QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of T and P**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
DATE:	06/05/2020
FILE NO(s):	2016/4594, 2016/4595
FINDINGS OF:	Ainslie Kirkegaard, A/Coroner
CATCHWORDS:	CORONERS: accidental child drowning; domestic swimming pool, non-compliance with pool safety standards, pool safety obligations for landlords & tenants of residential rental properties; protective parenting; relationship between supervisory neglect and risk of accidental death for children.

Contents

1. T was a four-year-old girl who drowned with her three-year-old sister P in a swimming pool at the family's rental home on the afternoon of 1 November 2016. They had three other young siblings including a five-year-old brother.

2. T attended pre-prep one day a week in preparation for starting prep in 2017. P did not attend kindergarten or day care. She was cared for at home by her parents who were both unemployed.

3. The girls' deaths were reported to the coroner because they died in a drowning incident.

The family's involvement with child safety services

4. The family had a child protection history from 2011-2016 arising from a series of child concern reports and notifications due to concerns about their exposure to domestic and family violence, including physical and emotional abuse, by the father towards the mother. There were multiple reports about the father's aggressive, controlling and threatening behaviours including socially isolating the family from other family members and the community, obstructing the mother's and the children's access to medical treatment, controlling family finances, using belittling and derogatory language and physical violence against the mother and the children (excessive discipline). There were also concerns about poor household hygiene and the children's educational, medical and developmental and supervision needs not being met. The eldest child had a high rate of school absenteeism and the children missed medical appointments and were displaying some developmental delays. There were also reports regarding concern that the father may be using illicit drugs and might have undiagnosed mental health issues.

5. There were two Investigation and Assessments, one finalised in January 2016 and the other in June 2016, both with an outcome of Unsubstantiated – Child Not in Need of Protection. The parents declined referral to support services stating they received support from their church (Jehovah's Witnesses).

6. There was no child safety involvement with the children or their family at the time of the girls' deaths.

7. There was a Domestic Violence Order in place naming the father as the respondent and the mother as the aggrieved at the time of the children's deaths. It also named the children. It was in force until 21 April 2018 and included no contact conditions with the mother. This order was made on application by police following an incident on 27 November 2015 when the father assaulted the mother at the family home. He was also charged with assault but the charge did not end up proceeding.

The family's accommodation

8. The family had been evicted from their accommodation in mid-2015 due to extremely poor living conditions. They moved into the rental property in early November 2015. They were renting it privately through the owner who had advertised the property on Gumtree.

9. The residence is a two-storey highset dwelling. There is a back deck with external stair to the backyard. Access to the back door is via another set of external stairs leading to a deck. This back door gains access to the upstairs dining room via a glass sliding door and sliding security door. The lock on the sliding security door was reportedly broken approximately one week prior to the children's deaths and was unable to be locked. The mother told police they called the owner asking for it be fixed but it was yet to be repaired.

10. There was a large trampoline (at least 12 foot in diameter) at the bottom of the rear external

stairs. Next to the trampoline was a large kidney shaped in-ground swimming pool enclosed by a metal pool fence. The pool gate had a latch that had to be pulled up to open the gate, with a small key left in the locking mechanism.

11. None of the children had ever received swimming lessons and none, including T and P, were able to swim. According to the parents, the family had only used the pool a couple of times previously at which times the children were supervised and had to remain on the pool step area.

Events leading to the children's deaths

12. A comprehensive police investigation established that on 1 November 2016, the family were all at home. T and her older brother were meant to have attended school and pre-prep that day but the parents decided to keep them at home because of the wet weather. They had to walk the children to school and did not want the children to get wet in the heavy rain.

13. The mother told police she was unwell and went to lie down in the main bedroom sometime between 11:30am – midday. It was later established that she was pregnant at the time and may have been suffering morning sickness. She said she put on a Pokemon movie for the three older children. The two youngest children were asleep in their cots. The mother said the father was out in the lounge area playing a computer game when she went to sleep. She told police he was supervising the children at this time.

14. The father told police that he put the movie on for the children in the lounge room and then went in the main bedroom to use his computer. He said he last observed the three older children at around 1:00pm from the lounge room.

