IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2022 000609

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	ZCZ
Date of birth:	19 October 2021
Date of death:	31 January 2022
Cause of death:	1(a) Unascertained
Place of death:	Robinvale District Health Services, 128-132 Latje Road, Robinvale, Victoria
Key words:	Infant death, rocker, unsafe sleeping, unapproved childcare service

INTRODUCTION

1. On 31 January 2022, Baby ZCZ was almost 15 weeks old when she passed away in hospital from an unknown cause.

2. At the time of her death, Baby ZCZ lived in Robinvale with her parents.

THE CORONIAL INVESTIGATION

3. Baby ZCZ's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. Victoria Police assigned Senior Constable Matt Fiebig to be the Coroner's Investigator for the investigation of Baby ZCZ's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into Baby ZCZ's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

Background

8. Mr FWI and Ms REB met in Thailand and married in 2012. They welcomed their first child the following year.

9. The couple migrated to Australia in 2015, moving to Swan Hill in early 2017. Their first child, YAU, remained in Thailand with his grandparents.

10. Mr FWI and Ms REB welcomed Baby ZCZ on 19 October 2021. At birth, she weighed 3.25 kilograms and was a healthy baby.

11. Baby ZCZ usually slept beside her mother in bed. Mr FWI slept on the floor on a mattress beside their bed. While Mr FWI did smoke cigarettes, he never smoked inside the house nor around ZCZ.

12. She was exclusively fed breastmilk via bottle and would drink approximately six bottles of breastmilk a day. She was described as a happy and healthy baby who was feeding well and slept well.

13. Baby ZCZ and her parents moved to Robinvale on 26 January 2022.

14. According to Ms REB, she was told about a local Thai woman, Ms OBU, who offered babysitting services at her home. Ms REB obtained Ms OBU's contact details from her cousin.

15. According to Ms OBU, she had been working in childcare for about 10 years, caring for children whose parents worked on farms. In her statement to police, Ms OBU stated that she had stopped that work in 2016, and since then had only cared for children as favours for friends and did not get paid. Her partner, Mr NBS, stated that Ms OBU usually cared for about five children per day, but he was not sure whether she was paid for her services.

16. On 30 January 2022, Ms REB contacted Ms OBU via text message to arrange for her to take care of Baby ZCZ on 31 January 2022. Ms REB and Mr FWI planned to travel to Swan Hill that day to have their car repaired. Ms REB enquired about the fee and Ms OBU replied that she would give her a discount because of her cousin.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

17. At approximately 8.00am on 31 January 2022, Ms REB and Mr FWI attended Ms OBU's home to drop Baby ZCZ off for the day. Ms REB gave Ms OBU four bottles of breastmilk to feed Baby ZCZ during the morning and afternoon. She also provided a Fisher Price rocker for Baby ZCZ to sit in. Ms REB and Mr FWI left a short time later and made their way to Swan Hill.

18. According to Mr NBS, there were four children at their home that morning, two of which were young babies who he had never seen before. However, the *Investigative Checklist Sleep-Related Sudden Unexpected Death of an Infant or Child* completed by Senior Constable Fiebig listed four children, not including Baby ZCZ, at the address.

19. According to Ms OBU[2], she attempted to feed Baby ZCZ some milk at 9.30am but she refused. Ms OBU noted that Baby ZCZ did not appear upset. She subsequently placed Baby ZCZ in the Fisher Price rocker and moved her to the spare room, which was adjacent to the play area.

20. She thereafter checked on Baby ZCZ at various times, observing that she was asleep in the rocker.

21. At about 10.45am, Ms OBU called Ms REB. Ms REB asked about Baby ZCZ. Ms OBU replied, *"She is sleeping well, I wrap her and put her on bed".* In her statement, Ms REB noted that she thought this was odd as she had only swaddled Baby ZCZ until she was one month old and thereafter just placed a blanket on her. She also found it odd that Baby ZCZ had been put to sleep on a bed when she had informed Ms OBU that Baby ZCZ sleeps in the rocker and not on a bed. However, these issues were not discussed further at the time.

