CLONCURRY CORONERS FILE 1/2007

FINDING AND RECOMMENDATIONS – INQUEST INTO THE DEATH OF CHRISTINE CHLOE ROUSE DELIVERED AT CLONCURRY 26 MAY 2008[i]

This afternoon has been set aside for the delivery of the finding and recommendations with respect to the cause and circumstances of the death of Chloe Christine Rouse.

An inquest into Chloe's death was held at this Court on 31st July 2007 and the 1st August 2007.

Section 45 of the *Coroner Act 2003* clearly sets out those matters which a Coroner must, if possible, establish. These are

1. That a death has, in fact, occurred
2. The identity of the deceased person
3. How the person died
4. When the person died
5. Where the person died
6. What caused the person to die

Section 46 of the Act provide that a Coroner may, where he or she deems it appropriate, comment on matters relating to

1. Public Health and Safety
2. The administration of justice
3. Ways to prevent deaths from happening in similar circumstances in the future

Section 48 of the Act provides the Coroner with authority to report to an appropriate authority when he/she reasonably suspects that offence has been committed or misconduct has occurred.

Further provisions of the Act preclude any finding of guilt for a criminal offence or any finding of civil liability on the part of any person.[1]

It is always important to bear in mind when considering these matters the observations of His Honour Justice Toohey in the matter of *Ennetts v. McCann*[2]. In following the words of Lord Lane, often quoted in matters of this nature[3], a framework to consider the evidence put before this Court is provided.

Lord Lane stated:-

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[1] Section 45(5) of the *Coroners Act 2003*
[2] (1990) 170 CLR 596
[3] For example see the Finding of R Spencer, Coroner in the matters of Phillip Allan Water Tognola (Cairns Coroner's File 37/03)

"It should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are not suitable for another. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish fact. It is an inquisitorial process, a process of investigation, unlike a trial. Although a coronial inquiry is not a judicial proceeding in the traditional sense, the rules of natural justice and procedural fairness are applicable, the content of such rules to be applied, depending on the particular facts of the case in question"[4].

The incident which brought about this inquest occurred at the Cloncurry Shire Pool located at King Street, Cloncurry on 12 March 2005. At the time of the incident the Shire Council was responsible for the staffing and operation of the pool.

Janelle Major, an aunt of Chloe's, took Chloe, Chloe's sister and her two of her children to the Cloncurry pool. She arrived at the pool with the children between 1.30pm and 2.00pm. At that time two adults, Sonia Savarra and Darren Metcalfe were also at the pool with their five children.

Just prior to 2.00pm Robin Watt, who was employed by the Council, commenced duties at the pool. Robin's four children and a cousin of her children accompanied her to the pool. Robin commenced various duties at the pool which included checking the chlorine levels and providing some pool noodles for the children in the pool to use. Janelle Major was sitting approximately five (5) metres from the pool under a tree with Sonia. Sonia had previously been in the pool with her children but had gotten out. Darren then went in to the pool.

Robin, during the course of performing her duties at the pool had placed a sleeping bag, which she sat on, at the northern end of the pool about 10 metres from the edge of the pool. From this position she was able to observe all persons who were in the pool. Chloe was one of those persons. She was playing on the disability ramp located at the shallow end of the pool. The ramp sloped towards the shallow end of the pool and had a inner railing which also sloped into the water. Towards the bottom of the ramp the railing stopped so that disabled persons would have enough space to enter the main area of the pool. At the time of this incident there was neither a wading pool nor a wet play area. The wet play area was, in fact, under construction and has to my knowledge, now been completed.

At approximately 2.45pm Robyn's son, Mitchell, came to her with a cut hand. She then took her son to the kiosk to tend to the wound.

