OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of William Chase Corben**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2015/860
DELIVERED ON:	7 April 2016
DELIVERED AT:	Brisbane
HEARING DATE(s):	16 November 2015, 14-15 December 2015
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, swimming pool child death, propping open of gate, supervision, enforcement of swimming pool regulations

REPRESENTATION:

Counsel Assisting:	Ms M Jarvis, Office of State Coroner
Counsel for Mr & Mrs Corben:	Mr B Reilly I/B Jacobsen Mahoney
Counsel for Mr & Mrs Stewart:	Ms S Thompson I/B Potts lawyers
Hannah's Foundation:	Ms K Plint

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Introduction

1. William Corben was four years of age when he died after being found unconscious in a swimming pool in his neighbours' backyard, at Pacific Pines in Queensland on Saturday 28 February 2015.

2. An investigation indicated that two critical factors may have played a part in the tragic events of that afternoon, namely:

   - whether there was a deliberate propping open of the pool gate, which then allowed access to the pool area by other children including William, and

   - the level of supervision that was provided to the children during that time.

3. However, the particular circumstances in which the pool gate was propped open and supervision was provided remained somewhat unclear.

4. A decision was made for these circumstances to be examined in further detail by way of inquest to gain a better understanding of the factors that may have contributed to William's tragic death.

5. It was further hoped that an inquest may help raise public awareness of the critical things parents and pool owners need to do to ensure the safety of children in and around swimming pools.

6. Ms K Plint of Hannah's Foundation was given leave to appear to make submissions and otherwise examine witnesses (subject to leave being granted), pursuant to s. 36(3) of the *Coroners Act 2003*.

List of issues

7. A Pre-Inquest Conference was held on 16 November 2015. The issues determined for the inquest were as follows:

   - The findings required by s. 45(2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death; and

   - To discover what happened so as to inform the family and the public how the death occurred, with a view to raising awareness and reducing the likelihood of similar deaths, including by way of preventive recommendations if appropriate.

8. The witnesses to be called included the following:

   - Detective Sergeant Mike Cahill, Gold Coast District Child Protection and Investigation Unit, QPS (QPS Investigating Officer)
   - Robert Hooper, Inspector, Gold Coast City Council (prepared 'Pool immersion incident report' dated 12 March 2015)
   - Hayley Corben (William's mother)
   - Rodney Stewart (pool owner)

- Lisa Stewart (pool owner)

Swimming pool access and safety compliance issues

9. William and his eight-year-old brother resided with their parents at an address at Pacific Pines, on the Gold Coast. The Corben family had moved there only one month previously but it appears they had quickly become acquainted and formed friendships with neighbouring families, including the Stewarts who lived across the road.

10. Hayley Corben provided evidence that due to William experiencing a reaction to chlorine they were unable to continue providing him with swimming lessons which he had taken for twelve months from around age two. This had come up in a conversation with Lisa Stewart and Hayley Corben stated that Lisa Stewart knew that William could not swim.

11. There had been two previous occasions when William and his older brother had been invited to swim in the Stewarts' pool. On the first occasion Hayley Corben had been present for the whole time and on the second occasion was a matter of minutes behind but Lisa Stewart was present supervising. Similarly, she had told Leanne Pledge another neighbour, that William could not swim and required direct supervision by either herself or an adult when in the pool.

12. The swimming pool in question was a recent addition to the Stewart residence having been certified by the Gold Coast City Council on 15 July 2014. It is evident the pool fence complied with the most recent regulations and standards and a post incident pool inspection revealed only a minor non-conformity unrelated to the immersion incident.

13. There was a glass and security mesh screen sliding door set allowing direct access to the pool area from the main bedroom of the house. To be compliant with pool regulations this opening had to be altered in such a way that it was no longer a 'door'. It was not sufficient merely to have a child resistant locking mechanism on the door set (which was allowed under earlier regulations). To comply with this requirement Rodney Stewart states that he installed a plastic bracket, secured with a bolt, to prevent the security mesh screen door being opened unless the bracket was removed. The glass door behind it was able to be opened for airflow reasons.

14. Leanne Pledge stated that Lisa Stewart had told her that the sliding doors from the bedroom were not to be opened as the pool inspector told them the doors would have to be kept locked. Leanne Pledge however recalls several times when she saw both the sliding doors open to the pool area such that she could see clearly into the bedroom. She confirmed this in her evidence at the inquest.