22. At approximately 12.00pm, Ms OBU checked on Baby ZCZ again and observed that she was not breathing. She commenced performing cardiopulmonary resuscitation (**CPR**) and attempted to telephone emergency services but *"couldn't get the number right".* She telephoned her partner who was at a friend's house and asked him to call emergency services. He subsequently dialled 000 and made his way back to the house.

[2] Also reflected in the Investigative Checklist Sleep-Related Sudden Unexpected Death of an Infant or Child.

23. At 12.06pm, Ms OBU telephoned Ms REB stating, *"You need to come now because baby not moving".* Ms REB and Mr FWI happened to be only 20 minutes away in Kenley and immediately drove toward Robinvale, later being directed to the local hospital.

24. At 12.17pm, Ambulance Victoria paramedics arrived at the house. According to one of the paramedics, he found Baby ZCZ *"limp, not breathing and non-responsive to any stimuli"* with froth on or in her mouth. The paramedics continued CPR and transferred Baby ZCZ to Robinvale District Hospital.

25. Sadly, Baby ZCZ was unable to be revived and her death was verified at 1.20pm.

26. Ms REB noted that there was nothing out of the ordinary leading up to Baby ZCZ's death. She had no health complications, was not on any medication, and was feeding well.

Identity of the deceased

27. On 31 January 2022, ZCZ, born 19 October 2021, was visually identified by her mother, Ms REB.

28. Identity is not in dispute and requires no further investigation.

Medical cause of death

29. Forensic Pathologist, Dr Judith Fronczek, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 2 February 2022 and provided a written report of her findings dated 10 June 2022.

30. The post-mortem examination showed a normally developed and well-nourished female infant with no congenital abnormalities. There were no features of neglect.

31. Dr Fronczek explained that after full autopsy with ancillary testing, including neuropathology, toxicology, biochemistry, microbiology, virology, and metabolic screening the cause of death is 'unascertained'.

32. Microbiology showed detection of the bacterium Klebsiella pneumoniae in blood, both lungs, both middle ears and the liver. Klebsiella pneumoniae can lead to pneumonia and sepsis. However, the significance of the positive cultures in this case is uncertain. Histological examination showed no evidence of infection and the inflammatory markers CRP and procalcitonin were not elevated. Therefore, the positive cultures are favoured to be contamination and not related to the cause of death. No viruses were detected.

33. Histological examination showed a mild chronic inflammation of the airways. This is insufficient to have caused to death.

34. Causes of unexpected death with no anatomical findings at autopsy include cardiac arrhythmias, particularly channelopathies, seizures and metabolic derangement.

35. Dr Fronczek noted that Baby ZCZ was put to sleep in a rocker. She explained that infants can suffocate when sleeping in so-called 'infant inclined products' and in the United States multiple infants died in incidents in inclined products (see further below).

36. She further noted that 'infant inclined products' can potentially be dangerous because infants may roll from their backs to their stomach or side if unrestrained, which can lead to suffocation. Also, upper airway obstruction can occur due to the position of the infant.

37. Dr Fronczek provided an opinion that the medical cause of death was *"1(a) Unascertained".*

38. I accept Dr Fronczek's opinion.

FURTHER INVESTIGATION

WorkSafe investigation

39. WorkSafe Victoria conducted a preliminary investigation which was finalised October 2022 without proceeding to prosecution.

Department of Education investigation

40. A person who wishes to provide an education and care service for children under the age of 13 years must either be approved under the Education and Care Service National Law (contained in the Schedule to the Education and *Care Services National Law Act 2010*) (**National Law**) or, if that regime does not apply, be approved under the *Children's Services Act 1996* (Vic) (**CS Act**).

41. Section 3 of the *Children's Services Act 1996* defines 'children's service' as a service providing education and care for four or more children under the age of 13 years in the absence of the parents or custodians of the children, where the service is provided for fee or reward or while the parents or custodians of the children use sports, leisure or other prescribed services or facilities provided by the provider of the service for the children and is not an education and care service, within the meaning of the National Law.

