QUEENSLAND COURTS

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Hannah Isabella Alyson PLINT**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Toowoomba
FILE NO:	TOOW-COR-00000105/07
DELIVERED ON:	22 December 2008
DELIVERED AT:	Toowoomba
HEARING DATES:	15 & 16 December 2008
FINDINGS OF:	Coroner Kay Ryan
CATCHWORDS:	CORONERS: Inquest – Child drowning

REPRESENTATION:

Constable Karen Dearling – appearing to assist the Coroner

Mr & Mrs Plint – representing themselves and Hannah

Mr C Wilson (instructed by O'Reilly Lillycrap) – appearing for Mark Lillicrap and Deborah Bailey

Mr A Malone – appearing for Queensland Health

Ms B Betts – appearing for Queensland Ambulance Service

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CORONERS FINDINGS AND DECISION

The *Coroners Act 2003* provides in s45 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 organisations granted leave to appear at the inquest. These are my findings in relation to the death of Hannah Isabella Alyson Plint. They will be distributed in accordance with the requirements of the Act and placed on the website of the Office of the State Coroner.

1. Introduction

The purpose of an inquest is to investigate a death to enable the Coroner to find –

(a) who the deceased person is;
(b) how the person died;
(c) when the person died;
(d) where the person died; and
(e) what caused the person to die.

The scope of my findings do not include, and indeed I am unable to find under the *Coroners Act 2003*, whether any person is guilty of an offence or is civilly liable for something. I can, however, where appropriate, comment on anything connected with a death which has been investigated and which relates to –

(a) public health or safety;
(b) the administration of justice; or
(c) ways to prevent deaths from happening in similar circumstances in the future.

At the outset, I extend my personal condolences to Mr & Mrs Plint and trust that these proceedings have assisted in their grieving process following Hannah's death.

I note that they have formed *Hannah's Foundation* which is charged with providing support for parents and friends of those who have lost loved ones in similar circumstances, and advocates for consistent, nationwide regulations for the installation of pools, spas and other man-made water features. Their efforts are to be supported and applauded. The Premier's recent announcement of a review of swimming pool laws has come following recent publicity with regard to child drownings and Mr & Mrs Plint's efforts in this arena are acknowledged.

2. Issues

The following issues were identified at the pre-inquest conference as being issues to be addressed at the formal inquest:

- Did any inadequacies in the pool gate or fence contribute to the death?
- Did the erection of a timber deck linking the house to the pool contribute to the death?

- Are there any changes to the inspection and approval process of local Councils which could reduce the chances of death occurring in similar circumstances?
- Are there any changes to the standard conveyancing practices which could reduce the chances of death occurring in similar circumstances?
- Whether local Councils should be required to identify which properties have pools?
- Whether the Standard Contract and legislation should be amended to require a condition of sale that all pool fences be compliant?
- Whether the regulations pertaining to pool fences and the Australian Standard should be reviewed, upgraded and inspected?
- Was the care provided at the Laidley Hospital to a standard expected?
- Whether the response time and treatment given by Queensland Ambulance Service to a standard expected?

3. Social History

Hannah was a lively 2 ½ year old; in fact she was almost 3 years old having been born on 10 December 2004. She was the second youngest of five siblings. The family lived in the Laidley area in a home located on small acreage. Hannah adored Thomas the Tank Engine and did not like wearing dresses. She could be described as a normal child for her age – making noise, running and jumping and living life to the full. Hannah often swam in the pool at her home under supervision and loved the water.

She was also very active and on numerous occasions used chairs to gain access to reach high articles and to climb. She was adventurous and full of life. Unfortunately, her adventurousness contributed to her death.

4. The incident

Shortly before 2.00 pm on 4 October 2007, Hannah went out to the pool at the back of her house, dragged a plastic chair to the pool gate, opened the gate and fell or jumped into the pool.

Mrs Plint has given evidence that she was at home with Hannah and her youngest son Harry (18 months). She had been on the telephone with of Child Support Agency and Hannah had been annoying her wanting to go for a “nudey” swim. Mrs Plint told Hannah that she had to call “daddy” (Mr Plint) and then go to the toilet. She told Hannah she would take her swimming after that. Mrs Plint spoke to Mr Plint (and Hannah did too) and then went to the toilet. She was speaking to Hannah whilst she was in the toilet about going for a swim.

