QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of E**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
DATE:	08 December 2021
FILE NO(s):	2019/5307
FINDINGS OF:	Christine Clements, Brisbane Coroner
CATCHWORDS:	CORONERS: Drowning in public pool; 5 year old; Migrant parents; English language skills.

Contents

Introduction

1. E was born in November 2014. He lived with his family at, Runcorn in Queensland.

2. His parents are A, father, and B, his mother.

3. On 16 November 2019, E was with all his family at the Runcorn Aquatic Centre, which is a public swimming pool owned by the Brisbane City Council. His parents were supervising their four children who were in the shallow ramp area of the indoor pool at the separated end of the main pool. Within a very short time, his mother realised she could no longer see him. E had moved across the concrete bulkhead separating the shallow pool from the main pool, which was deeper. E had entered the main pool, unobserved. He could not swim, and he went under the water to the bottom of the pool. He was retrieved and resuscitated before transfer to hospital.

4. E died in the Queensland Children's Hospital, Stanley Street Brisbane on 24 November 2019 due to hypoxic ischaemic encephalopathy caused by the near drowning. He was 5 years old at the time of his death.

Background circumstances

5. E has an older sister C, aged 10 and an older brother D aged 6 as well as a younger sister F aged 18 months.

6. Police were alerted to the incident at about 4.00pm on the afternoon of 16 November 2019. Officers attended the Runcorn public pool where they estimated 50-60 persons were present. The facility has a maximum capacity of 100 persons.

7. The pool business is a fully fenced complex with four separate pools. The incident occurred in the covered pool which has a maximum depth of 1.2 metres. There is an underwater ledge for sitting on which runs along the length of the pool.

8. At one end of the pool there is a ramp section of the pool, across the width of the pool, which varies in depth from zero to 80 centimetres. There is a concrete bulkhead in between the shallow varying depth ramp pool area and the deeper main pool. There is a stainless-steel handrail along the tiled top of the bulkhead divider between the shallow and deeper pools. There is no physical barrier between the two pools.

9. At the time of the incident, the parents were both at the ramped end of the pool area, supervising their four children. The father, A said the family arrived at the pool at around 1.00pm. He had taken the two older children to the pool a week earlier. It was E's first visit to the pool.

10. The children were all playing in the shallow ramp end of the covered pool. The father then took E outside to the children's water play area for about half an

hour. They returned to the inside pool when E became cold, and he then entered the shallow ramp pool and played with his sister. His two older siblings could swim a little because they had swimming classes at school but E had not yet started swimming lessons and he could not swim.

11. The children's mother B was watching her youngest daughter as well as the three older children. She was watching the two oldest children as they splashed and moved away from her towards the deeper water at the other end of the ramp. As she did so, she lost sight of E.

12. A was standing next to her. He did not recall being distracted from the children, but B suddenly realised that she could no longer see E with his brother and sisters. She looked over to the main deeper pool and she saw a dark figure under the water. She pointed this out to two other people who went underwater and retrieved E from the bottom of the pool.

13. Patrons and the swimming pool staff came to help, and emergency services were called. Cardiopulmonary resuscitation was commenced prior to the attendance of ambulance officers. E mother thought it looked like there were many people trying to help E, but she was not confident they knew what to do in a coordinated way.

14. A witness heard the mother crying out for help and he saw two men pull the boy out of the water. He saw the efforts to resuscitate the boy. He helped the father, who was distraught and needed assistance to drive to the hospital with his other children.

Safety and staffing

15. Police followed up with the general manager of the pool, "1" who runs the pool in the corporate form of City Venue Management Pty Ltd. He confirmed the pool operates in accordance with the Royal Life Saving Society Code and Guide for Safe Pool Operations.

16. Three lifeguards were assigned for duty at the venue at the time. There was also a receptionist with lifeguard qualification.

17. The owner stated the number of people at the venue that day was 40 people at the time. He said the capacity for the venue was 140.

18. "2" was one of the rostered lifeguards on the day. She had worked at the pool since February 2018. She held a first aid certificate and CPR qualification from April 2019. In September 2019 she completed a Pool Lifeguard qualification.

19. On this day she was working on the front counter serving customers. As part of her responsibility, she attended the change room at about 3.20pm to change a soap dispenser. In her absence, lifeguard 3 covered the front desk. While in the change rooms 2 heard a woman calling out. She came out and saw people around a child and she ran to phone triple zero.

20. “3” had worked at the pool for 18 months. He held lifesaving qualifications since December 2018. He was on duty to patrol the indoor pool, but at the time E was discovered underwater he was serving customers at the counter. He heard a woman calling out as she was running towards the counter. He came out and went to where a boy was laying on the ground. A member of the public was giving him CPR. “3” took over until ambulance officers arrived.

21. Two more lifeguards were working around the outside pools. They came in to help when they heard people calling out. “4” ran to get the defibrillator. He opened it and was about to use it when ambulance officers arrived and took over. “5” helped “3” with compressions on the boy.