Whilst Robyn was tending to the wound, Janelle Major was called to the fence of the pool complex to talk to her brother who had come to the pool to advise Janelle that her young baby, whom she had left at her house asleep, had awoken. The whole process of getting up, walking to the fence, having the conversation and then returning to the pool took no more than a couple of minutes

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[4] The Queen v. South London Coroner; Ex parte Thompson (The Times, 9 July 1982) quoted in Jervis on the Office and Duties of Coroners, 10th ed. (1986) page 6. Quoted by His Honour Justice Toohey in the matter of Annetts v McCann (1990) 170 CLR 596

Upon returning to the pool Janelle asked others present where Chloe was. She then observed Chloe to be at the bottom of the pool. Chloe was approximately one metre from the ramp and one metre from the end of the pool. Janelle then entered the pool and collected Chloe. Chloe was then collected at the side of the pool by Sonia and was then taken to Robyn who observed:-

"that Chloe wasn't moving and her eyes were open but she didn't seem to be moving at all. Her eyes weren't moving and she looked like she wasn't breathing"[5]

Robyn commenced a resuscitation procedure immediately. Darren phoned 000 for assistance.

Robyn further observed of Chloe-

"I saw that there was a lot of water and vomit coming out of her mouth and nose when I was breathing into her mouth. She didn't seem to be breathing and didn't cough or move in any way"[6]

Robyn continued the resuscitation procedure for a number of minutes before Senior Constable Susan Cramp attended the pool and commenced to assist Robyn with the resuscitation procedure. Officer Cramp observed water and a pink vomit discharging from Chloe's mouth.

An ambulance officer, Karen Franklin, attended the pool and Chloe was transported to the Cloncurry Base Hospital.

Dr Sheila Cronin was the Doctor on duty at the Cloncurry Hospital when Chloe was brought to it. Dr Cronin's evidence was that the resuscitation attempts up to the point that Chloe arrived at hospital had been competently administered and, in fact, were continuing when Chloe arrived. Dr Cronin's evidence was that she then continued the resuscitation procedure for a substantial period of time.

Dr Cronin's observations of Chloe upon her arrival at the hospital were as follows:-

"*She had fixed dilated pupils and she had no cardiac activity or respiratory effort. She was clinically deceased, but obviously you don't make that pronouncement at that time, you go on and attempt to resuscitate"*[7]

The attempt to resuscitate continued for approximately 45 minutes before Dr Cronin pronounced life extinct at 3.45pm.

On the basis of the evidence before the Court I make the following findings in this inquest:-

(1) That death did, in fact, occur
(2) That the deceased person was Chloe Christine Rouse
(3) That Chloe's date of birth was 4 September 2002

[5] Page 3 of Statement of Robyn Watt dated 12 March 2005
[6] Page 3 of Statement of Robyn Watt dated 12 March 2005
[7] Page 35 of Transcript

(4) Her last known place of residence was 27 Railway Street, Cloncurry
(5) At the time of her death she was a child
(6) Her date of death was 12 March 2005
(7) Her place of death was Cloncurry Hospital
(8) The formal cause of death was Drowning (Fresh Water)

The second and perhaps most important aspect of this Inquest is the recommendations to be made from the evidence which was put before the Court.

All witnesses who gave evidence in this matter were provided with the opportunity to place on the record what, in their opinion, were appropriate recommendations which should be made to avoid this tragic incident re-occurring.

It is clear from the evidence put before me that the provision of a public pool in townships such as Cloncurry is to be encouraged as it provides a vital recreational facility to the community. There are many reasons for this but I believe there are several which warrant mention here today.

The climate is one which springs to mind immediately. Cloncurry, and many western townships in this State, are subject to high temperatures in the summer months. The town pool offers families, and in particular children, the opportunity to "beat the heat".

Secondly, there are many health benefits, particularly to young children, in terms of the exercise aspect of water recreation. It encourages physical fitness in an enjoyable manner.

Finally, I believe it is important to note that if the town pool is not accessible to the community, then other options for water recreation, such as waterholes and creeks may become an attractive alternative.

Balanced against the desirability of town pools being accessible to the community is ensuring the safety of those who utilise these facilities.