After finishing in the toilet, Mrs Plint noticed that her son Harry needed changing. She attended to this and placed Harry in his high chair facing the door which opened out to the deck area adjacent to the pool. During this time she was calling out to Hannah. It was at this stage that she saw something moving in the pool through the curtains. She then saw Hannah face down in the pool and went outside, jumped into the pool and retrieved Hannah, commencing CPR.

It is helpful to describe the layout of the house and the pool. The house is a timber dwelling set about five feet off the ground which at the time of this tragic event had an above ground swimming pool attached to the back deck area. The house had an enclosed verandah around most of the house with the pool being attached to the rear deck. There was a powder coated steel swimming pool fence with a gate and approved swimming pool style locking mechanism which is operated by pulling the plastic knob in an upwards motion from the top of the latching post.

Mrs Plint's evidence is that the back sliding door leading onto the deck near the pool was locked. It was always locked to ensure that Hannah did not get out to the pool.

However, the front door was open and Hannah went out this way, took a white plastic chair from the front of the house and took it around the verandah to the deck beside the pool. Mrs Plint says that when she ran out to the pool, the white chair was situated so that it was blocking the pool gate from closing.

She had placed the telephone in her pocket while changing Harry and after retrieving Hannah from the pool, she telephoned emergency services and commenced CPR. She gave evidence in court that she had a certificate in CPR from 1993 and a certificate in sports medicine from 2001. She remained on the phone with the emergency operator who also gave some instructions.

When the ambulance arrived, the two paramedics took over the care of Hannah and then transported her to the Laidley Hospital where she was subsequently pronounced dead.

In her interview with police, she stated that Hannah would have been out of her sight and hearing for approximately 5 minutes.

5. Neighbours' response

Errolyne Noe, a neighbour of the Plints, who lived a few doors down has given evidence that she heard screaming coming from the Plints house at around 2.00 pm or so. She and the Plints are friends and Mrs Noe's horse had been grazing in the Plints' front paddock.

Mrs Noe said when she went out the back and looked over she could see Mrs Plint bending over near the pool gate, she could see Hannah on the pool deck and two ambulance officers who appeared to be working on Hannah. She heard Mrs Plint say "Breathe Hannah breathe". She also observed an ambulance parked beside the side of the house.

She then immediately ran inside, picked up her car keys and drove down the road to the Plints. As she drove into the property, the ambulance was driving out. She entered the house and found Mrs Plint collapsed in a highly distressed state, with Harry (the younger child) still in his high chair screaming.

Mrs Plint told Mrs Noe what had happened and Mrs Noe drove Mrs Plint and Harry to the Laidley Hospital and stayed with them whilst Hannah was being treated. Mrs Noe gave evidence in court that Mrs Plint was not offered any counselling, medication or assistance when she arrived at the hospital. Mrs Plint was soaking wet (from the pool) and she was not even offered a towel.

Mrs Noe described what happened when the doctor came to tell Mrs Plint that Hannah had passed away as well as Mrs Plint's actions from that time. She was with Mrs Plint when she was finally allowed to see Hannah and stated that Hannah was lying on a bed in a cubicle in the emergency section. The curtains were not drawn on the cubicle. A nurse told Mrs Plint not to touch Hannah as her body would be used for evidence by police.

Mrs Noe stayed with Mrs Plint in the emergency cubicle for about 5 minutes and then took Harry outside as he was becoming distressed. She then waited at the hospital until Mr Plint arrived and then took Harry home and waited for the other Plint children to arrive, caring for all children until Mr & Mrs Plint returned that night. Mrs Noe's husband also went to the hospital after he finished work at 3.00 pm to give support to his wife.

David and Lisa Edge (formerly Scott) lived next door to the Plints. Mr Edge has given evidence that he had arrived home early from work as a manager at Aldi at Yamanto on the 4th October 2007. He was unsure of the time, but said it was between 1.00 pm and 2 pm. He stated that he and his then wife had an argument. He could not recall what the argument was about. This argument happened inside one of the bedrooms. Mrs Edge then went to the local IGA store in Laidley to buy lunch. He states that he did not hear any screaming from the Plints, otherwise he would have assisted with Hannah's care as he has a first aid certificate.

Mrs Edge confirms that her husband came home early from work on that day. Mrs Edge was unable to recall much about the day in question in her evidence to the court. She stated that she had an argument with her husband and that she could not hear anything from next door as the argument took place next to one of the exhaust fans for an airconditioner outside the home.

However, in a note to the other neighbour Mrs Noe, which note is in evidence, Mrs Edge had stated that she had been out and had come home to find her husband had come home from work early. He asked her to go and get some lunch as there was nothing in the house. She had him put their son down for a sleep and she went to the local IGA store.