42. The *Education and Care Services National Law Act 2010* defines an education and care service as any service providing or intending to provide education and care on a regular basis to children under 13 years of age.

43. Under both the National Law and the CS Act, a person wishing to provide care in an 'education and care service', or a 'children's service' must be approved by the Regulatory Authority.

44. In February 2022, the Department of Education were informed that Ms OBU had conducted childcare services at her home at the time of Baby ZCZ's death and commenced an investigation. Over the following months, the investigation revealed that Ms OBU was operating an unapproved childcare service from her home.

45. On 20 June 2022, Authorised Officers attended the address at which time they observed seven children under school age. Ms OBU subsequently provided the following information to the officers:

    (a) she had been caring for more than three children under the age of 13 years since she left her role as a family day educator at Swan Hill Family Day Care Scheme about 10 years ago;[3]

    (b) she left family day care because there was too much paperwork;

    (c) she worked most weekdays, and some weekends, from about 7.00am to 4.00pm;

    (d) most families paid her a fee of $30 per day per child; and

    (e) she holds a Certificate III in Children's Services.

46. At the end of the visit, written guidance about the requirements for a children's service and education and care service was provided to Ms OBU.

47. After the visit, the Department of Education advised Ms OBU that she was required to cease operating if she was providing care or education to children that fell within the above definitions. Alternatively, the Department advised that Ms OBU could provide care for fewer than four children at any one time. It was noted that the Department would continue to monitor

[3] The Department of Education Skills and Employment confirmed that Ms OBU had previously worked at Swan Hill Family Day Care Scheme from 2005 to 2012.

Ms OBU and would take further action should any breaches be confirmed under the National Law or Regulations.

48. On 30 June 2022, Ms OBU's daughter sent an email on her behalf advising the Department that Ms OBU would be caring for fewer than four children and would comply with the recommendations of the correspondence.

49. The Department has informed me that where care is found to be delivered without approval, it usually directs the operator to immediately cease care of children. The Department then monitors the address periodically to determine if unauthorised care of children is occurring. Prosecution is considered where there is evidence that care has recommenced. An educative approach is usually taken in the first instance with information provided to the operator on legal requirements.

50. As part of the Department's investigation, Ms OBU disclosed that she had provided education and care at her residence for approximately 10 years without approval, in contravention of section 103[4] of the National Law. The Department did not instigate immediate prosecution at the time; however, it remains a possible action in future.

Australian Competition and Consumer Commission

51. In June 2023, the Australian Competition and Consumer Commission (**ACCC**) announced it planned to investigate infant sleep products as part of its product safety priorities for the year and also planned to implement strategies such as an education campaign to prevent injuries and deaths associated with infant sleep products including incline sleep products. It was noted that since 2001, about two infant deaths a year in Australia had been associated with inclined sleep products such as rockers and bouncers.

52. The ACCC's Product Safety Australia website notes that infant incline products such as rockers, bouncers, and swings are often marketed for play, transport, or sleep. However, while these products may be marketed for sleep, the ACCC advises that they are *unsafe* for babies to sleep in. The website explains that sleeping on an incline increases the risk of sudden death for babies from rolling into a position that blocks the airways or dropping their head onto their

[4] According to section 103, it is an offence to provide an education and care service without service approval. A person must not provide an education and care service unless— (a) the person is an approved provider in respect of that service; and (b) the education and care service is an approved education and care service. The section does not apply to a family day care educator providing education and care to children as part of an approved family day care service.

chest, which restricts their breathing. A number of such products have been recalled since 2016.[5]

53. The ACCC advises the following steps to use bouncers, rockers, and swings safely:[6]

(a) use them on a flat floor, away from potential hazards;

(b) never leave a baby to sleep in bouncers, rockers, and swings as the inclined backrest and soft sleeping surface are unsafe;

(c) always supervise the baby if using these products;

(d) when a baby begins to roll, it is time to stop using these products; and

(e) follow the manufacturer's instructions for safe use.

