OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of a 2 year old child**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO:	2008/124
DELIVERED ON:	13 December 2010
DELIVERED AT:	Brisbane
HEARING DATE(s):	10 - 12 November 2010
FINDINGS OF:	Coroner John Lock
CATCHWORDS:	CORONERS: Child drowning, adequacy of supervision, swimming pool legislation

REPRESENTATION:

Counsel Assisting:	Ms A Martens, for the Office of the State Coroner
Department of Communities - Child Safety (formerly Department of Child Safety):	Ms L O'Neill instructed by the Department of Communities - Child Safety
The father BR:	Ms J Gilfoyle of Gilfoyle Solicitors
Stephen Osmak:	Mr S Slasberg of Walsh Halligan Douglas Lawyers
Hannah's Foundation:	Mrs K Plint

Introduction

1. On 21 October 2008 a 2 year old girl, L drowned in a backyard swimming pool at rented premises at Kallangur. She lived there with her father, her 3 year old sister K and an uncle. Her parents were separated. L's sister first saw her lying facedown in the pool. Access to the pool was likely to have obtained through a sliding security door which was found to have the lock detached. It was not apparent how the lock got into that condition.

2. The family was known to the Department of Child Safety. There was a significant degree of parental conflict and proceedings were eventually brought in the Family Court with respect to child custody issues. After hearing an application from the Department and in accordance with established practice and following the procedure adopted by the Family Court, I have ordered that any details identifying the name of the child L and members of her family not be published or otherwise distributed.

3. The main issue for determination at the inquest was to determine how the faulty lock to the security door got into that condition and otherwise how the death occurred.

4. A second issue was to consider the interaction between the family and the Department of Child Safety and if any action or inaction on the part of this Department contributed to the death.

5. These findings will also consider the state of the pool fencing at the time of the death and whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future. Of significance it was noted that new Swimming Pool fencing legislation came into force on 1 December 2010 which, if it had been adopted at these premises back in 2008, may have significantly minimised the chances of L drowning.

6. Section 45 of the *Coroners Act 2003* ("the Act") provides that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These findings will be distributed in accordance with the requirements of the Act and also placed on the website of the Office of the State Coroner.

The scope of the Coroner's inquiry and findings

7. A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

    a. whether a death in fact happened;
    b. the identity of the deceased;
    c. when, where and how the death occurred; and
    d. what caused the person to die.

8. There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

9. An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:- *"It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires."*[1]

10. 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. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[2] However, a coroner must not include in the findings or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.[3]

The admissibility of evidence and the standard of proof

11. A coroner's court is not bound by the rules of evidence because the Act provides that the court "*may inform itself in any way it considers appropriate."*[4] That does not mean that any and every piece of information, however unreliable, will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

12. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt; an inquiry rather than a trial.[5]

13. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw* sliding scale is applicable.[6] This means that the more significant the issue to be determined; or the more serious an allegation; or the more inherently unlikely an occurrence; then in those cases the clearer and more persuasive the evidence should be in order for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[7]

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] Section 46 of the Act
[3] Sections 45(5) and 46(3) of the Act
[4] Section 37 of the Act
[5] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[6] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[7] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

14. It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[8] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[9] makes clear, that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

15. 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 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 if, from information obtained at an inquest or during the investigation, a coroner reasonably believes that the information may cause a disciplinary body for a person's profession or trade to inquire into, or take steps in relation to, the person's conduct, then the coroner may give that information to that body.[10]

The evidence

16. It is not necessary to repeat or summarise all of the information contained in the exhibits and from the oral evidence given, but I will refer to what I consider to be the more important parts of the evidence.

Social History

17. L's father BR and her mother DP were in a relationship for a number of years, and for one of those years they were married. Their relationship produced two children K who was born on 15 May 2005 and L who was born on 11 July 2006.

