QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Cheyenne Ruby DOWNING**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Cairns
FILE NO(s):	COR 2944/06(5)
DELIVERED ON:	1 June 2009
DELIVERED AT:	Cairns
HEARING DATE(s):	10 January, 7 – 11 April 2008
FINDINGS OF:	Trevor Black, Coroner
CATCHWORDS:	CORONERS: Inquest – Swimming pool drowning of a child. Recommendations concerning legislation with respect to construction and inspection of pool fencing
REPRESENTATION:	
Assisting the Coroner:	Ms Helen Price, Cairns Police Prosecution Corp
Cairns Regional Council:	Mr D.K. Boddice S.C instructed by Williams Graham and Carman
Peace Lutheran College:	Mr D.P. Morzone instructed Miller Harris Solicitors
Family:	Mr M.A. Fellows instructed by Farrelly's

These are my findings in relation to the death of Cheyenne Ruby Downing. These findings seek to explain how this death occurred and consider whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future. The *Coroners Act* 2003 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 organizations 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.

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

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

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. I will say something about the general nature of inquests for the sake of completeness.

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]

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]

A coroner must not include in the findings or any comments or recommendations or statements that a person is or may be guilty of an

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1 *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625

2 s46

offence or civilly liable for something.[3] However, if, as a result of considering the information gathered during an inquest, a coroner reasonably suspects that a person may be guilty of a criminal offence; the coroner must refer the information to the appropriate prosecuting authority.[4]

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "may inform itself in any way it considers appropriate." That doesn't 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 provenance when determining what weight should be given to the information.

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]

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, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trial of fact to be sufficiently satisfied that it has been proven to the civil standard.[7]

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.

I am truly regretful that more than one year has elapsed since the evidence was taken in these proceedings and submissions made. I acknowledge this has had a potential to cause pain and distress to the child's family and their friends. However, the state of the evidence was such that I sought to have a clear mind about my obligation to make recommendations that might prevent deaths of this nature in the future. Accordingly, I sought further advice and

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3 s45(5) and 46(3)

4 s48

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

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 (1991) 65 ALJR 167 at 168

information about the nature of pool deaths. In particular, I made further inquiries of the Cairns Regional Council and received a reply to my correspondence on the 4th August, 2008. I need to concede that the cause of the delay in delivering these findings lies with me and I apologise for it. It seems inappropriate to further delay.

There appears to be an increasing number of infants and young children dying as a result of immersion in domestic swimming pools or other bodies of impounded water. One of the causes of the delay is the continuing and increasing agitation for a more intrusive legislative approach to negative, as far as possible, this unacceptable loss of life. I am aware of a Review into pool fencing safety laws and the Report on that review that was published in April of this year.
http://www.dip.qld.gov.au/resources/poolfencing/pool-safety-report.pdf

The recommendations that flow from this review may or may not address the concerns that arise from this inquest.

I am now obliged to make these formal findings:

I find that a female child, Cheyenne Ruby DOWNING, died on the 22nd October, 2006 in the grounds of the Peace Lutheran College, situated at Cowley Street, Kamerunga, Cairns.

The child was aged two (2) years having been born 26th September, 2004.

Prior to her death, Cheyenne had resided with her parents, David and Natasha Downing at 5 Sugarglider Close, Kamerunga.

A pathologist, Dr M Jagusch, conducted an autopsy and certified that the disease or condition directly leading to death of the child was drowning. I am uncomfortable and have always been uncomfortable with a certification as to cause of death being drowning, being of the view that “drowning” is more a mode rather than a cause of death. However, in a Notice to the Coroner after the autopsy Dr Jagusch commented that the death “bore the features of drowning” and that no other abnormalities were identified. In his summary contained in the autopsy report Dr Jagusch also commented that the autopsy findings supported “asphyxial death associated with drowning”. That, in my view, ought to be the cause of death as established by this inquest.

These appear to be the facts surrounding the cause and circumstances of the death:

The child and her parents, David and Natasha Downing, had relatively recently moved to Australia from their homeland of South Africa. The family consisted of the parents, Cheyenne and a younger and older sibling. Mr Downing had been employed as a teacher with the Peace Lutheran College. The family had rented a home situated at 5 Sugarglider Close, Kamerunga which had a common boundary with the College grounds, and, in fact, with the College pool. Mr Downing, after taking up tenancy, created a gate in the

dividing boundary fence so as to provide ease of access between his home and the school grounds.