15. The eldest child told police that he used a wooden children's chair from upstairs to help him climb onto the trampoline. He then reached across from the trampoline to access the pool gate latch, turned the key and opened the pool gate. It appears that he, T and P all entered the pool area but only the girls entered the water. It is not known how they entered the pool. The oldest child told police that P fell down into the pool and he tried to help her. He said he tried to help both girls but he *"lost them*". He went back into the house to tell his parents. He recalled his father was angry.

16. The father told police his son came into the main bedroom twice saying words to the effect of "*can't find the girls*". The father said he thought his son was playing a game of hide and seek with them so he told the boy to find them. He did not leave the room at that time. The boy returned to the bedroom a third time saying words to the effect of "*they're dead*". The father said he left the bedroom and realised the girls were no longer in the lounge room. He said he started looking for them inside the house.

17. The mother recalled being woken by her son saying words to the effect of "*girls in pool, girls dead, the girls are died in pool, pool*". She told police the father was in the toilet at this time. She immediately ran to the back deck from where she could see something dark in the deep end of the pool. She had to move a children's chair from in front of the gate to enter the pool area. She entered the pool and located the two girls at the bottom of the pool. She was screaming for help. The father was upstairs at the time and immediately phoned 000 while the mother brought the girls to the edge of the pool. She and the father commenced CPR, with assistance from a neighbour, pending the paramedics' arrival. Paramedics attended soon afterwards but despite emergency resuscitation efforts neither of the girls were able to be revived.

18. The mother spoke to her son after the incident. She says he told her he opened the gate

and he was "*sorry, sorry the girls are dead*".

19. Officers from the QPS Child Protection Investigation Unit attended the scene and commenced an investigation.

20. Attending officers observed the property and the dwelling to be unkempt and dishevelled. The trampoline was positioned 410mm from the pool fence (regulation distance is a minimum 900mm). The pool water was unclean and murky green. The bottom of the pool was not visible due to the colour of the water. Police observed a small wooden children's chair situated next to the pool fence. This chair was a part of a chair and table set located in the dining room. The mother told police the chair that was in front of the pool gate was usually in the kitchen and had never been downstairs.

Photo 26: Chair next to pool fence

21. The parents admitted to having spent much of the day playing 'Age of Wushu' on their computers. Officers observed two large laptop computers on the bed in the main bedroom.

Autopsy findings

22. External examinations and full autopsies were performed at the John Tonge Centre on 2 November 2016. The final autopsy reports were received on 31 January 2017.

23. Both autopsies revealed features consistent with drowning which the pathologist considered caused the death. There were minor injuries consistent with normal childhood activity, falling into a pool and resuscitation efforts. Toxicological analysis detected no alcohol or other drugs.

Police investigation

24. The Coroner received the final police investigation report in November 2017.

25. The investigation found no evidence to support any criminality. Rather, the actions of the three young children in entering the pool area appeared to be that of childhood exploration. However, it was considered that lack of parental supervision by either parent was a contributing factor. The amount of the time the children were unsupervised is uncertain.

26. The evidence supports a finding that the children entered the pool area while the mother was asleep and after the father had left them unsupervised watching a movie in the lounge room for a period of at least 20 minutes while he played on his computer in the main

bedroom. I note the investigating officers speculated this timeframe was "*well understated by [the father]*."

27. Despite the mother's claim to have notified the landlord about the broken rear sliding door lock, this appears not to have been reported to the owner.

28. The police investigation involved an inspection of the pool, fence and gate and pool surrounds by building inspectors from the relevant City Council. The inspection found that the pool gate latch was faulty and would not automatically latch closed on each occasion. This may explain how the eldest child was able to exit the enclosed pool area.

29. The pool failed inspection in 12 areas namely:
    - Pool fence less than 1.2 metres above ground level
    - Trampoline within 900mm of pool fence/gate
    - Hole in gate post less than 900mm from bottom horizontal rail
    - Bucket attached to the pool fence (acting as climbing point)
    - Water pipe from water tank within the non-climbable zone
    - Pool gate does not self-close and latch from all positions
    - Right hand side boundary fence less than 1.8m high on the inside of the pool area
    - Climbable objects in neighbours' garden stacked against pool fence
    - No resuscitation sign displayed on the pool fence,
    - Rear balustrade height on deck 900mm high (required height is 1.2m)
    - Water tank in the non-climbable zone; and
    - Chair next to pool fence.