15. It is accepted that some type of bracket would likely have been in place at the time of inspection for certification. In his evidence Rodney Stewart stated that at no time had he subsequently touched or removed that bracket.

16. Rodney Stewart was asked about the glass door at the scene and he said it probably was also open.

17. It became evident for the first time at the inquest that Lisa Stewart was able to gain access to the pool area directly through the bedroom doorway upon being informed William had been removed from the pool unconscious. The circumstances in which this was possible was the subject of some conjecture at the inquest. Of significance is that this was not raised by Rodney Stewart in his interview with police or pointed out to police at the scene. Further there is no evidence from the scene photographs of a broken piece of plastic bracket or any bracket for that matter.

18. Sergeant Cahill from the Child Protection Investigation Unit recalls there was a screen and glass door and did not notice any brackets or other fixtures or debris or damage to the door or its surrounds.

19. On one photograph taken by the pool inspector conducting the post incident inspection there is evidence of a substantial metal bracket now installed after the incident by Rodney Stewart, as well as another hole in the metal consistent with what may have been a previous screw hole. All that establishes is that there may have been a bracket installed for

certification purposes but that does not prove or mean it had not otherwise been removed subsequently.

20. If Leanne Pledge is correct, it is clear that access through both doors was possible. Rodney Stewart says this is rubbish.

21. Lisa Stewart says she did not know how the door was secured only that they could not use the door anymore. She said she does not recall trying to open it or test to see if it could slide open. She denied the evidence of Leanne Pledge that there were occasions when both doors were open. She said there was a key to the screen door in a drawer in the bedroom. When she went outside to commence CPR she thought the quickest way to get there was through the doorway, so she grabbed the key. She says she has no idea if she had broken something and suggested the strength required to break the bracket may have been due to adrenaline. Otherwise she would have had to walk back through the house to the patio area.

Events of 28 February 2015

22. Late on the afternoon of 28 February 2015, at around 4.00pm, William and his older brother were over at the Stewarts' house, playing with their two young sons, aged eight and five, and a ten-year old child who lived next door to the Stewarts.

23. The exact events of that afternoon are unclear in so far as some of the detail is concerned, but in general the events can be summarised as follows. During the afternoon the Corbens were in their front yard attending to the garden and other maintenance. Their two children were out the front playing in view of their parents. Earlier in the afternoon they had been at a neighbour's swimming in their pool. The neighbour was Leanne Pledge and she supervised the children. The boys returned and got dressed. At one point the children were building a cubby house on the driveway of the Stewart's home with the Stewart boys. Neither of the Corben children were in swimming clothes. Both boys then went inside the Stewarts' home and Hayley Corben thought they were intending to play in the playroom.

24. It appears that the five young children were allowed to swim in the Stewarts' swimming pool for a period of time by Mr Stewart. There was some contention as to how that occurred (whether it was initiated by Mr Stewart or at the request of the children), but whatever are the precise details, I am satisfied that Mr Stewart, as the only adult present, allowed the children to go into the pool. He did not check with the Corbens if this was okay or otherwise inform them. I am satisfied that if Hayley Corben had been told the children were going to swim she would have intervened or otherwise supervised her children herself.

25. I am satisfied that Rodney Stewart remained either in the pool area or in the general vicinity of the children whilst they were in the pool. Lisa Stewart was at this time walking some distance away. Hayley Corben saw Lisa Stewart come home and saw her go into the house. It is apparent that at some earlier point Rodney Stewart made contact with his wife to

check on when she intended to return to the residence. Shortly after her return Rodney Stewart asked his wife to supervise the children in the pool while he mowed the lawn. At some stage, the children finished playing in the pool and began playing a game of 'hide and seek'. During this game, William went missing. Some of the children noticed this but believed William had gone home. Lisa Stewart asked the children where William was and she says this was the response.

26. According to the police report, approximately twenty minutes later, Rodney Stewart, entered the pool area and began removing the inflatable toys from the pool. Lisa Stewart thought the time between her last seeing William and him being found was about five minutes. In any event it was at this time that William was discovered, semi-submerged and floating in the corner of the pool face down. Rodney Stewart pulled William from the pool. He first alerted his wife and he says he was shocked when he saw her come through the bedroom doorway, which should have been secured by the bracket, and started CPR.