Dr Pitt was called as an expert witness in relation to these matters. His experience in this field is considerable and it is important to note that, in the course of giving evidence he identified (in his words):-

"*The need to provide outlets, exercise to make children safe, familiar with water, to encourage survival skills and swimming skills in pools. So it's not about decreasing access to pools, particularly for rural areas in Queensland. I think it's more about ensuring that appropriate standards are in place and those that are responsible for the pools recognise what is necessary in order to provide a safe aquatic environment"*[8]

What is obvious from the evidence from Dr Pitt and also other witnesses is the importance that the Royal Lifesaving Society of Australia (hereafter called RLSSA)

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can play in this process. The society publishes a document called the "Guidelines for Safe Pool Operation".

Dr Pitt and other witnesses who have experience in this area describe the processes detailed in this guideline as "best practice". Dr Pitt's evidence was that the document had evolved over a period of time. As improvements became obvious they were implemented into the document. The guidelines are framed in a flexible manner to take into consideration various local factors such as patronage, layout of the pool, staffing availability, etc….

Dr Pitt also gave evidence regarding a campaign which the society runs titled "Watch at Public Pools". Dr Pitt explained the concept of the campaign and the message it was attempting to get across as:-

"*it is the parental responsibility ultimately to supervise children at – at public pools, certainly children shouldn't attend public pools unsupervised, and that the – the responsibility of the safety officer or the life guard as the Royal Lifesaving Society refers to them, and many pool operators refer to them, is – is not to actually monitor the location of every young child in the pool area, but it is about making parents aware of their responsibilities, of making sure that the aquatic environment is safe, that there are appropriate standards in that aquatic environment to minimise the hazard, and taking an overview about the safe operation of that aquatic environment"*[9]

Dr Pitt in his evidence explained that the Society was attempting to provide rural communities access to the program.

It is important to note that the Guidelines which were in operation at time of this incident were clear on the issue of the Parental Supervision. Component SU10 of the document titled Parental Supervision describes it's purpose as:-

To outline the guidelines for entry for children to swimming pools and the expected parental behaviours

The document then goes further under the title of Description:

4.1 Children under 10 year should not be allowed entry unless under supervision of a person 16 years or older.

4.2 Parents or guardians (including those persons described in Section 4.1 above) should supervise their charges at all times and as such should be dressed ready for action including unexpected entry to a pool.

4.3 Signage or literature indicating the parental supervision policy of the pool is recommended.

The primacy of the supervision by the parent or guardian is, in my opinion, good sense. It is obvious, and would be expected, that a parent or guardian will have a great

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deal more knowledge of their child's ability or skill level in the water than staff who are in attendance at the pool.

The important issue of the number of supervisors which a facility such as the Cloncurry Shire Pool provides was raised in the submissions made by the Legal Representatives.

The RLSSA Guidelines address this issue.

Component SU1 is titled Bather Supervision. The guidelines as they existed at the time of the incident required two persons to be on duty. At least one of the persons on duty should be qualified to RLSSA Pool Lifeguard standard and the other should have a minimum qualification of First Aid, CPR and RLSSA Bronze Medallion.

It is to my mind important to note the purpose of SU1 which is stated as:-

To establish a minimum ratio of qualified people per number of bathers at swimming pool operating time and in particular recreational swimming times.

The document then details the minimum ratio of lifeguards to bathers as 1 to 100. Exceptions are then made to alter that ratio dependent on various factors which are not relevant to this inquest.

The Guidelines also deal with "Low Patronage Pools" which are pools in which there are less than 50 bathers in the water.

The document provides that in those circumstances (i.e less than 50 bathers in the pool) there should be a minimum of one responsible person in attendance at the pool at all times.

That person should be qualified to RLSSA Pool Lifeguard Award but where such training and assessment to obtain this qualification is not reasonably available, then the person should be qualified to a RLSSA Bronze Medallion level.

Miss Rebedello submitted that the low patronage provisions did not exempt the owners or operators of the complex, in this instance the Cloncurry Shire Council, from still having two persons on duty. Her argument was that it simply made allowance for the qualifications of those who were supervising or in attendance.

With respect, I disagree. I believe that when one looks at the two Guidelines, and in particular, at the ratios allocated to each guideline then the message seems clear. For pools where there are up to 100 bathers, two persons in attendance is the minimum required. For pools with up to 50 bathers, one person in attendance is the minimum required. The qualifications of those persons, or person, is then addressed by each respective guidelines.