54. To further assist my investigation, I provided photographs of the rocker Baby ZCZ had been sleeping in to ascertain whether the product had been recalled at any stage. I also requested the ACCC to provide further information about infant incline products. Tim Grimwade, Executive General Manager of the Consumer Product Safety Division provided a written response.

Whether Baby ZCZ's rocker had been recalled

55. Mr Grimwade noted that infant rockers are not currently regulated by mandatory standards and there are no bans under the Australian Consumer Law affecting this product type.

56. Since 2010, there had only been one recall[7] of a rocker or sleeper supplied by Fisher Price and this was not the rocker Baby ZCZ had been sleeping in when found unresponsive.

57. However, Mr Grimwade noted that in June 2022 a Joint Safety Notice was issued in the United States by the US Consumer Product Safety Commission and Fisher Price following several reported incidents of deaths in infant rockers.[8] The products to which the Safety Notice applied

[5] See Australian Competition and Consumer Commission, Product Safety, Infant inclined products and sudden death risks, published 1 August 2022, available at: https://www.productsafety.gov.au/products/babies-kids/kids-equipment/infant-inclined-products-and-sudden-death-risks.
[6] See Australian Competition and Consumer Commission, Product Safety, Bouncers, rockers and swings, available at: https://www.babyproductsafety.gov.au/soothe-safe/bouncers-rockers-and-swings.
[7] In May 2019 the Fisher Price Rock N Play Sleeper was recalled following reports of deaths overseas of unrestrained infants rolling from their backs to their stomachs and suffocating.
[8] See United States Consumer Product Safety Commission, CPSC and Fisher-Price Warn Consumers About 13 Deaths in Fisher-Price Infant-to-Toddler and Newborn-to-Toddler Rockers: Advise Rockers Should Never Be Used for Sleep, 14

appear similar to the rocker that Baby ZCZ had been sleeping in. The Safety Notice included warnings to consumers about 13 deaths in Fisher Price Infant-to-Toddler and Newborn-to-Toddler Rockers and advice that rockers should never be used for sleep.

58. The ACCC will continue to monitor reports of incidents or injuries in relation to the Fisher Price rocker and may consider this issue further if safety concerns emerged.

ACCC's ongoing work regarding infant sleep products

59. Mr Grimwade informed me that the ACCC has been examining the safety of infant sleep products (including but not limited to rockers) since 2019 and this remains a Product Safety priority as noted above. The ACCC's program of work in relation to this issue has included identifying and addressing measures to reduce the risk of injury and death from infant sleep products.

60. As part of its work in this area, the ACCC has undertaken comprehensive consultation and engagement with industry and product safety stakeholders in relation to the risks associated with infant sleep products including:

(a) evaluation of overseas research;

(b) engagement with Australian industry and experts in 2020;

(c) publication and release for comment of an Infant Inclined Products Issues Paper[9] in July 2021;

(d) commissioning two independent expert reports; and

(e) expanding the initial scope of the project to include all Infant Sleep Products and release of an Infant Sleep Products Consultation Paper in August 2022.[10]

June 2022, available at: https://www.cpsc.gov/Newsroom/News-Releases/2022/CPSC-and-Fisher-Price-Warn-Consumers-About-13-Deaths-in-Fisher-Price-Infant-to-Toddler-and-Newborn-to-Toddler-Rockers-Advise-Rockers-Should-Never-Be-Used-for-Sleep.

[9] Australian Competition and Consumer Commission, Infant Inclined Products Issues Paper, 19 July 2021, available at: https://consultation.accc.gov.au/product-safety/infant-inclined-products-issues-paper/supporting_documents/Infant%20Inclined%20Products%20Issues%20Paper.pdf.

[10] Australian Competition and Consumer Commission, Infant Sleep Products Consultation Paper, August 2022, available at: https://consultation.accc.gov.au/accc/infant-inclined-consultation-regulation-impact/supporting_documents/Infant%20Sleep%20Products%20Consultation%20Paper.pdf.

61. In August 2022, the ACCC launched the Your First Steps[11] website as an additional channel for infant product safety messages.