30. The co-owner of the property confirmed that a pool safety certificate was obtained when she purchased the property in October 2015. The certificate was issued by a licensed pool safety inspector and remained in effect until 9 October 2017 provided there were no changes or modifications made to the fence or surrounds that impacted on compliance.

31. The pool safety inspector told police that he attended the property on 24 September 2015 to conduct a pool fence safety inspection. His pool safety inspection report identified nine areas of non-compliance. These included the latch not being aligned and not self-closing; the fence height was not 1200mm in all places because a rock in the garden reduced the height; aspects of the non-climbable zone were climbable due to the placement of reinforcement mesh, plants growing over the fence and accessibility via verandah rails; and there was no CPR sign within the pool area. The inspector provided his report to the property owner together with a pool safety non-compliance notice. The inspector reattended the property on 10 October 2015 to reassess the pool fence. He was satisfied that all nine defects had been rectified satisfactorily and issued a pool safety certificate.

32. The owner told police that she and her partner had not made any changes or repairs to the pool or the pool fence since purchasing the property on 22 October 2015.

33. The owner conducted an inspection of the property approximately four to six months prior to the children's deaths. At that time she observed the house to be reasonably clean but did not take any photographs. She reattended the property approximately one month prior to the children's deaths to speak to the parents about being in arrears with their rent. On this occasion she noticed the front yard was overgrown. The inside of the house was clean.

34. The owner told police that she only became aware of the presence of the trampoline when she saw news footage about the children's deaths on the day of the incident.

35. A landlord is legally obliged to ensure a valid pool safety certificate is in effect before

signing a tenancy agreement. The tenancy agreement notes that the owners had provided the family with a copy of the pool safety certificate. There is no evidence that they provided any instruction or guidance to their tenants on pool maintenance or compliance with the pool safety certificate. This prompted the investigating officer to recommend that all tenants receive instructions, either from the landlord or agent, in relation to the pool maintenance and compliance with the pool safety certificate, and that regular compliance inspections be mandated for landlords or agents to ensure pool safety compliance is maintained.

Current pool safety standards in Queensland

36. The current pool safety standard setting out the technical requirements for pool safety barriers and CPR signs is contained in the Queensland Development Code Mandatory Part 3.4 for Swimming Pool Barriers, Australian Standard 1926-2007 (parts 1 and 2) and the *Building Regulation 2006*. Local governments are responsible for inspecting pools and enforcing pool safety laws, and are expected to comply with guidelines issued by the Department of Housing and Works under section 258 of the *Building Act 1975*. The most recent version of those guidelines is dated October 2016, one month prior to the children's deaths.

37. Following a 2008 review of Queensland's pool safety laws, the Queensland Government implemented a two stage swimming pool safety improvement strategy involving amendments to the swimming pool safety laws, education programs about the importance of supervising children around pools and encouraging people to teach children to swim at a young age.

38. Stage one commenced on 1 December 2009 and included introduction of the latest swimming pool safety standards and cardiopulmonary resuscitation signage standards.

39. Stage two commenced on 1 December 2010 and included introduction of the sale and lease compliance system, requiring pool safety certificates to be obtained from a licensed pool safety inspector when a property with a pool is sold or a lease or other accommodation agreement is entered into, and requiring all regulated pools to be included in a state-based pool safety register. Stage two also introduced mandatory inspections by local governments for immersion incidents of children under five in swimming pools.

40. Where a property with a pool is being leased, an owner must ensure a pool safety certificate is in effect for the pool before entering into a new or renewed lease, but there is no requirement to give a copy of the certificate to tenants. The certificate remains valid for two years, and there is no need to obtain a new certificate if new tenants move into the property within that two years. There is a pool safety register which enables the public (including tenants) to check if a pool safety certificate is in effect for a particular pool, by entering the property address or lot number.

41. There is otherwise no requirement for owners to provide tenants with pool safety information.

42. Occupiers of a property, including tenants, must ensure that gates and doors giving access to a pool are kept securely closed at all times when they are not in use. Occupiers and tenants must also ensure there are no climbable objects that would allow children to access the pool unattended.