22. Police reviewed CCTV footage at the pool. E had been retrieved from the bottom of the pool at 3.17pm.

23. They reviewed the CCTV. They noted the time recoding on the camera was showing a time 26 minutes “fast.”

Investigation

24. The Office of Industrial Relations investigated the circumstances in which E died at a workplace, the Runcorn Aquatic Centre. Inspection occurred on 22 November 2019. CCTV footage was reviewed.

25. It was noted the family was using the indoor pool ramp, which was designed to enable disability equipment and persons to enter and exit the pool. The shallow heated water on the ramp is a common area for young children to swim or paddle.

26. The CCTV footage recorded E playing in the shallow water which was about 30 centimetres deep. Then, he climbed under a handrail and across a separation bulkhead into the main indoor pool. He lowered himself into the water which was 1.2 metres deep. E was about 1.1 metres tall. He splashed for a short time before submerging under the water. No-one noticed this happening.

27. E was underwater for 1 minute 30 seconds before his mother saw that he was underwater at the bottom of the main pool. She attracted the attention of a person who dived into the pool and retrieved E, who was unresponsive.

28. People shouted for help and lifeguards were responded within 10-14 seconds and commenced cardiopulmonary resuscitation including chest compressions. After a couple of minutes one them ran to the counter and returned with a medical kit which contained oxygen and a defibrillator. CPR continued until ambulance officers took over about 8 minutes later.

29. As noted by police, the CCTV time stamp was incorrect. The actual time was 26 minutes earlier than stated on the CCTV footage.

30. The footage showed approximately 40 people in the indoor pool at the time.

31. There were three active lifeguards on duty which exceeded the guide ratio of lifeguards to persons in the water of 1:100. A fourth staff member was on duty at the counter. This person also had lifeguard qualifications.

32. The investigating inspector established the lifeguards were aware of their required responsibilities, and actions and equipment and communication. They acted in accordance with what was required of them.

The lifeguards participated in coercive interviews.

33. From this information the following has been extracted and noted:

34. Prior to this incident, there may not have been compliance with wrist bands identifying children underage.

35. The rotation plan to monitor around pools systemically was not adhered to throughout all the shift.

36. With hindsight, another additional lifeguard could have been called that day, (presumably because a jumping castle was being used outside and required two lifeguards to be in attendance.)

37. One lifeguard was serving at the counter for a couple of minutes and had not called for a replacement.

38. The response from the counter, which was 12 metres away, occurred within14 seconds.

39. A lifeguard who was at the outdoor pool at the time of alarm was 12 metres away and responded within 10 seconds.

40. The rostered counter service person, who was also a qualified as a lifeguard, was required to attend in the toilet area at the time of the alarm. The response time was 36 seconds.

41. The investigator also coercively interviewed the parents.

42. Of interest to the coroner, the following has been noted -

43. The father understands very little English.

44. He had attended the pool once before the day of incident, and once after.

45. He had not been to other pools or to the ocean.

46. He and his wife and 4 children attended the pool during the afternoon.

47. There was no conversation with parents and staff, just payment upon entry.

48. Conversation was with their 10 year old daughter.

49. He could not recall staff questions about the children's age.

50. No wrist bands were given. (used to identify children under a certain age.)

51. He cannot read (English) and did not know anything about the signs at the pool, (which gave information, including in pictorial form.)

52. He said only his daughter could swim a little.

53. Staff did not talk about watching his children or the children in the water.

54. He did not go in the water, he cannot swim. Although he had grown up around water.

55. He stood by his wife, about half a metre back from the water at the shallow ramp end.

56. He had been in Australia for 20 years.

57. He does not know what the pictogram supervision signs meant.

58. He could not recall seeing lifeguards.

59. He believes the lifeguards' job is to pick up anyone about to drown.

60. He noticed they have put up a fence since.

61. He does not understand what supervision of your child in the water means.

62. He thinks workers or lifeguards are responsible for keeping swimming children safe in the water.

63. He believed it was just seconds before realising E was missing and before he was found

The mother

64. The mother does not understand English at all.

65. She had attended the pool once before, on the day of incident, and once after.

66. She said her children, C and D could swim.

67. No arm bands were given upon entry to the pool.

68. She thinks her husband would have told her if they said anything at the front entry.

69. She said if “they “had told her it was our responsibility to take care of our kids, she would not have let them in.

70. She cannot swim and did not go in the water.

71. The two older children went down the ramp into deeper water.

72. She said she and her husband were watching the (older) children and we were distracted

73. E had moved across and jumped into deep water.

74. It only took a moment. She thought he had gone to the play area, so his father went to check.

75. She went around the other area of the pool and saw E

76. She did not know what the pictogram sign on the wall meant.

77. She assumed there was supervision to watch out for everyone

78. Immediately before, there was a lifeguard going around the place

79. She has been back with the lawyer.

80. She had seen that now the pool has a fence which would have saved her child.

81. She had not grown up around water.

82. She had been in Australia for 8 years

83. She thinks that parents are responsible for ensuring children are safe.

84. She thinks more lifeguards should be at the pool, and videos to monitor.

85. Her older children are still going to swimming classes at school

86. She does not let them go back to this pool

87. She insisted to see part of the video to see E falling as she wanted to see if he was pushed. (He was not.)

Signage

88. There are numerous safety signs throughout the swimming complex, explaining the need for active and constant supervision of children and non-swimmers. Patrons are informed that lifeguards are not babysitters.

