QUEENSLAND COURTS

# OFFICE OF THE STATE CORONER

# FINDINGS OF INVESTIGATION

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| CITATION: | **Non-inquest findings into the death of Child A** |
| TITLE OF COURT: | Coroner's Court |
| JURISDICTION: | Brisbane |
| DATE: | 11 November 2015 |
| FILE NO(s): | 2013/3869 |
| FINDINGS OF: | John Hutton, Brisbane Coroner |
| CATCHWORDS: | CORONERS: child death, drowning, recreational dam |

**Findings required under s. 45(2) of the *Coroners Act 2003* in relation to the death of Child A**

I find as follows:

- The deceased person is Child A, born on 23 January 2005.
- Child A died from Anoxia due to fresh water drowning and a blow to the face causing minor trauma.
- Child A died on Sunday 27 October 2013.
- Child A died at Lake Dyer (Bill Gunn Dam) located at Lot 132 Gatton Laidley Road East, Laidley, QLD 4341.
- The circumstances of Child A's death are as per the outline below.

## EVIDENCE, DISCUSSION AND GENERAL CIRCUMSTANCES OF DEATH

### Background

On Sunday 27 October 2013 at around 11:00am, the deceased's family met with friends at the Lake Dyer picnic area to celebrate a friend's birthday. Lake Dyer is also known as the Bill Gunn Dam and is located at Lot 132 Gatton Laidley Road East, Laidley, QLD 4341. There were approximately 20 people at the party. Their friends had recreational boats and a jet ski and spent most of the day water skiing and wake boarding. The children were swimming and playing in the water.

It was a clear sunny day. In the afternoon, the wind increased to at least 20 knots. Between 2:30pm and 3:30pm, the family and friends were gathered around a covered picnic table approximately 80 metres from the main boat ramp. Four children (Child A (8 years old), her older brother (10 years old), and two friends (6 and 7 years old)) were playing in the water with an inflatable green 'ski biscuit' and an inflatable black and blue ski tube. They were climbing them, jumping off them, and floating around on the water. Child A was 136cm tall, had blonde hair, and was wearing a pink rash vest and green shorts.

Child A's mother and a family friend were sitting on the grass on the embankment, supervising the children from a distance. Child A's parents stated that they had a rule that the kids were not allowed to go out too deep (past their shoulders) and were not to swim too close to the boat ramp.

At approximately 3:10pm, the ski biscuit and ski tube were propelled towards the boat ramp, most likely due to a gust of wind and the wake caused by jet skis, which were close by. Child A's mother witnessed Child A swimming after the green ski biscuit and her brother swimming after the black and blue ski tube. At this time, a black and white boat (described as a 20 – 30 foot 'tinnie' with a deep sea hull) had come into the boat ramp and blocked Child A's mother's line of sight of the children. This caused Child A's mother to get up and walk around to the other side of the boat ramp to the water's

edge, where she had last seen Child A swimming. Child A's mother was unable to locate Child A.

Child A's mother immediately alerted her family and friends and they commenced a search of the area. Child A's father entered the water up to his armpits, 'sweeping' the area, to see if he could feel Child A with his feet. After about 20 minutes of searching, Child A's father phoned the police at 3:32pm to report Child A as missing.

Crews from the Queensland Police Service (QPS) and Queensland Ambulance Service (QAS) arrived at the scene by about 3:45pm and commenced a search of the reserve. A crew from the Queensland Fire and Rescue Service (QFRS) also arrived by about 4:00pm. QFRS officers waded out into the water in front of the boat ramp where A was last sighted and commenced a grid search. A member of the public, MP, who had previous experience in search and rescue, assisted QFRS officers.

At about 4:20pm, MP located Child A's body submerged face down, in approximately 1.5 metres of water, about 10 metres from the boat ramp. The bottom of the lake was sandy in that area and the water was clear. MP raised Child A's body out of the water. He checked Child A's pulse and could not find one. He alerted QFRS officer Troy Tozer. A was immediately taken into a waiting ambulance, where she was ventilated and CPR was commenced.