18. L was described by her mother as a well loved child who brightened up every one's day. She said she was a typical redhead. L's father said she was a great little girl, his little mate who liked the things that he liked and was loved by everyone. I have no doubt that both parents cared deeply about their children, a conclusion also reached by Justice Murphy in the Family Court proceedings which took place earlier this year. The loss of L in these tragic circumstances has no doubt had a damaging impact on both parents and it would also seem on her sister's own bereavement and ongoing emotional issues.[11]

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[8] Harmsworth v State Coroner [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in The inquest handbook, Selby H., Federation Press, 1998 at 13

[9] (1990) 65 ALJR 167 at 168

[10] Section 48(4) of the Act

[11] Comments made by Justice Murphy in his decision in the Family Court. Mrs Plint requested that I recommend that the parents undergo a Triple P parenting course and K and the family receive further support by the Department of Communities or the Family Court but it is beyond the scope of an inquest to make such a recommendation. I heard no evidence on this point and it is a subject for the jurisdiction of the Family Court.

19. On 8 July 2007 the relationship between the parents ceased. The father initially retained custody of the two children and he and the children resided with his parents. L's mother would see the children approximately once a month. Between August 2007 and January 2008, the mother suffered a manic depressive episode and she sought treatment. She had previously been diagnosed with depression as a teenager.

20. In January 2008 the mother made contact with a lawyer and as a result, L's parents were required to attend a Legal Aid mediation. This mediation occurred in April or May 2008 and as a result an agreement was reached that the mother would have access to the children from Friday afternoon until Monday morning once a fortnight. This arrangement continued up until L's death.

Domestic violence incident in December 2007

21. In December 2007 an incident occurred between L's parents which was witnessed by the children.

22. The incident was reported to the police several days later. As a result of the information provided, the police conducted a welfare check to determine the welfare of L and K. The girls appeared well cared for and dressed in appropriate clothing.

23. On 6 December 2007, Ms NB, an intake officer within the Department of Child Safety (now known as the Department of Communities - Child Safety, however I will refer to it as "the Department") received a call in relation to L and her family. The notifier advised that the parents had separated 5 months earlier and the father BR had taken the children to live with him. The caller indicated the relationship had deteriorated as the father was making threats to kill the mother DP, and the children K and L and on Sunday the father had abducted DP and was driving around with her and the children. The notifier indicated the children were in the car screaming. The notifier indicated the mother had left her home and was currently hiding from the father. The caller also stated the father had been seen driving around the mother's house looking for her and on the morning of 7 December 2007 he had telephoned the mother threatening her. The notifier also indicated the father had contacted the maternal grandmother and stated "if DP does not speak to me I will hurt the girls". The notifier heard K laughing however she then started screaming. The caller advised there were concerns for the children. The mother had only been allowed to see the children when the father allowed it.

24. Ms NB advised the caller to have DP and her mother contact the police and advise them of the situation and request a welfare check to be conducted. The notifier was advised to re-contact the Department once they had spoken with the police to advise of the police's response.

25. On 7 December 2007 Ms NB entered this information into the Department's database. As a result of entering the information, she was

required to complete screening criteria which related to alleged harm/risk of harm to the children. The topics covered were neglect, physical harm, sexual abuse and emotional harm. Because none of these items were selected, the screening criteria indicated the matter should be recorded as a Child Concern Report.

26. As a result of completing the Child Concern Report, Ms NB made the following assessment of the concerns raised “the mother is currently in Melbourne as she was sent down there by her parents in order to get her away from the father. The notifier advised that the mother will be seeking a DVO and is looking to apply for custody of the children. Notifier was advised to have the person the father has been making the threats to (the mother and the maternal grandmother) call the police and request for a welfare check to be conducted. The notifier advised that the maternal grandmother would attend the Browns Plains police station and report their concerns and ask for a welfare check to be completed. Notifier was asked to re-contact the Dept and advise of the Police’s response. At this time the information will be recorded as a Child Concern Report, however if further information is received, this information is to be re-assessed in order to ascertain the current safety and well-being of the children.”

27. On 2 January 2008 the Child Concern Report was approved by Ms NB’s Team Leader, Ms WR. As a result, no further action was taken by the Department in relation to this information.

28. In November 2008, the father was charged with 6 offences as result of the incident in December 2007. The reason for the delay in commencing the proceedings certainly seems unacceptable. An explanation is provided in a statement of Plainclothes Senior Constable Kellie Brooks[12] and seems to be related to the fact she was aware a welfare check had been conducted in relation to the children and there were no problems identified and subsequently Queensland Police resources, recreation leave and a four-month period of sick leave delayed the investigation. It was not until after the death of L that the charges were commenced. It would be fair to say it is apparent the matter simply got lost in the system.