The evidence supports the view that on the fatal day, Cheyenne had spent her time between the company of her mother, in the home proper, and father in the school pool/nursery area. At some point, perhaps about 5pm Mrs Downing ventured into the pool area to seek her husband's assistance in the home. It cannot be said with any certainty that Cheyenne accompanied her mother at this time or whether she had come and gone throughout the afternoon. Some 30-40 minutes later the child's absence was noticed and when a search was instituted she was found by her father face down in the school pool, unconscious. Tragically, despite the application of CPR, she was not able to be revived.

At this point, one might comment about the necessity to maintain extreme vigilance at all times in relation to young children and volumes of water. That, sadly, will contribute little to the debate concerning the adequacy or otherwise of pool fencing legislation. From submissions made on behalf of the child's parents, it seems apparent that their home nation has a low incidence of home swimming pools and they were not alert to the legislated requirements of pool fencing. However, it is of significant concern that a number of people were aware of the gate and alert to the danger it posed but did not take appropriate steps to forestall the tragedy that resulted.

The Peace Lutheran College's Business Manager, Mr Rodney KRENSKE, was approached by Mr Downing and gave him approval to construct the gate between the rental property and the school grounds in about March, 2006, at his (Downing) own expense. Mr Krenske says that it was a condition of installation that the gate be padlocked at all times and that it only be unlocked to allow Downing's access to the school grounds. It is apparent that Mr Krenske was cognizant of the potential danger posed by the creation of the gate but his fears were mollified when he found the gate padlocked, as agreed, on two unscheduled visits to the Downing home.

On the 11th September, 2006, not long before Cheyenne's tragic death, an audit of the school's workplace health and safety practices was conducted. No issues with respect to the gate arose as a result, given that the gate was again found to be padlocked.

The existence of the gate, however, was of concern to a Mrs Deborah Gibson, a house parent at the school, who raised the issue at a meeting of house parents. It seems nothing of any great moment followed. Coincidently, Mrs Gibson found the pool gate unlocked and open about 4.30pm on the day of the tragedy. She had gone down to conduct some school business with Mr Downing but could not locate him.

Both Mrs Gibson and another house parent, Mrs Diane Bliesner, had previously seen a young child, now thought to be Cheyenne, running around the perimeter of the pool but when attending, out of natural concern, had found Mr Downing present and were assured he was supervising the child.

It is appropriate here to note that Coroner, Magistrate Robert Spencer, had made extremely detailed and cogent recommendations regarding pool safety fencing following an inquest into the cause and circumstances surrounding the death of a child, Tognola, in 2005. I will refer to these findings later.

It should be noted that the pool in question is not covered by State Government legislation. Being a pool constructed within the grounds of a school or college, the applicable legislation covering matters such as pool fencing is a local government ordinance, in this case Local Law 29 of the Cairns City Council by-laws. But for all intents and purposes it applies the same provisions as those for domestic swimming pools.

After the child's death, Mr Phipps, the Building and Environmental Manager of the then Cairns City Council, conducted an inspection of the property at 5 Sugarloaf Crescent, Kamerunga (the deceased child's home) and in particular, the gate in question. He found the gate to have the following defects:

(a) the gate opened into the pool area as opposed to swinging away from the pool area as required by Local Law 29;
(b) the gate was not fitted with a self-closing mechanism or a self-latching device;
(c) the gate latch was only 900mm above ground height instead of the legislated 1500mm;
(d) the design of the gate was such that it was climbable by a child.

Mr Phipps identified several other defects in the surrounding pool fence but those defects did not contribute to this cause of death.

Thankfully, the school acted responsibly and expeditiously and by the 3rd November, 2006 the pool was found to be fully compliant with the legislation then in force. One might cynically comment: "Too little too late". I note that annual health and safety audits are now conducted.

The Coroner asked for further information as to the implementation of the recommendations made by Coroner Spencer following the Tognola inquest. Mr Phipps reported that he had recommended to Council that it establish a pilot home pool inspection programme to ensure compliance with legislation. It was disheartening to note that the Council deferred action pending a State Government decision with respect to pool fencing legislation.