27. Rodney Stewart then alerted Hayley Corben who was mowing her front lawn and she ran over to the house. Hayley Corben could see all of the children were wet and William was in his underwear. She screamed to them about who had let them into the pool and why she had not been told that they were going to swim

28. The QAS Electronic Ambulance Report recorded a call to Queensland Ambulance Service was made at 5:24. QAS dispatched the first unit at 5:27 and a second at 5:29 and were with the patient at 5:33. At that time the pulse and blood pressure were unrecordable and William was in pulseless electrical activity. Advanced CPR was commenced. There was a low pulse obtained at 5:39 and a return to a more regular spontaneous circulation by 5:43. William was loaded at 5:50 and transported to the nearest hospital for emergency medical care and arrived at Gold Coast University Hospital at 6:03. He was later taken to the Lady Cilento Children's Hospital, where he was placed on life support. William's condition did not improve and tests failed to identify any brain function or signs of life. William's family made the decision to cease life support, and William died on 4 March 2015.

29. A pathologist determined William's cause of death as 'hypoxic ischaemic encephalopathy' following a near drowning event.

30. Hayley Corben was told by a doctor at the hospital that on the way William presented it is likely he had been without oxygen for in the vicinity of 20 to 27 minutes. Lisa Stewart had said there was only a gap of 5 minutes between when she last saw William and him being found. Whether that is the case or not (and it appears to be longer than that), it is apparent there was at least a period of over 20 minutes and likely longer (given the first call seems to have been made by Mr Corben) during which William was without any oxygen being produced in his circulation before CPR was successful.

31. Upon being notified of the incident on 28 February 2015, police officers immediately attended the scene. An electronically recorded statement from Rodney Stewart was taken as he took the officers on a walk-through of the pool area. Scene photographs were taken. Lisa Stewart also provided an electronically recorded statement to police shortly after the incident. Police officers also interviewed and obtained section 93A statements from the four children who were playing with William later that evening.

32. Mr Stewart admitted in his interview to have 'likely' propped open the pool gate with timber blocks. Photographs taken by police after the incident show timber blocks left near the metal and glass gate. He told police that he did use these to prop open the gates. He contended in his evidence at the inquest that he did that so he could push his mower through and they had not been left open in that state on the day. In his interview he said he would sometimes use the blocks of wood to keep the gate open when the children were in the pool and they were directly present. In his interview he stated that in relation to the pool gate he could not recall whether the pool fence was closed or open.

33. Sergeant Cahill observed one of the gates was chocked open with the lump of wood when he attended.

34. An 8 year old child of the Stewarts and William's brother aged 8 both told police in the course of their s 93A interview that Mr Stewart had secured the pool gate open by putting a block on them. William's brother in particular said Mr Stewart was going in and out of the house with the washing and left the gate open to go in and out of the house.

35. Mr Stewart stated that he was initially watching the children for about 30 minutes at the swimming pool. Then his wife came home about 4:30 (in evidence he said it was closer to 4:40/45) and he asked her to keep an eye on the children whilst he did the mowing. When he left to start the mowing she was at the pool.

36. He says that his wife must have gone inside for a few seconds to change and when she came out she asked the other children where William was and the children said he must have gone home.

37. He was also questioned about his knowledge of William's ability to swim and he stated that he was wearing a floaty whenever he saw him and he always remained on the step into the pool.

38. Lisa Stewart told police that her husband contacted her about 4:30 to ask how much longer she would be out as the neighbour's boys had come across to swim and he was hoping to mow the lawn.

39. She said she was watching the children in the pool area whilst her husband started mowing. She stated that she saw Mrs Corben mowing her lawn. She said in her evidence that she was in the pool area the whole time while the children were swimming. She said she did not go out of the pool area or inside her home until after the children started getting out of

the pool and running around and playing hide and seek. In her evidence at the inquest she, for the first time, described hearing the 'bang, bang, bang' of the gate closing.

40. She stated that she asked the children three times where William was and her children said he had gone home.

41. At some point she agreed she was in her bedroom getting ready to go to the movies with some friends but this was only after the children had got out of the pool. They had arranged to meet at 6pm. There was some contention as to whether she had a shower in this time. She denied this was the case.

42. The 10 year old child of Leanne Pledge stated in his interview that Mrs Stewart was watching the children from the sliding door of her bedroom as they were swimming. He said he saw her making her bed. She asked the children to get out of the pool as she wanted to have a shower and the children complied. He said both the glass door and screen door were open. They then started to play hide and seek. William's brother had hidden behind the vegetable garden and William was under a table. It was at this stage that William ran away behind the pool pump and when they could not find him he thought he had gone home. He repeated that Lisa Stewart was in the shower.