29. The charges included deprivation of liberty, two charges of common assault, unlawful entry of a vehicle for committing an indictable offence, stealing and unlawful stalking. On 19 August 2009, the father pleaded guilty to one charge of common assault and stalking, and the remaining charges were dropped. A conviction was not recorded, and the father was sentenced to 18 months probation and a restraining order.

30. Neither SCAN nor the Department were notified of the circumstances relating to the incident or the charges. Dectective Senior Sergeant Zitny[13] details the Queensland Police Service policies regarding the investigation

[12] Exhibit B23
[13] Exhibit B25

of domestic violence and other action to protect children which I accept are all appropriate policies. He stated that if there had been a significant history of domestic violence or an escalation in such matters then certainly there would be a referral to the Department of Child Safety and to SCAN. At the time of this incident there were no domestic violence application current reports or orders recorded within the Queensland Police Service records and given the attendance of police conducting a welfare check and there being no concerns he can understand why no referrals were made. He conceded it was somewhat of a borderline decision. I accept this is the case and in general do not consider the actions of Queensland Police require any further comment.

The property situated at 15 Campbell Street, Kallangur

31. The address is a two storey wooden dwelling with a double garage. In July 1990 building approval was granted for a swimming pool to be constructed. The approval noted that the swimming pool shall be enclosed by fencing and gated design, constructed and maintained in accordance with the standards contained in the Standards Association of Australian Publication AS 1926-1986.

32. AS 1926-1986 provided that an inground pool needed to be fenced however a side of a building could form part of an intended barrier. The Standard also required that all gates providing access to the pool had an automatic self closing device (so the device would return the gate to the closed position and operate the latching device from any position with a stationary device) and a latching device which would automatically operate on the closing of the gate and would prevent the gate from being re-opened without manually releasing the mechanism.

33. Checks made by the Office of the State Coroner have revealed that Council records indicate the 1990 Building Development Approval for the swimming pool and swimming pool fence did not receive a final inspection.

34. However, it is apparent a compliance inspection in January 1996 conducted at the request of the property owners at that time revealed there were no outstanding requisitions in relation to the swimming pool fencing and therefore at that time the swimming pool fence was compliant.

35. As at October 2008, the property had an inground pool approximately 5 metres in length by 2 metres wide in a kidney shape. The rear yard was enclosed by a 6 foot wooden fence. There was also a pool fence dividing the pool area from the clothes line and grassed area. The pool area had three access points: a metal pool gate with key lockable magnetic latch located on the eastern side near the rear stairs, a 6 foot wooden paling fence with an inward swinging metal frame wooden paling gate with a barrel bolt locking mechanism located on the western side of the pool enclosure and a sliding glass door and security door downstairs.

36. The director of the company (Mr Stephen Osmak) that purchased the property, engaged a conveyancing lawyer. He was unaware if any searches had been conducted regarding the compliance of the pool fencing with the relevant standards and became aware later (after L's death) that a pool search was not done. When he purchased the property there had been some fire damage to the front bedroom which he had repaired. These repairs did not require a building application approval. He recalls being requested by the agent to remove the cubby house which he did.

37. In June 2008, Claymore Real Estate was approached to provide a rental appraisal and discuss managing the property with Mr Osmak. According to property manager, Mrs Cassandra Beecham, at that stage the downstairs rear sliding security door did not have an automatic closing mechanism. She recommended he put one on and she recalls he did. She also had a key for the sliding door. Ms Beecham also recalls telling the owner she had some concerns regarding a cubby house being too close to the pool fencing and recommended it be removed, which he did.

38. Mr Osmak's recollection is that the security door did have an automatic closing mechanism and this did not have to be attached as was suggested by the evidence of Mrs Beecham. Given these events occurred some years ago it is probable and understandable that one or the other of them have a different recollection but in any event nothing turns on that inconsistency. He certainly denies the condition of the sliding door security lock was in the condition as indicated in photograph 41. After L's death, he received a show cause notice from the council in relation to the pool fence which he took immediate steps to rectify by erecting a temporary fence and to eventually construct a compliant fence.

39. On 16 June 2008, Mr Osmak signed the management documentation for Claymore Real Estate to manage the property. In mid July 2008, the father BR and his girlfriend, Ms ET, decided to move in together. In July 2008 Ms ET attended the property and inspected it for the purposes of renting the property. They decided to rent the property at 15 Campbell Street.

