to obtain a defibrillator were given too high a priority in the list of instructions.[198] It was unclear whether Ms Thorn was meant to proceed directly to the instructions to utilise the defibrillator once it became available.

20.47. Professor Kelly was very concerned about the SAAS instruction to perform the Heimlich manoeuvre on a conscious and choking child.[199]

20.48. She stated there was cogent evidence that some interventions, including the Heimlich manoeuvre, can cause serious damage, in particular to children.[200]

20.49. She gave an example that the Heimlich manoeuvre on a child can cause lacerations of the liver and other things which can be fatal.[201] Professor Kelly agreed that if a first responder had undertaken first aid training in Australia, which advises against the Heimlich manoeuvre, an instruction by a SAAS call taker to perform this manoeuvre on a child might create conflict or confusion. This should be avoided if at all possible.[202] She opined that the instruction should be replaced with instructions to perform back slaps and then chest thrusts, in line with the ARC Guidelines. I find that Professor Kelly's criticisms as set out above in paragraphs 20.45 to 20.48 are warranted and the suggestions she made should be adopted by SAAS.

[197] Transcript, page 101
[198] Transcript, page 102
[199] Transcript, page 103
[200] Transcript, page 72
[201] Transcript, page 72
[202] Transcript, page 78

20.50. Information sharing between Pre-school and Reception

This inquest also brought to light the difficulties experienced by DECD schools in obtaining additional necessary information about children with special needs in a timely manner. This difficulty extends to obtaining funding for their care and education.

20.51. Mr Misso stated that it would be ideal for the school to receive a detailed package of information about each student at the time when the announcement is made that they will be commencing at the school.[203] It was his evidence that this would enable the teachers to have access to allied health professionals treating the student to inform their practice in relation to that particular child.

20.52. I find Mr Misso was an impressive witness. He had an obvious passion for the education of children with special needs. His credentials in this area, both as a teacher and an administrator, were well established.

20.53. Issues concerning funding for children with special needs

Ms Reddick's evidence was that it would be helpful to have additional funding, and the supports that funding made possible, when the child commenced Reception. The beginning of the term is usually a particularly challenging time.[204] Ms Reddick also recalled Lucas needing extra support in developing his continence.[205]

20.54. An application for extra SSO hours to support Lucas with developing his independence and to assist him in his outside play was lodged by HBPS on 2 February 2017.[206] On 17 March 2017, 10 days before his death, DECD funded an SSO to further assist Lucas for five hours a week from 1 May 2017 to July 2017.[207]

20.55. Ms Reddick and Mr Misso both told the Court that this additional funding could not be applied for before Lucas started school as a result of the requirements set by the DFE.[208] Ms Reddick told the Court that the funding panel expected teachers to wait and see how students went in the special class before they would consider an application for

[203] Transcript, page 472
[204] Transcript, page 238
[205] Transcript, page 237
[206] Exhibit C16c
[207] Second Term for HBPS in 2017
[208] Transcript, page 393

additional funding.[209] Once an application was made, a special educator would then conduct a visit to the school to evaluate the application.[210] Ms Reddick agreed that it would be helpful to have this funding in place on the first day of term.[211]

20.56. I accept the evidence of Ms Reddick and Mr Misso about what improvements should be implemented and make findings accordingly.

21. Recommendations

21.1. Pursuant to section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest. Recommendations can also be made concerning the matters of '*the quality of care, treatment and supervision of the dead person prior to death*'.[212]

21.2. Counsel assisting myself in this Inquest, the Crown who represent the Department for Education and SAAS, together with Lucas' parents have all urged that the Court exercise its power of recommendations in relation to Lucas' death. As stated before, the motive of Lucas' parents before and during this Inquest was to prevent any other child dying in circumstances similar to Lucas' death.

21.3. I have listened carefully to submissions on this topic, as well as studying the written submissions. I agree it is appropriate to make the following recommendations as authorised under the Act.

21.4. The Court therefore makes the following recommendations, directed to the Minister for Education, Training and Skills and the Chief Executive of the Department for Education. It is recommended that:

1) The Department for Education is directed to review its policy and procedures for obtaining and sharing information concerning students with special needs and/or medical conditions to enable teaching staff of that student to become aware, at the

[209] Transcript, page 183
[210] Transcript, page 397
[211] Transcript, page 238
[212] Section 25(2)(b)(i)

earliest opportunity, about how the student needs to be cared for during his or her attendance at a school day or school sanctioned event. This review should also undertake to examine and implement a procedure for easy and quick access of that information by the student's teaching staff. In conducting this review it is recommended that the Minister for Education, Training and Skills consider the evidence presented at this Inquest from Catholic Education South Australia[213] and St Patricks Special School, Dulwich.[214]

2) All teaching staff be required to hold up-to-date qualifications in providing first aid assistance in an education and care setting.

3) The first aid guidelines for a choking emergency are reviewed and amended to reflect those of the Australian Resuscitation Council, in particular concerning a first responders actions if the person choking becomes unresponsive.[215]

4) All telecommunication equipment for teaching staff be portable to allow the device to be taken by the first aid responder to the person in distress.

5) The Department's policy and procedures are reviewed and amended for the safe storing and consumption of food and drinks within its educational sites and for events sanctioned by the Department.

21.5. The Court makes the following recommendations, directed to the Minister for Health and Wellbeing and the Chief Executive of SA Health. It is recommended that:

1) The Minister urges the Australian Committee of the International Academies of Emergency Dispatch to give urgent consideration to updating the Australasian procedures of the Pro Q/A software with respect to instructions being provided to a responder of a child or adult choking and conscious to be consistent with the Australian Resuscitation Council Guidelines.

[213] Exhibit C19
[214] Exhibit C20
[215] Exhibit C26h

2) The Minister directs the SA Ambulance Service to review its training and procedures to be consistent with the Australian Resuscitation Council Guidelines, in particular to review whether the Heimlich manoeuvre, as described, should be recommended to a first responder which is contrary to the Australian Resuscitation Council recommendations.

22. Final comment

22.1. I express my gratitude to counsel for their assistance in this Inquest.

22.1. In particular, I thank solicitor Mr Jeremy Moore and barrister Mr Paul Charman in representing Lucas' parents who were unable to obtain funding assistance from the Legal Services Commission as contemplated by section 20A of the Act. They did so free of charge and provided thorough submissions and exploration of relevant issues on behalf of Lucas' parents.

Key Words: *Succinic Semialdehyde Dehydrogenase Deficiency; Choking; Department for Education*

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 26th day of May, 2023.

Deputy State Coroner