43. The 8 year old Stewart child in his interview repeated on a number of occasions that his mother had been taking a shower. The Stewarts both stated that he has been diagnosed ADHD and Asperger's Syndrome and the court should have concerns as to his reliability on this issue.

44. Leanne Pledge described Lisa Stewart as appearing quite different when she saw her applying CPR as she appeared to have freshly washed hair and was dressed in clothes for going out and previously she appeared to be hot and sweaty and in exercise clothing. Lisa Stewart disagreed that she had had a shower. She said she may have said she wanted a shower but she decided she did not require one.

45. Lisa Stewart's evidence was essentially that she had gone for a walk during the afternoon wearing a singlet, shorts and thongs. She had intended to meet friends at the movies at 6pm. She had intended to have a shower but she noticed the time and decided she did not have enough time.

Conclusions

46. In reaching my conclusions it should be kept in mind that a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.[1] The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths.

[1] s 45(5) *Coroners Act 2003*

47. If, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed a criminal offence, the coroner must give the information to the Director of Public Prosecutions (DPP) in the case of an indictable offence, and to the chief executive of the department which administers legislation creating an offence which is not indictable.[2] The evidentiary threshold for making such a referral is a low one and any response is for the DPP alone to consider.

48. In this case, submissions were made that there is sufficient information for me to refer the facts of this case to the DPP in relation to a possible offence under s. 364A – Leaving a child under 12 unattended. I agree that the appropriate threshold has been reached to so do.

49. I can readily conclude that Hayley Corben had impressed upon Lisa Stewart about William's poor swimming capability. Lisa Stewart was aware from experience that Hayley had attended personally on the only two previous occasions when William was swimming in their pool.

50. When the children had gone over to the Stewarts' house that afternoon, Hayley Corben had not expected the children to go swimming again. They had already had a swim and were in play clothes, not swimming clothes. Permission to swim seems to have been initiated either by Mr Stewart or at least with his agreement.

51. Rodney Stewart had initiated a 'bad practice'[3] of propping open the pool gates. He had two blocks of wood near the gates for that purpose. He says this was to allow him to bring his mower through but it is evident it was more frequent than that. The pool gates were propped open that afternoon before he started mowing. The evidence of the children in their interviews they gave to police within hours of the incident are very consistent in that respect. He was likely to have been exercising greater supervision than his wife and seems to have been generally in the vicinity of the pool. He was anxious to start his mowing so he rang his wife and asked if she could come back from her walk soon to take over.

52. Lisa Stewart had been walking in shorts, shirt and thongs during the afternoon of a February day. She returned around 4:45. She was intending to meet friends for a movie at 6pm. She took over the supervision of the children. They continued to swim for a time until she requested they leave the pool area. She said she wanted to take a shower. She believed the boys left the pool area. I expect that they did and this is not a case of William having been left in the pool area. They started a game of hide and seek. It was at this point that William made his way back into the pool area because the gates were propped open.

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[2] s. 48(2)

[3] His words

53. Lisa Stewart was by this time in the house getting ready to go out. The resolution of whether she took a shower or not is not altogether significant. It does defy common sense and logic that in the face of having been walking during a February afternoon; expecting to go to the movies with friends; expressing that she wished to take a shower; saying that was her intention to a number of the children, that she did not do so. Leanne Pledge was adamant she appeared to be fresher than she was on her return from her walk.

54. Whether she was taking a shower or simply changing and putting on make-up as she says, there was a gap in her supervision of the children. She relied on young children to impart the information that William had gone home. She did not check this with the Corbens. All however would have been different if the gates had not been propped open.

55. There is the issue of the open screen door. It is difficult to reconcile the evidence of Mr and Mrs Stewart in this respect with the other evidence. Whatever bracket had been placed on the door to meet certification, I am satisfied it had been removed. No evidence of a broken bracket was found at the scene or noted in police photographs. Neither Lisa Stewart nor Rodney Stewart made any mention of this to the police on the day.

56. Leanne Pledge says she saw both doors open on occasions. Lisa Stewart says she has no idea how the door was secured. Yet she decided to use the key found in a set of drawers to burst her way through the ‘plastic’ bracket she did not know existed. This was not a case where she needed to pull William from the water. Her husband had already secured William from the pool. She was able to come out so quickly because the door was easily able to be open, she knew this, and had no reason to consider other longer options of getting to the area.