The ambulance departed Lake Dyer at 4:22pm and arrived at the Laidley Hospital at 4:28pm. QAS officers continued CPR in transit, with the assistance of QFRS officers. Child A was ventilated by a bag. Child A was unresponsive - she was not breathing, there was no pulse, and her pupils were fixed.

The on duty doctor at the Laidley Hospital, Dr John Lancashire, had been pre-warned by QAS that Child A was enroute. Dr Lancashire activated a 'telehealth link' with Dr Bruce Lister, a Paediatric Intensive Care Unit Consultant from the Mater Hospital in Brisbane. Dr Lister provided Dr Lancashire with specialist advice via the telehealth link.

Dr Lancashire has attached his account of his medical management of Child A on her hospital medical file dated 27 October 2013. Dr Lancashire stated that upon Child A's arrival at the hospital, he observed that she was not breathing. There was no carotid pulse, her pupils were fixed and dilated, and her body was pale and cold with some rigidity (Glasgow Coma Scale 3). CPR was continued at the hospital and adrenaline was administered. Cardiac monitoring was put in place and showed that Child A's heart remained in asystole the entire time. A large amount of gastric contents and fluid was expelled during compressions. Attempts to ventilate Child A were unsuccessful. After close to 30 minutes of attempted resuscitation at the hospital, Dr Lancashire and Dr Lister agreed that it was unlikely to be successful, given Child A's failure to respond and her condition on arrival. Dr Lancashire determined that Child A was life extinct at 4:50pm.

Child A was examined at the Laidley Hospital by forensic officer Senior Constable Everylyn. Child A's body was observed to have some minor cuts to her nose area and a minor lip laceration but there were no other notable injuries to the rest of her body.

Child A's parents have confirmed that these injuries were not pre-existing.

**Police investigation**

A police investigation was conducted by Detective Sergeant Bronagh Gillespie from the Laidley Child Protection Investigation Unit and completed on 27 November 2014. A number of witness statements, photographs and diagrams of the scene were obtained.

Child A's parents provided statements dated 28 October 2013 and 31 October 2013 respectively. They stated that they had been taking their children to swim at the same location at Lake Dyer between the picnic table and boat ramp all their lives. During the September 2013 school holidays, they were there almost every day. They stated that Child A was fit and healthy. She had been taught to swim by the family. She was a confident swimmer who knew her limitations, and she had been in the water all of her life. They often took their children to the public swimming pools at Laidley and Gatton. Child A was easily able to swim 25 metres in a pool, freestyle with correct stroke, technique and breathing. Child A was familiar with the ski biscuit, as she had played with it at Lake Dyer on many occasions.

From all accounts, the boat ramp was busy at the time of Child A's disappearance, with a number of boats exiting the ramp. Detective Sergeant Gillespie made enquiries with the owners and operators of the boats that were near or at the boat ramp at the time in order to determine whether it was possible that Child A could have been hit or dragged by a boat that was coming into the boat ramp.

Mr S stated to police that when he was coming into the boat ramp with his boat there were a few tubes floating across the boat ramp and there were kids swimming in the vicinity. He parked his boat on the western side of the boat ramp and dropped people off. When he was informed that Child A was missing, he assisted by conducting a search of the water in waist deep water. He then took his boat back into the water and searched the bottom using his depth finder but did not find anything.

Mr P was also coming into the ramp at the time Child A disappeared. Mr P stated to police that he saw three children in the water but only one child on a tube. He noticed a blonde child (whom he thought was a boy) as he was going to be in the way as he came into the ramp. Sergeant Robert Bairstow from the water police obtained the version from Mr P and examined Mr P's boat and there were no signs of any damage.

Detective Sergeant Gillespie formed the opinion that Child A's death was accidental and was caused by drowning. There were no suspicious circumstances. Due to the lack of more serious injuries and other evidence, Detective Sergeant Gillespie does not believe that Child A was struck by a boat. He does not believe that there was any negligence on the part of the parents, as the children were being supervised. He noted that the area was not designated for swimming but that Child A's family had spent a lot of time swimming there in the past and had never been advised that they could not swim there. There were also no signs in the area saying that swimming was prohibited. The foreshore area of the dam was commonly utilised by the community for swimming.