40. On 16 July 2008, the property manager, Mrs Beecham, attended the property for an inspection. Mrs Beecham completed her part of the Entry Condition Report for the property. She noted the keys and locks for the sliding security door were undamaged and working. She gave very clear evidence the lock of the sliding door was not in the condition as it was found after L drowned and as indicated in the photographs taken by police and in particular the state as shown in photograph 41 of Exhibit F1. There is no reference to this defect listed in the Entry Condition Report[14].

[14] Exhibit G2

41. On 17 July 2008 the father and Ms ET attended the property with Mr Colin Cruden and Mrs Alice Cruden, the owners of Claymore Real Estate. Mrs Beecham is their daughter. They also happened to live in a house across the road. The lease agreement was signed and the father and Ms ET were provided with keys to the property. Ms ET recalls that neither the father nor the real estate agent were able to open the back screen door that provided direct access to the pool area and a key to this area was not provided. Mrs Beecham states there was a key which opened the sliding door but as there was only one copy another had to be cut.

42. Alice and Colin Cruden confirm and I accept their evidence that the sliding security door as shown in photograph 41 was not in that condition when it was let. It is clear a spare key did have to be cut for the sliding door so it certainly was not able to be opened at the time the tenants moved in. There was a suggestion put to Mr Cruden that he tampered with or put the lock in that condition during the inspection. He denies this and I accept his evidence.

43. It is most likely a spare key had to be cut. There does not appear to be any clear evidence of the spare key ever being provided to the tenants but it may have. There is some documentary evidence of keys being cut. Why the lock had to be tampered with subsequently is unclear. It could be that the key was not provided or it may have been lost. On this issue there is no clear evidence one way or the other.

44. The father, K and L moved into the property as did Ms ET and her two children.

45. Ms ET indicated in her statement she recalls discussing the screen door with the father. She said they both believed the door was unsafe and they did not know whether to raise it with the real estate agent. Ms ET explained in her statement that she and the father believed there should have been a fence separating the door and the pool instead of the door opening up to the pool. They did not make a point of getting the key for this door as they felt it would have been safer if they were unable to open the door. Ms ET said she never received a key to this door. When she gave evidence Ms ET agreed the state of the sliding door lock as shown in photograph 41 was not in that state when they moved in.

46. Importantly, what she did state in her evidence and which was not contained in her statement to police, was that after they moved in the father decided he wanted to have access to the area and he decided to take the barrel of the lock out. He used a Phillips screw driver. She told him that was unsafe and did not agree with his actions and his reply was “don't be stupid we will hear them splash”. She says she moved out of the property reasonably soon after. When asked why she had not told the police this important information after L’s death, she stated the father was unstable, she was distressed by L’s death and she felt threatened about the matter.

47. Ms ET and the father separated approximately 3 weeks after they had moved in together and Ms ET vacated the property. This occurred in late August 2008. It is apparent she moved out and separated after the father had some form of relationship with one of her friends.

48. On 28 August 2008 a new lease agreement was entered into with the father. Mrs Beecham attended the property on 28 August 2008 and provided the father with a new lease agreement and blank maintenance forms. Mrs Beecham attended the property and inspected the damage to the vanity unit upstairs in the bathroom. She says the father did not raise any other maintenance issues for the property.

49. On 11 September 2008, the father paid $1520 in bond for the property. He did not raise any maintenance concerns with the property at that time.

50. At some point the father's brother ("the uncle") moved in with the father and his daughters. The upstairs area was the primary residence of the father, K and L and the downstairs area was converted into a living area where the uncle stayed. When the uncle moved in the screen door did not have a lock but it had a mechanism that kept it shut. The lock on the screen door was not working and was hanging down outside of the frame and was in the condition as shown in photograph 41. He says he was never given any explanation as to why it was in that state other than his brother having told him the real estate would come over to fix it but they did not end up doing so. In relation to the screen door he said it did have a mechanism which kept it shut and it was hard to open but it could be slid across by grabbing hold of the handle or the grilles.