57. The resolution of that issue is also not determinative of the cause of William’s drowning as there is no evidence he had been seen in the bedroom area or obtained access through the door. It arguably points to a fairly cavalier approach by the Stewarts to their obligations to maintain pool safety.

58. Mrs Plint on behalf of Hannah’s Foundation stated that since 2013 there had been 13 deaths in backyard pools and all related to some extent to the propping open of pool gates. Supervision or a lapse in supervision of course is always an issue in swimming pool child deaths. Hannah’s Foundation, in conjunction with the Corben family, launched an awareness campaign ‘STOP! DON”T PROP’. They are also advocating for changes to the law making it a criminal offence for breaching swimming pool legislation when a drowning occurs.

59. What this statistic says is that the enhanced pool safety and fencing laws that have been introduced into Queensland have been very successful. But deaths have continued to occur because of deliberate breaches of the pool safety laws by placing obstacles in front of gates, which effectively

renders useless the safety features intended by pool fencing and compliant gates in the first place.

60. In December 2015, I conducted two inquests involving the deaths of children in swimming pools where a gate had been propped open.

61. In the matter of T, after T's death, T's mother issued this message for other parents [The Toowoomba Chronicle, 26 March 2015]:

> *Always make sure your pool gate is shut, check that it has closed correctly and never prop it open. Tragedies happen in a second; don't believe it can't happen to you.*

62. That message is particularly pertinent to the events that occurred in both cases and is essentially the safety message that needs to be impressed on all pool owners.

63. I can also say that both Counsel Assisting and I in separate incidents over the Christmas holiday season have seen swimming pool gates propped open.

64. In T's case, he was apparently capable of swimming to save himself. However, it is likely he fell and in the process hit his head and became unconscious. He was in the water for a 5 to 10 minute period, long enough to suffer the effects of drowning.

65. The capability to swim to save oneself is of course a significant prevention strategy, but is no substitute for compliant barriers to prevent unnoticed entry to pool areas or adequate supervision.

66. In William's case, he was not capable of swimming to save himself and this should have been evident to both the Stewarts.

67. William's death was preventable. Vigilance in preventing access by children to the pool must be maintained at all times. There are two simple ways of doing this. Firstly, maintain the efficacy of pool fencing and gates in preventing unobserved access. Secondly, maintain direct supervision of young children. In this case there was a lapse in direct supervision as well as access to the pool being enabled by propping open the gate. William was able to re-enter the pool unnoticed and drowned.

Findings required by s. 45

Identity of the deceased – William Chase Corben

How he died – William was aged four at the time of his death. He drowned in his neighbours' residential swimming pool. At the time William was being supervised by his neighbours. There was a

lapse in that supervision and William was able to gain access to the swimming pool unnoticed. Access was facilitated because the swimming pool gates had been intentionally propped open with a block of wood. His death was preventable.

Place of death – Lady Cilento Children's Hospital, South Brisbane

Date of death– 4 March 2015

Cause of death – Drowning

Comments and recommendations

68. At the conclusion of this inquest and the inquest in respect to the death of T, I received submissions on a number of proposed recommendations. Those recommendations included proposals to introduce new legislation (Williams Law) making it a criminal offence where a death or serious harm occurs in a swimming pool where there are intentional or negligent breaches to pool safety regulations. Such laws have been recommended by coroners in New South Wales[4] but as far as I am aware have not been introduced. Such laws are the subject of some controversy as it may be argued that current laws relating to offences in the Criminal Code are sufficient.[5]

69. The evidence in this inquest as well as that of T also suggests some concerns with respect to efficacy of the regime of pool inspections and training of inspectors.

70. I became aware that a State Government Inter-departmental Committee for Pool Safety convened by the Department of Housing and Public Works was reviewing a number of aspects of pool safety including:
    - Immersion Incident Reporting
    - Pool safety Management Plans for Category 3 building such as resorts and hotels
    - Pool Safety Inspectors and training
    - Dam Drownings
    - Whether there should be new offences for people who commit intentional breaches of pool safety and death or serious harm occurs.

71. Counsel Assisting has met with the Department and I have been provided with a copy of their draft report. A final report has not yet been received

[4] Inquest into Multiple Deaths, 30 April 2010, Deputy State Coroner P MacMahon; Inquest into the Death of Sebastien Yeomans, 1 April 2015, Magistrate K Stafford

[5] s 364A – Leaving a child under 12 unattended, s 289 – Persons in charge of dangerous things

and it may be that a different view is finally taken on some aspects of the review. My comments reflect only what is contained in the draft report.