Detective Sergeant Gillespie noted that Lake Dyer (Bill Gunn dam) is managed by Seqwater. He recommended that signs be erected at the boat ramp, at the picnic area, and around the foreshore, specifically prohibiting swimming. He noted that Seqwater had plans to designate an area at Lake Dyer for swimming in the future. He was concerned about this because he had obtained photos of the dam from 2009/10, showing that the topography of the dam in that area was undulating. He was of the opinion that it would be very easy to lose your footing and suddenly be in deeper water than anticipated. For a child, this could cause panic and may lead to drowning.

**Seqwater's management of Lake Dyer (signage)**

A statement dated 28 October 2014 was obtained from Ms Donna Gregory, the acting General Manager of Operations – Catchment and Raw Water from Seqwater.

Ms Gregory stated that Seqwater manages the dam itself, signage, water quality, and updates. The Seqwater web page displayed information relating to prohibited activities and rules for dam usage. There was also a chart, which indicated that swimming was not permitted at Lake Dyer.

The following warning was located on the Seqwater website:

> *"Please remember, there are no lifeguards on duty at swimming areas at Seqwater lakes. While your safety is important to us, it is your responsibility.*
>
> - *Only swim in designated areas*
> - *Ensure children are supervised at all times*
> - *Do not swim after drinking alcohol*
> - *Use common sense"*

Ms Gregory confirmed that at the time of Child A's death, Lake Dyer was restricted to boating (and fishing) only. Ms Gregory advised that after a recent review, which included extensive community consultation, Seqwater had plans to amend the recreational designations at Lake Dyer to include a designated swimming area.

In terms of signage, Ms Gregory explained that Seqwater installs and maintains some of the signs at Lake Dyer (in addition to the Caravan Park operators and the Lockyer Valley Council). The signs at Lake Dyer stated that boating and fishing were permitted activities but they did not specifically say that swimming was prohibited. It would appear from Ms Gregory's statement that Seqwater is of the view that their responsibilities are only to provide 'Orientation' and 'Visitor Information' on their signs. She stated that their signs at Lake Dyer did not say anything about swimming because swimming was not encouraged or a 'designated' recreation activity.

**Autopsy results**

An external examination and a full body CT scan were conducted on 29 October 2013 by a forensic pathologist. Toxicology testing was also conducted on a sample of Child A's femoral blood. A toxicology certificate of analysis was produced on 11 December 2013. The Autopsy report was concluded on 2 January 2014.

There was no alcohol or drugs detected in Child A's blood.

There was no debris identified within Child A's central airways.

The forensic pathologist noted abrasions to Child A's face. The tip of her nose had skin missing over an area of approximately 5 x 5mm and also skin missing on the left ala nasi of similar size. There was slight thickening to the upper lip and minor abrasions on the inside of the lip. There were no fractures to the facial bone. There did not appear to be any other injury to the skull.

The forensic pathologist was of the opinion that Child A's face had been struck against an object. He was not of the opinion that this injury would have caused unconsciousness. However, he noted that it would have been a fairly severe blow to the face and would have caused a considerable fright reaction and possibly precipitated a panic attack, resulting in failure to successfully swim out of the lake.

The forensic pathologist was of the opinion that the medical cause of Child A's death was:

1.a. Anoxia due to

1. b. Fresh water drowning.

2. Blow to the face causing minor trauma

**Recommendations by Hannah's Foundation**

I received a letter dated 27 January 2014 from Ms Katherine Plint, Coronial Research Officer, of Hannah's Foundation. Hannah's Foundation is a support group registered charity that provides education regarding drowning prevention and awareness. Ms Plint has advised that she was present as a support person when Child A's mother provided her statement to police.