51. In relation to the lock the father stated that when they first attended the property, the lock was all put together and could not be unlocked. He says the real estate agent from across the road came over with a screwdriver and put it in that condition. He was asked about why this was not noted in the condition report and he said he assumed it would have been fixed quickly. He says his former partner Ms ET gave false evidence when she told the court he had undone the lock. His explanation as to why she would do that was she was a jealous ex-girlfriend. He said he does not recall having any other discussions with the real estate agent about the door again. He agrees he did not put anything in writing about the door.

52. The father, in his affidavit to the Family Court, stated "I have made numerous complaints about the dwelling including the lack of sufficient pool fencing, in that the pool wasn't fenced and that the back wasn't sufficiently secured. However no action was taken."[15] I simply do not accept this.

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[15] Page 4 of exhibit B14

53. On 1 October 2008 Claymore Real Estate ceased trading and Coronis Realty Burpengary purchased the business.

54. On 13 October 2008, the father was issued with a Form 11 - Notice to Remedy Breach due to rent arrears. He contacted Mrs Beecham and advised he would attend the real estate agency the following night to pay the outstanding rent and sign a new direct debit form. The father did not attend as arranged.

55. Mrs Beecham attempted to contact the father on numerous occasions. On the night of 20 October 2008 he left a voicemail for Mrs Beecham.

56. In relation to the condition of the door I accept the totality of the evidence would support a very clear finding that the father was the person who put the lock of the screen door in the condition shown in photograph 41 soon after moving in and left it in that state up until the date when his daughter drowned.

57. In making that finding I accept the totality of the evidence of Mrs Beecham and Mr and Mrs Cruden and that of Ms ET. There is support for their evidence to be found in that the condition of the lock is not referred to in the Entry Condition Report and there is no evidence on the real estate file of complaints being made about the lock. It is note worthy the real estate agency did attend to a number of other maintenance issues such as the bathroom cabinet and some initial plumbing issues to the dishwasher when they moved in.

58. I also do not consider the father should be considered a person whose credit could be considered reliable. He denied drinking or smoking marijuana on the evening before L died. He also made those denials in the Family Court. He agreed in those proceedings that he did use marijuana but not on a regular basis and at that time when giving evidence in January 2008 he was still using the drug. He agreed there was a bong at the house and was surprised when the Police did not find it.[16]

59. He told this court there was no bong or utensil in the house. When the transcript of the Family Court proceedings was put to him he continued to deny the undeniable and said he did not know why that was recorded in the transcript.

60. In making the finding that the father deliberately tampered with and rendered the lock of the screen door useless, I accept the father did so without realising this would have contributed to the tragic consequences that subsequently occurred

[16] Exhibit H1 p50 of Family Court transcript

Events of night before and day of L's death on 21 October 2008

61. In his statement the uncle stated that on 20 October 2008 he and his friend Mr John Richards arrived at the residence at approximately 10.30pm. They watched a DVD and then went to sleep. The uncle woke at 5.00am and contacted his employer to update on his progress to obtain a blue card. He was due to commence work at 6.30am however he was unable to do so because he did not have his blue card. The uncle walked past the internal stairs, through the laundry and into the carport. He did not walk outside at any point. He returned to his room and opened the sliding glass door because it was hot. The screen door was shut when he did this. The uncle then laid down on his bed and went to sleep.

62. The uncle was then awoken by K who indicated L was in the pool. He went outside and observed L face down in the pool to the left of the internal stairs of the pool. He had to get into the pool to retrieve L.

63. The Police interviewed the father that day. He later refused to provide a statement to the Police or to the Coroner. He told Police his alarm went off at 7am. He heard the children wake up after his alarm went off. He heard them because his door was open and they shut his door and went and played. He told police the fence was not legal and he told the real estate agent on the first day they moved in that the fence was not right and that the owner knew about the fencing.

64. John Richards provided a statement. He was not called to give evidence for medical reasons. Given he could not be cross examined I do have to treat his evidence as contained in his statement with some caution. He stated he heard singing between 6 - 9am outside. He was sleeping downstairs on the couch. Before 9am a child was sitting on the lounge downstairs. He or she said "lying in the water". Then he and BR went outside through the screen door and he saw the baby lying face down in the water at the end of the pool, further enough away that BR had to reach in. Solar panel installers at a neighbouring property from over the back came over and did CPR on L. The uncle and the father were red in the face and crying. He said he didn't hear any splashes and only heard singing. He ran upstairs and told the father. He said that he did not drink liquor and he did not see the uncle or the father drinking at all. He had not seen the father that night but he could smell marijuana coming from upstairs. He did not see the father using marijuana but was confident the smell was definitely marijuana.