72. The committee's position is that the offence provisions in the Criminal Code (including negligent acts causing harm, leaving a child under 12 years unattended, grievous bodily harm and manslaughter) are sufficient. The committee recommended that no changes be made to any offences relating to pool safety.

73. One issue that appears to have been argued is that generally there was no public interest in creating criminal offences or pursuing criminal charges in these cases, as the child who has drowned or been injured is usually the child or other relative of the pool owner, and the act of leaving a gate propped open is not sufficiently serious in any case to perhaps warrant a criminal charge.

74. Although I can understand the reasoning behind the view adopted, I respectfully disagree to this extent. It is apparent that all child pool deaths that have occurred in recent years have involved deliberate or reckless acts of breaching pool safety laws. The creation of a new offence may make it clear to those supervising children in this context of the importance of total compliance with pool safety legislation and adopting vigilant adult supervision. The discretion to prosecute or not would remain with the police or the DPP who could still consider those matters concerning public interest and the particular personal circumstances of the family.

75. It is apparent from the evidence in these cases that the use of fines have been irregular and inspectors have adopted other methods of ensuring compliance by voluntary rectification by pool owners, issue of rectification notices before any enforcement by way of penalty occurs. This is similarly the experience identified in New South Wales.[6]

76. In those circumstances it is my recommendation that the issue of creating a new offence where serious injury or death occurs in circumstances where there has been intentional or negligent breaches of pool safety laws be reconsidered in the context of the facts arising from these cases as well as the support for the implementation of such additional offences by other coronial jurisdictions.

77. The Committee relevantly also considered the Immersion Incident Reporting system and professional development of pool safety inspectors and recommended that:
    - Additional support be provided to local government through an enforcement protocol and formalised information sharing between investigating authorities.
    - The Department work with Queensland Health to amend the immersion incident form.

[6] See discussion by Magistrate Stafford in the Inquest into the Death of Sebastien Yeomans, 1 April 2015 at pp 23-25

- An enforcement protocol be developed, which will assist local governments to undertake inspections and investigations following an immersion incident.
- The need for continuing professional development for pool safety inspectors was supported but agreed that the current requirements did not sufficiently recognise periods of experience that have been gained by many inspectors and the decrease in new information within the industry. The committee supported and recommended a sliding scale framework.

78. The committee also considered other matters which are not relevant to the issues that arise from the facts of these particular cases. Of particular note were the conclusions drawn in relation to the examination of dam drownings, of which there had been a number in recent times in Queensland. The committee considered that although dam safety is an important issue, it does not believe that a regulatory response is warranted or justified, and in particular with respect to whether dams or homesteads near dams should be required to be fenced. Rather an awareness campaign about the risks of young children drowning in dams should be developed. No doubt these are issues which will be considered in the context of coronial investigations concerning those dam drownings.

79. Ms Plint also made a submission that the evidence suggested that the QPS investigators and Scenes of Crime officers who attended were not fully aware of the complete compliance issues for swimming pools and as a result there may have been a gap in information gathering at the immediate scene. Accepting that the protocol for investigations involves advising the local council to inspect and advise on compliance issues, there is still merit in that submission. In this case, the issue of the screen door compliance was not considered at the scene and an opportunity may have been missed to have clarified the issue of the presence or non-presence of the so called plastic bracket either by photographs or other evidence.

80. Further the scene had obviously been disturbed by the time photographs were taken of the pool gates as they were not propped open when photographed. That evidence certainly would have assisted me, although ultimately I am confident in making my findings on the balance of probability without that assistance.

81. Although I am not particularly critical of the investigation, there is always room for improvement and I support the submission that QPS review their Operational Procedures Manual regarding the investigation of swimming pool deaths to ensure or emphasise that all possible aspects of swimming pool compliance and safety are considered.

Recommendations

I. It is recommended that the issue of creating a new offence where serious injury or death occurs in circumstances where there have been intentional or negligent breaches of pool safety laws be reconsidered by the

responsible State Government Minister in the context of the facts arising from these cases as well as the support for the implementation of such additional offences by other coronial jurisdictions.

II. QPS review their Operational Procedures Manual Chapter 8.5.11 regarding the investigation of swimming pool deaths to ensure all possible aspects of swimming pool compliance and safety are included in the investigation.

I close the inquest.

John Lock
Deputy State Coroner
BRISBANE
7 April 2016