It is not in dispute that at time of the incident, Robyn Watt had the minimum qualification, namely a RLSSA Bronze Medallion. That, combined with the fact that there were clearly less than 50 bathers in the pool at the time of the incident leads me

to conclude that the Guidelines were being complied with by the Cloncurry Shire Council.

Another aspect of the Guidelines was whether or not a recommendation should be made to mandate these guidelines, that is, whether to impose obligations upon the operators of such pools by way of specific legislation.

Inspector Rea was clear in his evidence that such an approach was warranted.

I note the evidence of Dr Pitt on this issue and that, in his opinion such an approach was not warranted or necessary. His comments are worth considering:-

"*My philosophy on all of this, is you can only do what's doable and it's mistake to actually push things to the point where you suggest solutions that in fact are not practical in the wider context, because that then just decreases everybody's likelihood of implementing them."*[10]

Dr Pitt then went on to explain that, in his opinion, if the guidelines were to be mandated an extensive consultative process would be required to take place.

In my opinion the mandating of the guidelines is not an appropriate recommendation. I believe Dr Pitt's preferred method of providing information and encouragement to the necessary people is far more practical and using Dr Pitt's words, "doable".

There are several other issues which were raised which I considered when determining the appropriate recommendations to be made.

Flotation Devices

The issue in relation to flotation devices was raised during the course of the Inquest. Inspector Coggins in his report which was tendered as Exhibit 8 listed the failure to affix a flotation device to Chloe as factor, whether direct or indirect, contributing to Chloe's death.

I note the submission from the Council on this matter and am in agreeance that the issue of whether a child wears a flotation device, and if they do, what type of flotation device they wear, should be entirely in the hands of the child's parent or guardian.

Once again, I am firmly of the view that a parent or guardian would have the most detailed knowledge of each of their child's or children's skill and ability in the water. If a parent or guardian decides that their child will wear a flotation device they can make an informed decision as to which device their child will wear based on that knowledge.

To expect an operator of pool to provide such equipment to me is unrealistic. There is little to no chance of making available every appropriate flotation device for every child that swims in the pool. This matter is more appropriately dealt with by the parent or guardian.

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Provision of Oxygen Equipment

This issue arose in the evidence at the Inquest and was one that I paid particular attention to. The evidence of Dr Pitt and Dr Cronin specifically addressed the issue and their opinions were given due consideration.

Dr Pitt's evidence was that a basic first aid bag/mask set and access to oxygen were the single most effective intervention likely to provide a successful outcome once a victim has been retrieved from the water.

Dr Cronin's evidence was that oxygen equipment was not appropriate.

Both were clear that the obtaining and maintaining of CPR skills was of primary importance.

I am mindful that the provision of oxygen equipment will increase the expense and the burden on those who are operating public pools. Dr Cronin's evidence was that she considered it to be medical equipment requiring medical training.

I think that whilst the importance of CPR training should be emphasised and encouraged, there was insufficient evidence before me indicate that the compulsory provision of oxygen equipment is either necessary or warranted.

Department of Workplace Health and Safety

Another issue which I believe warranted consideration was the role which the Department of Workplace Health and Safety played in this matter.

The evidence before the Court made it apparent that:-

1. The Department had never had any cause to visit the pool at Cloncurry prior to Chloe's death. The only investigation it had ever conducted prior to this time involved an issue with the storage of pool chemicals which was resolved without actual physical attendance at the pool.

2. That the inspector for the local region indicated that there would be perhaps 15-20 public pools operating in his region and that he would not have sufficient time or resources to visit them even on an annual basis.

3. That the department does not distribute any information to stakeholders regarding incidents such as this one. Only information regarding successful prosecutions are distributed to various stakeholders.

4. That whilst there had been some Departmental consideration of safety in the recreational industry, which includes the operation of public swimming pools, no strategies, at the time of the Inquest, had been developed.

It seems obvious to me that a requirement for some process of self-audit or self-assessment of pool operators is essential. It is clear from the evidence that the

Department of Workplace Health and Safety do not have the resources to conduct audits on a regular basis by actually visiting the pool sites.