62. In June 2023, the ACCC also launched an education campaign with social media communications, a poster resource, and updated website content aimed at raising awareness, particularly for new proposed safety and information standards for infant sleep products, including infant rockers which the ACCC recommended that the Commonwealth Minister make in the form of new regulation. Mr Grimwade explained that these standards are intended to, amongst other things, mandate a maximum allowable incline for sleeping surfaces and require warnings on products to draw attention to the hazards associated with sleeping infants in them.

63. As noted above, the safety of infant sleep products remains a Product Safety priority for the ACCC. This will involve implementing strategies to prevent injuries and deaths associated with infant sleep products, with a focus on, amongst others, increasing consumer awareness about safety risks in this area to support informed buying decisions.

64. I thank the ACCC for their informative and detailed submission to the Court.

FINDINGS AND CONCLUSION

65. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Baby ZCZ, born 19 October 2021;

    (b) the death occurred on 31 January 2022 at Robinvale District Health Services, 128-132 Latje Road, Robinvale, Victoria, from an unascertained cause; and

    (c) the death occurred in the circumstances described above.

[11] Australian Competition and Consumer Commission, Product Safety, Your First Steps, https://www.babyproductsafety.gov.au/.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Infant deaths associated with rockers

66. To assist my investigation, I asked the Coroners Prevention Unit[12] (**CPU**) to compile information about the incidence of infant and baby deaths involving rockers.

67. The CPU identified 10 cases in Australia between 1 January 2000 and 31 May 2023, where the deceased was aged 0-4 years and was in a baby rocker at the time of the fatal incident.

68. Among the 10 cases, the CPU identified only one case where the evidence suggested that the rocker design may have enabled the child to move into a position that contributed to death. In that case, a four-month old child died after his father placed him in a rocker to sleep on his back. He was subsequently found unresponsive lying on his front. The coroner concluded that the cause of death may be attributable to sudden infant death in a child who had been placed to sleep in an unsafe position, on equipment not designed for use by a sleeping infant.

Safe-sleeping advice

69. Red Nose, the leading Australian non-government organisation involved in safe sleeping research and education and advocacy, recommends that the safest place for a baby to sleep is in a cot, on a firm and flat mattress, with safe bedding. In addition, babies should be placed on their back to sleep, their face and head should be uncovered, and they should sleep in their own safe sleep space in a parent or caregiver's room for the first six months.[13]

70. This advice is reflected in the Victorian Government's *Safe Sleeping Checklist* used by the Maternal and Child Health Service.[14]

71. In the *Finding into Death Without Inquest into the death of Maddox Garry Wheeler*,[15] Coroner Caitlin English (as she then was) noted that despite previous initiatives for implementation, the Victorian government at that time did not have an overarching guideline to ensure

[12] The CPU was established in 2008 to strengthen the coroner's prevention role and to assist in formulating recommendations following a death. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health. The CPU may also review the medical care and treatment in cases referred by the coroner as well as assist with research into public health and safety.
[13] Red Nose Limited, Red Nose Six Safe Sleep Recommendations, 9 January 2023, https://rednose.org.au/article/red-nose-six-safe-sleep-recommendations.
[14] Victorian Government, *Maternal and Child Health Service: Safe Sleeping Checklist*, July 2022, available at: https://www.betterhealth.vic.gov.au/health/healthyliving/Maternal-and-child-health-home-visit
[15] Available at: https://www.coronerscourt.vic.gov.au/sites/default/files/2020-02/MaddoxGarryWheeler_31816_0.pdf.

consistent safe infant sleeping messages. South Australia, Western Australia, and New South Wales all have overarching guidelines and policy frameworks for delivering safe sleeping messages and education to new parents. Her Honour therefore made a recommendation that within six months of the date of that finding (being 11 December 2019), the Department of Health and Human Services finalise and release the Victorian Safe Infant Sleeping Guideline.