65. The father denies having smoked any marijuana that evening or drinking alcohol. This issue is of some importance and given the seriousness of the allegation and based on the Briginshaw principles referred to earlier in this decision I am unable to make such a finding to a sufficient standard of proof although I note the finding of Justice Murphy in the Family Court proceedings that his use of marijuana was greater than the extent he was prepared to admit.

66. Matthew Clerehan, Ian Stromilo, Dawson Patterson, were working at a nearby property installing solar panels when they heard swearing coming from 15 Campbell Street, Kallangur at approximately 8.50/9am. They immediately went to assist. They performed CPR on L until the QAS arrived. During this time they were not able to feel a pulse, they noted L was cold and blue and clear coloured fluid expelled from her mouth and bubbly white coloured fluid from her nose.

67. Whilst CPR was being administered, and prior to QAS arriving, Mr Clerehan overheard the two men [assume to be the father and the uncle] arguing over who left the sliding door and gate open. Mr Clerehan assumed it was L's father yelling "who left the door open" and the other man kept repeating "I'm sure I locked it".

68. Whilst CPR was being administered, and prior to QAS arriving, Mr Patterson overhead one male say "How did she get out, who was watching her?"

69. Prior to the QAS arriving, Mr Clerehan observed both males to be crying and yelling. One yelled "why weren't you looking after the kids?" and the other bloke said "get fucked, they're your kids."

70. The Court acknowledged these events would have been very distressing for Messrs Clerehan, Dawson and Patterson. They provided valuable efforts at CPR given it seemed the other persons present were incapable of doing so. Their efforts should be commended. Mrs Plint representing Hannah's Foundation wished to join in that commendation.

71. The QAS were called at 8.58am and arrived at the scene at 9.14am. Student ICP Buchanan, ICP Eaton, ICP Smith, ACP Kenn, OIC Petrie Station Campbell and student paramedic Howie attended. An off duty Registered Nurse Lloyd also arrived to assist. Monitoring was conducted and it was determined L's rhythm was unshockable however despite this, CPR efforts continued, L was ventilated, an intraocular cannular was inserted and adrenaline was administered. QAS left the scene at 9.38am with ventilation and compressions continued until QAS arrived with L at the Redcliffe Hospital at 10am. The Hospital continued resuscitation efforts however they also discontinued. L was pronounced deceased at 10.20am by Dr Stephen Kolera.

Investigation and likely entry point of L to the Pool

72. Small rocks and pebbles were found by the side of the pool between the door and the pool edge and there appeared to be some inside the pool. A toy doll was also found in the pool area. There was no evidence of any items being placed up against the pool fence for L to gain access to the pool.

73. Scenes of Crimes Officer Senior Constable Dash inspected the three access points to the pool. The metal pool gate was tested a number of times and found to be fully functional and closed on every occasion. The

wooden paling gate was in a sound condition and in a locked position. The downstairs glass sliding door was found to be in a sound condition and latch lockable from the inside. The security screen door had a retracting wire attached which was in a sound condition and pulled the security screen door towards a shut position however the latch or latch handle was broken whereby a displaced screw caused the door to jamb open approximately one centimetre. Senior Constable Dash was of the view this latch appeared to have been broken for some time as there was some scarring on the metal door jamb where the screw was positioned. There was also a metal washer attached to the latch with electrical wire and this could only have been attached after the latch was broken.

74. Brendon Woodbury, a locksmith, attended the property and provided a report to the QPS. He concluded that the Ryobi Doorman sliding door closer was operational and latched sufficiently and would latch effectively during normal entry and exit of a person however this door could be left ajar if the door is brought to rest against the lock strike slowly.

75. Mr Woodbury reviewed the photographs taken by QPS of the security screen door. He concluded that a person had removed the top screw from the handles, lowered the handles and then replaced the screw back into the internal plate. Projecting from the internal handle plate was a threaded screw stud. With the stud in this position, Mr Woodbury was of the opinion the operation of the lock would not have been effective.