A process whereby pool operators are informed that the RLSSA Guidelines are best practice, and further, some information on how to implement them is sorely needed in my view. Obviously as changes to the Guidelines occur this information should be passed on to the pool operators. In addition to these updates it is, in my opinion, imperative that operators also be advised of any incidents, such as this one, as soon as possible. This information could be distributed in bulletin fashion and provide some details as to how the incident occurred and some advice on what operators should be aware of to minimise the possibility of a re-occurrence at their particular pools.

Obligations of the Cloncurry Shire Council

Another important consideration is the obligations of the Shire Council in relation to this matter.

Miss Rebedello made detailed submissions on the areas she believe the Council has failed to fulfil it's obligations. She raised issues of the lack of Staff Training, (particularly in relation to the lack of Induction Training), and an absence of an emergency plan or procedure.

Miss Rebedello submitted that criminal responsibility could be made out against the Council in that if failed in its duty of care by

1. Not replacing the wading pool
2. Delaying the construction of the wet play area
3. Not providing additional supervision for toddlers at the pool when it knew that the community had a high percentage of single parents who would be utilising the pool and they did not have a specific area for toddlers to play in.

With respect to the submission regarding the criminal responsibility I am unable to agree with Miss Rebedello's submission.

The decision not to replace the wading pool is one for the Council to make. There is nothing in the evidence to indicate that the provision of a wading pool was compulsory and that the failure to supply one constituted any breach of any legislation or duty of care. It appears on the evidence presented to the Court that there was a consultative process undertaken with stakeholders within the community as to what type of facility was to be built. Government funding was obtained for the project and it would seem obvious that had there been any flaw or failing in the Council's approach to the new facility, the process of obtaining funding would have revealed it.

With respect to the construction of the wet play area there is nothing that I was able to glean from the evidence which showed that the Council contributed to any delay in it's construction. Conversely, Mr Chester, the Council CEO, gave evidence of the difficulties of finding and then retaining appropriately qualified or trained staff due to the lucrative conditions which the mining industry offers potential employees. The employment climate is an extremely competitive one and Council, like all persons in remote communities, have to be patient in waiting to have work, such as the

construction of the wet play area, completed. This was quite simply beyond Council's control.

The issue of failing to provide sufficient supervisors has been addressed by me previously. The demographics of the community, particularly in relation to the high percentage of single parents, is not, in my opinion, of such importance, that it places a higher obligation with respect to the number of supervisors required than that expressed in the RLSSA Guidelines. That is not to say that demographics of the community would not be important to consider, simply that it is one amongst many factors and would not, in my opinion, be amongst the most important. There is nothing from the evidence which indicates to me that the Council has failed in it's duty of care in this regard.

It would therefore follow that there is, in my opinion, no evidence which will lead me to make any recommendations pursuant to Section 48 of the Coroners Act.

Conclusion and Recommendations

I have approached the making of recommendations by attempting to introduce measures which I believe will assist to minimise the possibility of a re-occurrence of a death such as Chloe's. As was made clear in the evidence during the course of the inquest, the town pool would have to be closed to completely eliminate risk.

I bear in mind the importance of keeping public pools open and accessible to the community but at the same time ensuring that pool operators put in place reasonable measures to ensure that such pools provide a safe environment for all users, particularly children.

I am of the opinion that the only way forward in the medium to long term is to recommend measures which encourage a collaborative approach from the RLSSA, the Department of Workplace Health and Safety, and the Local Government Association of Queensland.

In the short term I believe that recommendations which inform parents or guardians of their responsibilities with respect to child supervision and which provide facilities to encourage them to fulfil their responsibilities is appropriate. In relation to the issue of signage, I have recommended that the RLSSA Guidelines on this issue, which have recently been updated, be adopted statewide for Low Patronage pools.