In the note she stated that she saw the ambulance go past her at Lake Dyer when she was on her way to IGA and then when she was on her way back from IGA, she saw the ambulance again at around the same place. In her evidence in court she was unable to remember seeing the ambulance on the way back.

6. Emergency Service Response

Eric Eyre and Ross Breckenridge were the paramedics on duty at the Laidley Ambulance Service on the day this tragic event occurred. Emergency Service records indicate that the emergency call from Mrs Plint was received by their despatch operator at 2.04.29 pm. The ambulance unit was dispatched from the Laidley station at 2.05.02 pm and arrived at the Plints address at 2.15.06 pm.

Paramedic Eric Eyre was driving the ambulance and Paramedic Ross Breckenridge sat in the passenger seat. Breckenridge identified the best route from the Laidley ambulance station to the Plints' residence, using a local directory as a guide.

On arrival, Mr Breckenridge saw a white plastic chair near the pool gate. He then moved Hannah to a dry area outside the pool fence to continue treatment. Hannah was rolled onto her side to clear her airway. Suction was applied in accordance with the QAS Clinical Practice Manual.

On assessing Hannah, it was found that –

- Her skin colour was pale;
- Her skin temperature was cold;
- Her body temperature was not recorded;
- There was no palpable carotid pulse;
- There was no spontaneous respiratory effort;
- Blood pressure was not attempted;
- Her Glasgow Coma Score was recorded at 3;
- Her pupils were dilated to approximately 5 mm, equal and not reactive to light (pencil torch).

On connection to the defibrillator, Hannah's cardiac rhythm was asystole. CPR and oxygen therapy was conducted and the paramedics decided that Hannah should be transported to hospital as soon as possible.

The ambulance was brought up beside the house and Hannah was lifted over the railings, placed in the ambulance and transported to the Laidley Hospital at 14.21.04 pm arriving at the Hospital at 2.27.00 pm.

There have been questions asked as to why Mrs Plint was not taken in the ambulance with Hannah. Mr Breckenridge stated that ordinarily, the parent is transported with the child, but as Mrs Plint had another smaller child to look after and Hannah required immediate and urgent transportation, she was not taken in the ambulance with Hannah.

Mr Eyre contacted the communications centre and asked that police attend at the address urgently. He says he did not advise why the police were required as he doubted the privacy of the radio communication.

This doubt was put to rest by Dr Rashford, the current medical director for the Queensland Ambulance Service in his evidence, when he stated that the expectation was that full information be given to the central communication centre.

Mr Breckenridge stated that once the call had been received at the Laidley Ambulance Station, he locked up the doors, got into the ambulance and pressed the mobile data terminal. There is then some small delay while the automatic door is opened and then closed behind the ambulance before the ambulance leaves the station.

The ambulance station is located in the centre of the Laidley township and the ambulance was required to proceed carefully (albeit with lights flashing and siren activated) to navigate through pedestrian and vehicular traffic. This circumstance appears to explain the delay of some 2 minutes 35 seconds from the station to Ambrose Road (a relatively short distance).

Ambulance response time to being "on case" was 47 seconds. A review of compliance with the response time following the event gave a 98% compliance score.

Dr Rashford stated that since November 2007 all emergency calls had been centralised and were channelled through a clinical co-ordination centre when a decision was made whether an event required the despatch of an aerial ambulance. A decision was able to be made whether to despatch an aerial ambulance within 15 seconds of receiving the call.

As Hannah was within 30 kilometres of a trauma service (the Laidley Hospital), an aerial ambulance was not activated as by the time it would have arrived, Hannah would have been at the Laidley Hospital.

Dr Rashford described the introduction of tele-medicine which has introduced cameras into rural hospitals to assist local medical providers with treatment in emergency and other situations. He further stated that having cameras at the Laidley Hospital would not have made any difference to Hannah's outcome.

Dr Rashford's evidence has been very helpful in consideration of a number of the issues.

7. Medical Treatment

Dr Rashford also gave evidence with regard to the benefits of CPR being performed by one or two persons and the benefits of 2 breaths to 30 compressions as against 2 breaths to 5 compressions. In cases of child drowning, the emphasis is to concentrate on breathing and maintaining an airway in circumstances of drowning can be very very difficult. He was of the view that carrying out the 2:5 regime probably makes no difference to the outcome.