89. Pictorial messaging is used as a means of communication to address lack of English language skills.

Cause of death

90. Autopsy examination was limited to external examination only, together with review of hospital records, toxicology, CT and imaging and review of the CCTV footage from the pool.

91. CT imaging did not show any skeletal injury. There were changes evident in the brain (loss of cerebral grey and white differentiation.)

92. A pre-existing right sided aortic arch which had been diagnosed antenatally was evident.
93. On arrival to hospital E's Glasgow coma score was at the lowest reading of 3/15, with fixed dilated pupils and profound metabolic acidosis. There was swelling in the brain and evidence of aspiration in the lungs. His condition was attributed to severe hypoxic brain injury. He was cared for in the intensive care unit and his family were told of his very poor condition and the likelihood that he would not live. His family held onto the hope of his recovery and treatment and supportive measures were continued for longer than usual, respecting the family's wishes. Despite all treatment E did not recover and he died on 24 November 2019.

94. The pathologist concluded E died due to hypoxic ischaemic encephalopathy, because of near- drowning.

Conclusion

95. E was a five year who could not swim when he moved across a bulkhead, separating the shallow and deeper water at the indoor pool at the Runcorn Aquatic Centre.

96. At the time, there was no physical barrier between the shallow water at one end of the pool and the main pool area of greater depth. E moved across from the smaller shallow water into the main pool area, unobserved by his parents, who were in the immediate vicinity. This occurred within a matter of seconds.

97. CCTV footage recorded E momentarily splashed at the surface before sinking below the water surface. His mother realised she could no longer see E and she pointed out to a bystander what she thought was someone on the bottom of the deeper pool. That person retrieved E who had been underwater for 90 seconds.

98. All efforts to resuscitate E were made by staff who were trained in resuscitation, and ambulance officers continued resuscitation before transfer to hospital. Sadly, E died on 24 November 2019 in the Queensland Children's Hospital due to oxygen deprivation to the brain which occurred during the near drowning.

99. The investigation information indicates E's father had been in Australia for twenty years but had very limited English language. His mother had been in Australia for eight years and had no English language. They relied on the language skills of their 10 year old daughter to a large extent.

100. They did not understand the written large signage at the entrance to the pool warning parents / guardians of " KEEP WATCH POLICY". This specifically stated parents and guardians be prepared to get wet at all times.

It stated :
"0-5 year olds & non-swimmers must be within arm's reach of you."

"6-10 year olds must require your constant active supervision."

101. There was a large pictorial sign at the end of the ramp where E and his siblings were in the water. The sign was headed:

"LIFEGUARDS ARE NOT BABYSITTERS "

101. The sign showed pictograms to visually convey the message of the kind of supervision required by for the different age groups of children when in the water.

102. Afterwards, E's parents indicated they did not understand the pictogram's meaning.

103. Neither parent could swim.

104. They assumed pool lifeguards had responsibility to keep their children safe from drowning although the mother acknowledged parents are responsible for their children's safety.

105. The facts of E's tragic death are clear and do not require an inquest.

106. The information available to the coroner indicates E's parents had very limited English language skills. Accepting this as factual, it follows that lack of knowledge of the spoken and written English language was a critical factor in the circumstances leading to E's death.

107. E and his siblings were learning English, and his two older siblings had commenced swimming classes through school, but his parents remained at significant disadvantage due to their lack of English language skills, and the physical skill of swimming. His father had been in Australia for 20 years, and his mother for 8 years.

108. Preventing another similar death of a child from a migrant family requires resourcing to parents to develop English language skills, as well as how to swim.

109. I understand there are programs such as Adult Migrant English Program, which is advertised as a free Commonwealth program available to migrants, permanent visas holders and those eligible for temporary visas as well as Australian citizens previously holding a permanent visa. Access includes those who may have been in Australia for many years.

110. The web site has information pamphlets about the service in 47 languages.

111. A web search also indicates the Royal Life Saving Service publishes a National Drowning Report which includes research into epidemiology of unintentional fatal drowning among migrants in Australia, as well as reducing inequalities among adult female migrants at higher risk for drowning in Australasia.

112. There is also information online about swimming and beach safety classes for migrants in some areas of Queensland.

113. Developing English language skills as well as swimming skills in adult migrants is imperative to safeguard non-swimming children in their care.

Findings required by s.45

Identity of the deceased – E

How he died – 1(a) Hypoxic Ischaemic encephalopathy
1(b) Near-drowning

Place of death – Queensland Children's Hospital SOUTH BRISBANE QLD 4101 AUSTRALIA

Date of death– 24/11/2019

I close the investigations.

Christine Clements
Brisbane Coroner
CORONERS COURT OF QUEENSLAND

8 December 2021