76. Dr Ong conducted an autopsy on L. He concluded L's cause of death was as a result of drowning

77. Mr Parkin, an Accredited Assistant Building Surveyor, employed by the Moreton Bay Regional Council attended in relation to the pool fencing compliance. Mr Parkin was of the view the swimming pool was non-compliant because the position of the swimming fence differed from the position of the pool indicated in the approved plans. Mr Parkin identified 17 items of non-compliance with the Australian Standards AS1926-1986[17]. Of relevance he identified that the sliding security screen self-closing door was not functioning and the pool fence configuration was not as per the approved plans.

78. As a result an enforcement notice was issued by Moreton Bay Regional Council to Kamso Constructions Pty Ltd requiring the pool to be emptied or to have a fence erected that complied with standard.

Review by the Department of Child Safety now Department of Communities - Child Safety ("the Department")

79. On 26 November 2008 the Department conducted a Systems and Practice Review Plan which reviewed factors influencing the Department's service delivery to L. The Review Plan concluded on 12 December 2008 that "a reasonable person, knowing all the facts, would

[17] See exhibit D2 page 5 for the entire list of items of non-compliance

not believe there to be a connection between the action or inaction of the department and the death of the child. The death was as a result of drowning in the family pool." The Court accepts that is a reasonable finding to make.

80. The Review Plan noted that whilst the recording of the information as a Child Concern Report was questionable, this would be the focus of the review. The Review Plan concluded that the review could be conducted by a systems and practice review.

81. A Root Cause Analysis was conducted (the report was completed on 23 March 2009) into the Department's involvement with the family in 2007. The Root Cause Analysis Report identified a lack of alignment between relevant officers' personal frameworks and knowledge and the Department's framework for child protection service delivery.

82. The Report determined the following risk factors existed:
    - Age and vulnerability of the girls;
    - The potentially cumulative effect on the children's developmental, emotional and psychological wellbeing through ongoing exposure to a violent environment;
    - Potential risk for physical harm when present during domestic violence incident; and
    - Impact of domestically violent relationship on parental capacity to provide a safe environment and ensure the health and developmental wellbeing for children of a vulnerable age.

83. The report also concluded that the decision to record the information provided in December 2007 significantly hindered service delivery to L. The Report was of the view the information received identified evidence of significant risk to L and K and should have been screened as a child concern notification.

84. The RCA determined that should have been recorded as Child Concern Notification because:

    - Significant risk of harm to children identified by the father's threats to kill the children on the day he abducted the mother. This placed them at an unacceptable risk of suffering serious physical trauma or injury of a non-accidental nature;
    - The concerns provided by the notifier clearly indicated an escalating pattern of domestic violence through incidences on two separate days with the father initially abducting the mother and then four days later again making statements to the notifier of his intent to harm the children if he was not able to access the mother;
    - The subject child and her sibling's exposure to domestic and family violence placed them at unacceptable risk of significant emotional harm due to the violent environment created by the father's pervasive threats and a climate of terror and fear. The

concerns provided clearly stated the presence of both the girls during both of the incidents; and

- The father had custody of both the subject children who were of a vulnerable age and highly dependant on him as their caregiver to protect them from harm.

85. The decision to record the information as a Child Concern Report meant no investigation and assessment occurred regarding the children and no further information about the family was gathered. It is of course unknown what such a process may have determined and whether referral to other agencies or services and/or monitoring may have occurred as a result.

86. The RCA was also critical of Ms NB and Ms WR's failure to appreciate the Department's statutory obligation under section 14(2) of the Child Protection Act which states that 'if the chief executive believes alleged harm may have involved the commission of a criminal offence relating to the child, the chief executive must immediately give details of the alleged harm to the police commissioner'.

87. The RCA was also critical of Ms NB and Ms WR's failure to appreciate the indicators of domestic and family violence throughout the child protection continuum.

88. The RCA recommended the report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings. The RCA also recommended the key practice learnings from the review be disseminated to the managers of all Child Safety Service Centres and be included on the agenda of the next Senior Practitioner teleconference for dissemination.

89. Both Ms NB and Ms WR gave evidence at the inquest. They accepted the findings of the RCA. Since that time there had been further training with respect to notifications to Queensland Police and on family domestic violence. Ms WR stated that in hindsight she should have caused a referral to Queensland Police although she was not sure if this would have provided sufficient information to change the notification to a Child Concern report.