Water temperature **may** have a bearing on survival rates, with a possible gasp reaction causing the ingestion of water to the lungs. Dr Rashford opined

that it was impossible to speculate with regard to the effect of the temperature of the water in the Plints' pool at the relevant time.

The clinical assessment and treatment provided by the Queensland Ambulance advanced care paramedics (ACP) was basic life support. They are able to deliver CPR, defibrillation and basic airway management including oropharyngeal or laryngeal mask airways. There are a number of other advanced procedures such as IV adrenalin, inserting a canular and intubation. However, these are advanced procedures and are not skills which are expected of the ACPs.

Intensive care paramedics (ICP) can carry out intubations, but need to be utilising such skills on a regular basis to ensure that the levels of skill are retained. There are 241 Intensive care paramedics in Queensland constituting approximately 10% of the total clinical workforce. It is essential that each ICP be allocated to work in areas where they will be exposed to opportunities to use the skills which they have acquired. It is not possible to have intensive care paramedics in all areas of Queensland given the competency issues. Accordingly, ICPs are mostly deployed to work in populated areas where there is a heavy case load and high acuity work.

In Dr Rashford's opinion, had an ICP or physician attended Hannah at her residence on the day, based on the presenting clinical condition and cardiac rhythm, the outcome would not have been any different.

Hannah was transported to the Laidley Hospital where Dr Yee, the medical superintendent and a small team had been gathered to receive her. On arrival Hannah was described as very, very pale and cyanosed, very frothy and asystolic on the cardiac monitor with dilated pupils.

Compressions were continued while Dr Yee prepared to intubate Hannah, but found this very difficult due to the amount of vomitus and fluid coming out of her mouth. She undertook suctioning and inserted the tube, but found more fluid coming out. She then removed the tube, held Hannah upside down by her feet to try to drain more of the fluid and then re-inserted the tube. She still found it very hard to make progress. There was no response from Hannah and there was no heart beat.

Dr Yee worked in Alice Springs for 12 years before coming to Laidley in 2004, working as a paediatric registrar for 4 years and as emergency registrar for more than 4 years. The last paediatric intubation she had undertaken was in Alice Springs, some 3 years prior. However, she had undertaken remote and rural training with regard to paediatric intubations.

When asked about inverting Hannah, Dr Yee stated that it was a normal procedure for new borns and that she had done this to try to clear the fluid so that Hannah could be intubated. Erica Fletcher, the RN assisting Dr Yee as the "airways person" described the actions taken to intubate Hannah and stated that inverting Hannah was not an unusual action to take in the circumstances and that she had experience of this being done on other occasions in drowning situations with which she had been involved.

In his evidence, Dr Rashford stated that this was an unusual procedure to undertake and he would not do it. Such inversion would cause the blood to run with the gravity to her upper body, but with her condition described as being asystole, there would be no other benefit.

According to the oral evidence of Dr Rashford, it is highly probable that Hannah died prior to the arrival of the paramedics. Dr Rashford referred to the asystolic cardiac rhythm 'where the heart has no electrical activity what so ever' and stated that survival from cardiac arrest is extremely rare where the presenting rhythm is asystole.

Dr Rashford also referred to Hannah's pupil size and reaction to light. He stated that this would indicate that the most basic of brain reflexes were not present suggesting that severe brain injury had already occurred.

Dr Robert Pitt, Director of the Paediatric Unit at the Mater Childrens' Hospital, director of the Queensland Injury Surveillance Unit and child injury prevention expert for over 20 years, stated that inversion was usually used in cases of choking, and was not usually standard for cases of drowning. However, sometimes medical practitioners have to be creative on the spot and inversion in the circumstances of this case could be accepted as such and a last ditch effort to clear the airways where there appeared to be little or no hope of resuscitation.

In the late 1980s there was a study undertaken of 34 children who presented at the hospital pulseless. At that time, aggressive interventions were being tried and of those 34 children, a pulse was re-established in 17. On follow up 8 or 9 of those children were in a vegetative state and 8 or 9 had minor neurological conditions. After a maximum of 20 minutes of intervention at a hospital with no response, there were severe risks of a vegetative outcome.

Dr Pitt stated that it was extraordinarily difficult for a mother (or others) who had not practiced CPR skills on a monthly basis, to undertake CPR on her child.

On her arrival at the Laidley Hospital, Mrs Plint says that she was not allowed to enter by the emergency entrance and that Mrs Noe took her in the front entrance. Mrs Plint was still wet and obviously extremely distressed about the condition of her daughter. She was not provided with a towel to dry off and she was taken into a front room and left there.