43. The circumstances in which T and P were able to access the backyard swimming pool were related largely to supervision issues. However, it is clear from the inspection report that the pool was not compliant with pool safety requirements, despite having a current

pool safety certificate. One of those matters of non-compliance related to the trampoline being within 900mm of the pool fence/gate and it was this structure, together with the chair brought out from inside the house that enabled the oldest child to climb to a height where he could open the gate and let them in.

Child Death Case Review Panel outcomes

44. As the family was known to child safety services, the actions of the Department responsible for child safety in Queensland were examined by the Child Death Case Review Panel. The Panel report was provided to the Coroner in October 2017.

45. The Panel expressed concerns regarding the quality of the Department's response to child protection concerns in the years preceding the girls' deaths, particularly in relation to the father's alleged controlling and violent behaviours towards the mother. There was no departmental involvement with the family at the time of the deaths.

46. Relevant to the circumstances of the girls' deaths, the Panel made the following comments and finding:[1]

The Panel noted that all of the children died as a result of tragic accidents. However, in three of the cases, the Panel considered the children had experienced precursors of cumulative harm and neglect, including previous concerns regarding inadequate supervision.

In the cases presented to the Panel, there was a theme of families who had previous child protection history and chaotic family circumstances – all with factors that created risk for the children, such as domestic and family violence, parental drug and alcohol misuse, overcrowded housing situations, and unmanaged mental health conditions – leading to poor supervision. These parental factors can create situations where the risk of preventable accidents is higher due to the absence of protective parenting.

The Panel considered that it is critical for the department to incorporate current research in relation to the relationship between supervisory neglect and the risk of accidental death for children in training and resources available to departmental staff.

> *Finding 3 – Child protection workers in the department should be encouraged to develop their knowledge about child accidental death to ensure they are thinking about child safety holistically and have an evidence-based understanding of the links between neglect, inadequate supervision, and accidental death or injury of children.*
>
> *Workers should be provided child accidental injury training and access to available child injury prevention resources (such as those available through Kidsafe (www.kidsafe.com.au). In situations of substandard housing, the department should consider utilising home safety inspection services to assess fire and safety hazards around the home and identify primary prevention opportunities (For example, Queensland Fire and Rescue Service provide a free home safety inspection).*

47. The Panel's findings were provided to the Department for appropriate action, and to help inform ongoing learning and child protection reform activities.

[1] It should be noted the Panel reviewed a total of four accidental drowning deaths of children known to the Department. The comments and finding are in reference to all four deaths, not just those of T and P.

48. I am satisfied the Queensland child death review process has operated to ensure a level of independent review of child safety services provided to the girls and their family in the years prior to their deaths, and that further coronial investigation is not required in this regard. I note that while the circumstances of the girls' were accidental, the Panel pointed to links between neglect, inadequate supervision, and accidental death or injury of children and recommended child protection workers be provided child accidental injury training and access to available child injury prevention resources. I support this recommendation.

Findings required by s.45 of the *Coroners Act 2003*

49. I am required to find, as far as possible, the matters set out under section 45(2) of the *Coroners Act 2003*. Having considered all of the evidence, I am able to make the following findings:

Identity of the deceased: [de-identified for publication]

How they died: T and P died from accidental drowning when they entered a swimming pool after they and their five-year-old brother entered the pool area unsupervised. The children gained access to the pool area after their brother was able to climb to a height to where he could open the gate and let them in. He did this by reaching the pool gate lock from a large trampoline that was placed closer than the regulated distance from the pool gate. He used a children's chair from inside the house to get on to the trampoline. The children were able to access the backyard because the lock on a rear sliding door was broken. This defect had not been notified to the landlord. At the time of the incident T and her brother had been kept home from school because of wet weather. The three children had been left unsupervised in the house for an unknown period of time while their parents were in the main bedroom. Although the owner of property held a current pool safety certificate, inspection subsequent to the children's death revealed the pool was non-compliant in a number of respects including the location of the trampoline proximate to the pool gate. The children's family circumstances were such that they were at risk of preventable accident or death due to the absence of protective parenting.

Place of death: [de-identified for publication]

Date of death: 1 November 2016

Cause of death: Drowning

50. I close the investigations.

Ainslie Kirkegaard
Acting Coroner
CORONERS COURT OF QUEENSLAND
SOUTHERN REGION
6 May 2020