Ms Plint has raised some concerns about this particular incident, many of which appear to be based on misinformation. Ms Plint has suggested further lines of investigation, which have either already been conducted by the police, or I have discounted.

Ms Plint has advised that Hannah's Foundations is concerned at the lack of inquests into drowning incidents and would support an inquest to raise public awareness.

Below is my summary of Ms Plint's recommendations:

- That parents are educated that swimming is not a skill that saves lives; that

more than three children in the water requires closer supervision; and that there are dangers associated with ‘shallow water blackouts’;

- That the wearing of life jackets is crucial when swimming in inland water ways (particularly in water that has low visibility);

- That dam operators introduce signage encouraging people to wear life jackets when swimming in dams;

- That dam operators or councils supply fully qualified Lifeguards where more than 20 people are known to swim in the area;

- That swimming areas in dams are closed/sectioned off;

- That there are clearer warning signs on ski tubes etc. about the dangers of becoming stuck or inverted, that a life jacket must be worn, and active parental supervision is required;

- That school swimming curriculum in Queensland include education to students over 7 years of age about the dangers of ‘shallow water blackouts’;

- That police powers be increased to test parents/carers for alcohol/drug intoxication at the time of a child’s death due to drowning; and

- That caretakers of dams are trained and have in place emergency procedures (and signs at relevant locations) setting out the action to be taken where there is a missing person or accident at the dam.

## Conclusion

I accept the medical evidence that Child A received a blow to the face by an object causing minor trauma. I have considered Detective Sergeant Gillespie’s theory that the injuries could have been caused by Child A dragging along the bottom of the dam after submerging.

However, given that the boat ramp was quiet busy at the time in question and boat operators recall seeing children and inflatables in their way as they were coming in, I have determined that the most likely cause of Child A’s injuries is that she was struck by a boat. If this did in fact occur, it is unlikely that the boat operator would not have realised.

Given Child A’s swimming ability, I have determined that the blow to Child A’s face is likely to have been what led to her drowning. Whilst she would not have been knocked unconscious, the fright caused by such a blow is likely to have led to a fright reaction and panic, which has led to her being unable to successfully swim out of the lake.

It is possible that Child A also lost her footing on the bottom of the lake, due to the undulating topography.

I have determined that Child A is most likely to have died at Lake Dyer prior to her discovery at around 4:20pm, as there were no signs of life the entire time during the attempts by ambulance and hospital staff to resuscitate her.

I have determined that Child A's mother's supervision was sufficient in the circumstances at the time. There is no evidence to suggest that Child A's mother was intoxicated. It was an unfortunate set of circumstances that led to Child A's mother losing momentary line of sight due to a boat impairing her vision.

There is no evidence to support a conclusion that Child A became inverted or stuck in the 'ski biscuit'.

There is no evidence to support a conclusion that Child A had a 'shallow water blackout'.

It is possible that a life jacket may have assisted in the circumstances but it was not unreasonable for Child A not to be wearing one at the time.

Seqwater should have had better signage at Lake Dyer making it clearer that swimming was prohibited in the area.

The presence of Lifeguards may have assisted, but it is unknown whether this is economically and practically feasible.

An emergency procedure outlined on a sign at Lake Dyer is unlikely to have assisted in this case. It is understandable that it took some time for Child A's parents to establish that Child A was missing and to conduct their own searches in and out of the water, before calling the police.

## Follow up action

As a result of the circumstances of Child A's death, I will write to Seqwater suggesting that they consider introducing signs specifically warning against swimming at Lake Dyer, if they have not already.

In the event that Seqwater decides (or has decided) to designate a swimming area at Lake Dyer, or where they do so at other dams, I will suggest that Seqwater:

- carefully examine the topography of the area that they have chosen;
- consider cordoning off the designated swimming area;
- consider introducing signs encouraging the use of life jackets; and

consider the feasibility of introducing Lifeguards in popular swimming areas at dams (in conjunction with local and State government, and organisations such as Surf Life Saving Australia).

John Hutton
Brisbane Coroner
11 November 2015