I therefore recommend

1. Through the collaboration of the RLSSA, the Department of Workplace Health and Safety and the Local Government Association of Queensland

    *that a register of all low-patronage pools (as defined by the RLSSA Guidelines) which are owned or operated by Regional/Shire Councils be kept and maintained by the Department of Workplace Health and Safety

    *That the RLSSA Guidelines be promoted to all Regional/Shire Councils listed on the register as "best practice" and that compliance with the

guidelines is to be encouraged and monitored. The promotion of the guidelines should stress the importance of appropriate supervision, the implementation of emergency procedures, the provision of appropriate emergency equipment and the provision of First-Aid equipment.

*that a self-audit tool, in the form of a checklist, be developed to encourage compliance with the RLSSA Guidelines. The checklist should be distributed to all Regional/Shire Councils on the register and the lodgement of the checklist with the Department of Workplace Health and Safety be required annually.

*that pool-related incidents which come to the attention of the Department of Workplace Health and Safety should be reported to all of the Regional/Shire Councils listed on the register. This should take the form of a Safety Alert advising of the details of the incident. After any prosecution or Coroner's Inquest has been completed a more formal Safety Report or Bulletin should be provided. The comments of any Judicial Officer or Coroner should be included in this report where it is deemed appropriate.

1. That all Regional/Shire Councils listed on the register ensure that all Low Patronage pools under their control have signage clearly displayed which should read:-

   "THIS POOL IS OPERATING UNDER LOW PATRONAGE GUIDELINES. THERE IS NO ROVING LIFEGUARD ON DUTY. FOR EMERGENCY ASSISTANCE SEE A STAFF MEMBER"

2. That all Regional/Shire Councils on the Register put in place procedures to actively seek assistance from the RLSSA to provide training to all staff who supervise at pools within their council to obtain the RLSSA Pool Lifeguard Award qualification, or alternatively, the RLSSA Bronze Medallion qualification, and to ensure that all staff who have obtained such qualifications obtain further training as and when required.

3. That all Regional/Shire Councils on the register put in place procedures which actively seek assistance from RLSSA to promote the "Water Watch" programme in the community. The promotion should be directed at both children through schools and directed at adults through the wider community.

4. That to encourage adults to supervise children in pools that all Regional/Shire Councils placed on the register provide, wherever practicable, shaded seating which is close enough to the pool to enable an adult or guardian to supervise children under their care in an appropriate manner

I wish to place on record my thanks to Mr John Tate, Counsel assisting, for all of his endeavours in the holding of this Inquest.

I also wish to make special mention of two witnesses, namely Robyn Watt and Janelle Major who showed great courage in giving their evidence before this Inquest. It was

no doubt a harrowing experience re-living the events of 12 March 2005 but I should indicate that without such evidence the Court would struggle to consider all of the relevant issues and make fully-informed findings and recommendations. I thank both of you for your efforts.

And lastly, I wish to place on record my thanks to Chloe's mother Maureen Major and members of her family who attended this Inquest. Mrs Major, I cannot begin to imagine what a painful experience it must have been. I can only thank you, as I did on the final day of the Inquest, for the dignity and courtesy you displayed to this Court during the proceedings. I am certain that the pain of losing Chloe will never pass but I hope that the completion of this Inquest will, in some manner, allow you some form of closure.

S.D. Luxton
Coroner
26 May 2008

It was ordered that the following parties be supplied with a transcript of this Decision:-

Janelle Major
Maureen Major
Robyn Watt
Queensland Division of the Department of Workplace Health and Safety
Department of Local Government Sport and Recreation
Royal Lifesaving Association
Legal Representatives of all parties who appeared before this Inquest

[i] These findings and recommendations were handed down at Cloncurry on 26 May 2008 and adjourned until 27 May 2008 to allow the Cloncurry Shire Council to compile and read to the Court a letter outlining it's response to the finding and recommendations. This letter was read to the Court, in the presence of members of Chloe's family on 27 May 2008. A copy of the letter is attached to this decision.

Cloncurry Shire Council

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27 May 2008

Acting Coroner Luxton
Cloncurry Magistrates Court
PO Box 335
CLONCURRY QLD 4824

Dear Sir

RE: Cloncurry Swimming Pool

I advise that I am currently the Acting Chief Executive Officer of the Cloncurry Shire Council due to the absence of the current Chief Executive Officer, Mr Ken Timms. When Mr Ken Timms is present, my position is that of Manager of Corporate Services.