90. Given the review process conducted by the Department and its findings and recommendations I do not consider I need to make any further comment or recommendations on this issue.

Changes to the Swimming Pool legislation

91. In 2009 the Queensland State Government undertook a comprehensive review of the current laws relating to swimming pools. Up until then, numerous pool safety standards applied, depending on the date the pool was constructed. Prior to the review, inspection of swimming pools and enforcement of non-compliance was delegated to local councils.

92. Following the review the Queensland government introduced legislation in two stages which is now contained within the *Building Act 1975*. The first stage commenced on 1 December 2009 and dealt with new residential outdoor swimming pools. The second stage, commenced on 1 December 2010. The second stage replaced the 11 different pool safety standards with the one pool safety standard (Queensland Development Code Mandatory Part 3.4) and requires both new and existing pools to be upgraded to comply with the standard within 5 years unless the house is sold or leased first. The new standard prohibits a door from being used to provide a barrier, even if it is child resistant and this applies to all existing pools.

93. The second stage also introduced a sale and lease compliance system which requires any person or company selling or leasing a property with a pool to obtain a pool safety certificate from a licensed pool safety inspector.

94. If the property had been rented now, under the new legislation, the property would not have obtained a pool safety certificate because the door was being used as a barrier which is now prohibited. A pool safety certificate would have ensured the fence around the pool was in accordance with the new safety standard.

95. It is noted in various media reports that there is some agitation being expressed to roll back the commencement of some of these provisions and that the government has publicly resisted that pressure. By way of further support I will recommend the complete second stage of the pool legislation be fully implemented.

Swimming Pool Safety and Supervision

96. Mrs Plint and Hannah's Foundation have been valuable advocates concerning pool and water safety for which they should be commended. I have no doubt advocacy together with a combination of previous coronial recommendations and policy decisions made by the State Government resulted in this very welcome major reform to legislation.

97. Of course as Mrs Plint states in her written submission to this inquest and as stated in some of the valuable pool safety material the Foundation has produced, supervision of children is the most crucial primary preventive measure. Her pool safety brochure states, and I accept, that it is statistically proven children will drown when supervision breaks down and a non-compliant barrier is in existence at the same time.

98. That is precisely what occurred on this occasion. The father, for reasons which he will no doubt regret for a long time, failed to properly supervise his two young children L and K early that morning on 21 October 2008. His brother unlocked the sliding glass door which gave

direct access to the pool area because it was hot. He failed to hear the two children when they were downstairs early that morning. That left the opportunity for the children to access the pool area through the sliding screen, the lock of which had been deliberately tampered with and made non-functioning by the father. The inevitable and foreseeable and totally preventable consequences of those actions brought about the tragic death of this young girl.

Findings required by section 45

I am required to find, as far as is possible, who the deceased was, when and where she died, what caused the death and how she came by her death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses, I am able to make the following findings in relation to L's death:

(a) The identity of the deceased was LDR;

(b) The date of death was 21 October 2008;

(c) The place of death was at 15 Campbell Street, Kallangur;

(d) The formal cause of death was due to drowning;

(e) L drowned as a result of entering the swimming pool in the backyard. She was able to enter the pool area via the rear sliding security screen door which was faulty and non-compliant with swimming pool standards of the time because the locking mechanism had been tampered with and made non-functioning and because she was not adequately supervised by the adults present in the house and in particular her father.

Concerns, comments and recommendations

Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

I make the following comments:-

To the extent it is necessary, it is recommended the amendments to swimming pool fencing legislation as set out in Chapter 8 of the *Building Act 1975* and which commenced on 1 December 2010 be implemented and regulated in full. I note the website of the Department of Infrastructure and Planning relating to pool fences and safety has a comprehensive list of information and resources concerning the new laws and pool safety in general.

It is apparent that with such major changes Real Estate and Property Managers will need to be made aware of the new legislation and it would be expected the appropriate professional bodies are engaged in that process. I

heard no evidence on that issue and cannot presume that this would not be the case but to the extent necessary I endorse the submission of Mrs Plint that the REIQ and independent real estate agents be educated and informed of the new laws and protocols for pool/spa safety in Queensland and this would require some form of ongoing awareness campaign.

I close this inquest.

John Lock
Brisbane Coroner
13 December 2010