72. In February 2020, Kym Peake, Secretary of the Department of Health and Human Services, advised the Court that the guidelines were being produced by the Maternity and Newborn Clinical Network within Safer Care Victoria and provided a response from Professor Euan Wallace, Chief Executive Officer of Safer Care Victoria.

73. Professor Wallace advised the Maternity and Newborn Clinical Network was in the process of finalising the *Victorian Infant Safe Sleeping Guidelines* and were committed to publishing the document by March 2020. He also advised the document would be published in the Neonatal eHandbook online resource, which provides accessible and contemporaneous practice, evidence-based guidance for neonatal care providers. The guideline would also be accessible to Maternal and Child Health Nurses.

74. On 21 May 2021, Safer Care Victoria advised that all available resources were redeployed to develop the COVID-19 guidance for the maternity and newborn sector, which continued throughout the previous year. They had however recruited additional resources and the guideline would be published in the very near future.

75. In July 2021, Safer Care Victoria published its *Infant safe sleeping* guideline[16] which echoes the above advice – infants should sleep *"on a firm, flat surface, preferably in a cot/bassinet that meets Australian safety standards, with a well-fitting mattress and lightweight bedding."*

76. In addition, the guideline advises parents not to use commercially available nests/cocoons/hammocks that may curve an infant's position as this results in the chin falling towards the chest and obstructing the airway.

77. Similarly, it advises that cots/bassinets should not be elevated – *"All infants should sleep on a flat surface."*

[16] See Safer Care Victoria, Infant safe sleeping, available at: https://www.safercare.vic.gov.au/best-practice-improvement/clinical-guidance/neonatal/infant-safe-sleeping.

Baby ZCZ's death

78. After reviewing the available evidence regarding the circumstances of Baby ZCZ's death, I am satisfied of the following:

    (a) at the time of Baby ZCZ's death, Ms OBU was operating an unapproved childcare service;

    (b) on 31 January 2022, Baby ZCZ's parents placed her in the care of Ms OBU's childcare service for a fee;[17]

    (c) Baby ZCZ was a previously well breastfed infant who was up to date with her required vaccinations;

    (d) Baby ZCZ was placed in her Fisher Price rocker to sleep where she remained and was monitored on a number of occasions prior to her being found unresponsive;

    (e) Red Nose and other government authorities advise that infants should be placed in a safe cot, on a safe mattress, with safe bedding to sleep; and

    (f) as such, Baby ZCZ was not placed in a safe sleeping environment immediately before being found unresponsive.

79. However, given Baby ZCZ's cause of death is unascertained, I am unable to make a finding that her unsafe sleeping environment directly contributed to her death.

80. For procedural fairness reasons, I informed Ms OBU of my proposed adverse comments and provided her with an opportunity to provide submissions in response.[18] No response was received.

Conclusion

81. Although on my appraisal of the available evidence I cannot be satisfied that unsafe sleeping directly caused or contributed to Baby ZCZ's death, the circumstances in which she died once again highlight the vulnerability of infants sleeping in an unsafe environment.

[17] Baby ZCZ's parents could not recall the agreed amount to be paid.
[18] Letter dated 3 August 2023 sent to Ms OBU with a copy sent to her solicitor.

82. Consistent and government-led messaging for new parents and neonatal care providers is therefore critical and I acknowledge Safer Care Victoria's work in this area.

83. In the hope that the circumstances of this finding will raise public awareness of safe-sleeping and the potential dangers of placing infants in rockers or similar products to sleep, I will publish my finding.

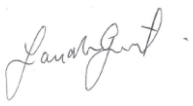
I convey my sincere condolences to Baby ZCZ's family for their loss and acknowledge the profound grief caused by the passing of such a young child.

Pursuant to section 73(1A) of the Act, I order that this finding (in redacted form) be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Mr FWI and Ms REB, senior next of kin
Ms OBU
Australian Competition and Consumer Commission
Department of Education
WorkSafe Victoria
Safer Care Victoria
Senior Constable Matt Fiebig, Victoria Police, Coroner's Investigator

Signature:



Coroner Sarah Gebert

Date: 17 January 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.