The Cairns City Council region at that time had over 10,000 recorded swimming pools. In response to the Tognola findings, the Council had been proactive in preparing and posting to all recorded pool owners an information letter setting out the legislative requirements and urging that pool owners insured that pools were properly fenced and reminding them that the responsibility was theirs. Mr Phipps suggests that this triggered an adverse reaction from some pool owners. Regrettably, it is apparent that some level of self interest prevails.

Mr Phipps also reports that following amalgamation and the creation of the Cairns Regional Council, 17% of all homes in the area have a pool. As a "work-in-progress" all pools in the area are to be included on a specific data base which Mr Phipps anticipated would be completed by 31st October, 2008.

From the material I have seen, it seems that the requirements for new pool fences and the obtaining of approval with respect thereto is well catered for in the legislation existing and proposed. Mr Phipps reports that the enforcement of swimming pool regulations is carried out in accordance with the Building Act requirements.

It is with respect to established pools where there seems to be a legislative black-hole.

However, it seems that the Council inspects existing swimming pools only upon a complaint being received or as when requested by the property owner. This cannot be regarded as being adequate in these circumstances.

Without pre-empting anything that might be recommended in the current review, these matters might well be considered:

Legislation should be passed to ensure:

1. As recommended by Coroner Spencer in 2005 the Parliament proclaim a single piece of legislation containing a uniform set of rules and regulations relating to the construction of pool fencing, irrespective of the date of construction of the pool. The legislation ought to make provision for safety inspection of all recorded swimming pools on a regular basis and, at least, on every occasion where the integrity of the pool fence has been compromised by any alteration.

2. All common fences between contiguous properties, one of which contains a swimming pool, must be a "pool fence" as defined by the prevailing legislation and not merely a "boundary fence". Further, any gate that intersects the pool/boundary fence must be self-closing and self-latching. The onus of ensuring compliance with the legislation ought to be that of the owner of the land on which the pool is sited. This death, as in the matter of Tognola, resulted from a boundary fence, as distinct from a pool fence, being modified.

3. The Parliament ought to consider, in drafting legislation, enacting a provision that requires owners of properties adjoining a pool to keep the boundary fence clear of objects that would assist a young child to gain access to the pool (e.g. the planting of trees or the building a barbecue within about 1 metre of the boundary fence.)

4. The legislation enacted should also provide that where a boundary fence of adjoining properties forms part of a pool fence, any

inspection of the swimming pool fence should also entail an inspection of the property owner's boundary fence.

5. The legislation might also provide that where an owner rents or leases a property where a boundary fence forms part of a pool fence any rental, tenancy or lease agreement include a provision that the renter or lessee be provided with information about pool fencing requirements and an acknowledgement as to a responsibility to ensure such fencing is kept in a good, safe state of repair.

Regrettably there seems to be a selfish attitude in the community that revolts against any suggestion that pool owners ought to be levied a fee to cover the anticipated substantial cost of regular pool fencing safety inspections. I think it behoves authorities, including State and Local Governments, to embark on an education programme highlighting the tragedy of the loss of even one infant's life needlessly. An advertising campaign emphasising the dangers swimming pools (any other water impoundments) pose to young children should be commenced and/or continued. The material ought to be directed not only at owners whose properties have had pools installed but also at persons, whether owners, renters or lessees, who reside in properties where the boundary fence adjoins a pool. The community ought to be encouraged to be proactive and report to the appropriate authority situations in which, as a result of a breach of pool fence safety, the life of a child is placed at risk. Finally, legislation must provide for substantial penalties where pool owners refuse or neglect to maintain pool fencing to the requisite standard.

I ought to say here that late last Friday I received communication from an organisation, Hannah's Foundation, asking to be permitted to appear and make submissions in this Inquest. In the normal course of events, I may have entertained that submission. Many people and organisations are appalled at the continuing death toll in these circumstances.

This tragic death occurred nearly three years ago. I doubt those affected, certainly not Cheyenne's parents, have recovered from the loss of this child. For what comfort it may be, I extend my sympathy and that of my staff to them. I trust that appropriate steps may be taken to ensure there is not another tragedy of this magnitude.

This inquest is closed.

Trevor Black, Coroner
1 June 2009