I confirm that Council was to advise the Court any progress or changes which have been made to the Cloncurry Swimming Pool ("the pool"), any safety issues which have arisen since the Inquest, any new procedures and protocols, any education or awareness programs, and the undertaking of any risk assessments or any audits in relation to the pool.

I advise that I have been employed with Council since 31 March 2008 and I advise that in my position as Manager of Corporate Services I have been delegated the task of liaising with the current lessee of the pool to amongst other things ensure that the pool complies with Council policies.

I request leave of the Court to make known the following in relation to the pool on behalf of Council:

1. At the time the Inquest was held, the pool was shut. The pool reopened for the summer season in September 2007 following the inquest and remained open until the end of April 2008. Since 1 May 2008, it has been closed for winter.

2. Council's policy in relation to the pool is to ensure the current lessee operates the pool in accordance with the Royal Life Saving Society Guidelines.

3. I can advise that during the season, Council representatives, including myself, have visited the pool and have had ongoing information exchange with the lessee of the pool, Mirage Aquatics, and some of the information contained herein comes from these visits and discussions.

4. Mirage Aquatics continues to formally report on a monthly basis to Council statistics such as pool attendances and notifies Council of any serious incidents and/or matters requiring Council's attention.

5. The lessee has advised that the pool was very well attended over the swimming season that has just ended.

6. During the past swimming season, the current lessee of the pool has continued operating their tender to the satisfaction of Council.

7. The Watch Around Water program is continuing and Mirage Aquatics has and remains committed to helping parents supervise their children at the pool. Mirage Aquatics have also been running a program to educate children and adults as to water safety. Council fully supports Mirage Aquatics in this program. (the Learn to Swim Program)

8. I can report to the Court that no safety incidents of note have been reported during the past season, and to Council's knowledge, there were no fatalities or serious injuries at the pool during the last season.

9. Likewise, to the best of my knowledge Council has not been notified of any other incidents occurring at any other low patronage public swimming pool in any other regional centre since the Inquest.

10. Mirage Aquatics have actively got behind the Cloncurry Swimming Club which has been well attended during the past season.

11. Physically, some of the facilities at the pool have been altered since the Inquest. This includes the installation of additional seating and shade umbrellas to give shade to those around the pool. Subject to available funding, Council is also planning to install shade cloth over the pool (this may involve a retractable system) so as to give shade to those in the pool and also reduce the water temperature in the summer months. Additional seating and shade may also be installed. Council notes the recommendation made by the Acting Coroner in this regard.

12. Mirage Aquatics continues to provide its staff with ongoing training and opportunities for staff to update/upgrade their qualifications.

Council's initial response to the recommendations made by the Acting Coroner on 26 May 2008 is that Council will commit to implement them. Of particular interest is the recommendation of annual audits and as such, Council eagerly awaits the provision of the checklist as recommended to assist in this process. Council will also implement the recommendations in terms of signage and will cooperate with the implementation of the register of low patronage pools and the ongoing need to have that register updated from time to time.

Council will, in addition, make available the findings of this Inquest to the current lessee and work actively with them to ensure the recommendations are adhered to. A clause to this effect will be placed in the lease document which is currently being renewed.

I can further advise the Court that Council has been approached in relation to a plaque at the swimming pool dedicated to the memory of Chloe. I confirm to the Court that Council will erect such a plaque in time for the opening of the pool for the new season. We will liaise with the family of Chloe with respect to this.

I request leave of the Court to have this letter read into the transcript for the public record and that this transcript is appended to any further publication of the findings. Should the Acting Coroner so desire, copies will be made available to the parties present.

Finally, on behalf of Council I wish to formally apologise to the Court and to those persons affected by the late provision of this letter. A commitment to do so was given at the time of the hearing and it is most disappointing that the then Chief Executive Officer and Council's legal advisors failed to ensure that this was fulfilled.

Yours faithfully

Craig Turnour
ACTING CHIEF EXECUTIVE OFFICER