Bev Giebel, was the District Director of Rural Services on the day and she gave evidence that she was on hand on the day to provide access to any notes or charts for the child, make telephone calls and offer support to Mrs Plint. It is Queensland health policy and procedure to offer psychological support in circumstances such as this. These latter points are vigorously contested by Mrs Plint who stated that nursing staff tried to prevent her from seeing Hannah and from holding her at the hospital and that she was offered no support.

8. Approval of Pool Fencing/other structures

The Plints had purchased the home in October 2006. The house had been built by previous owners Mr & Mrs Liddy, who were owner/builders and who had erected a shed as well as the pool deck and pool.

There seems to be some confusion as to when the pool and back deck were constructed. Mrs Liddy states that the pool was erected in 1997 and the deck in 1995. However, Mr Liddy described the deck originally being constructed on two sides of the pool with a fence around the whole thing.

Both Mr & Mrs Liddy confirmed that they did not make application to the Council for compliance of the pool or the deck. Then when the Liddys wished to sell the property, the back deck was reconstructed due to original boards being rotted and railing panels left over from an extension of the original dwelling were utilised on the new back deck. This construction took place in 2004 and included the extension and garage.

A council inspector attended at the property in 1997 and advised Mrs Liddy that a fence would not be required around the pool. Her evidence is contradictory as she stated that the inspector did not even go out and look at the pool or the deck and then later stated that he undid the deadbolt she had placed on the back door and went outside and looked at the pool and deck.

Mrs Liddy did not think they needed approval for an above ground pool that was 1200 mm high. She and her husband trusted what the Council inspector had told them.

Allison Kenna, a former neighbour gave evidence with regard to the existence of the aboveground pool which she stated had already been erected when she moved into her house in Lakes Drive in 2005. She had moved out before the incident of 4 October 2007. She also gave evidence that the pool was not fenced at any time prior to the renovations which took place shortly before the Plints purchased the property.

The Plints signed a contract to purchase the house and insisted on a special condition in the contract as follows:-

> *The Sellers and Buyers hereby agree that this Contract is subject to and conditional upon the buyers satisfying themselves in every respect in regards to investigations with the Laidley Shire council and any other relevant authority that all permits and consents for all structures are in place and have unconditional approval and are completely satisfactory to the Buyers in every respect on or before 14 days from the contract date. Should the searches not be satisfactory to the Buyers then they may terminate in which case this Contract shall be at an end and all monies paid by way of deposit shall be refunded in full and either party shall have no further claim against the other whatsoever.*

The Plints engaged solicitors O'Reilly Lillicrap to undertake the conveyance on their behalf. The first letter of O'Reilly Lillicrap to Mr and Mrs Plint,

specifically drew their attention to the special condition and asked specific for instructions regarding additional searches. There is no evidence to show that Mr and Mrs Plint responded to that request or relied on any information supplied by O'Reilly Lillicrap to satisfy themselves of the matters referred to in the special condition.

The contract was also subject to the purchasers obtaining a satisfactory building and pest inspection report. The due date for reliance upon this condition was 26 September 2006. The building and pest inspection was undertaken on Thursday 21 September 2006 in the presence of Mrs Plint. The report dated of the same date states at page 7:

> "COMMENTS: RECOMMEND FULL POOL FENCE TO COUNCIL'S REQUIREMENTS"

Mrs Plint states that she gave a copy of the report to Deborah Bailey (the conveyancing clerk) and that Ms Bailey "flicked through it" and commented that the matters with regard to the guttering and to the pool fence would be clarified on receipt of the Council searches. It is disputed by Ms Bailey that she never saw the report and she states that the rates search authorised by the Plints would not show such detail in any event.

Ms Bailey is an experienced conveyancing para-legal having worked in the area for over 10 years.

There was a file note relating to the building and pest inspection which records a telephone communication with Mr Plint on the due date stating:

> *"B&P okay / S.C. okay".*

Also on that day an express written instruction was signed by Mr & Mrs Plint indicating that they did not require any additional searches to be conducted on their behalf. A misspelling of Mr Plint's name was corrected indicating that some consideration was given to the form's contents.

Even if the building and pest inspection report was shown to Ms Bailey, this would have no effect as O'Reilly Lillicrap received express written instructions not to undertake further searches.

It has been submitted that the special condition in the contract with regard to compliance of all structures on the property is sufficient authority for the solicitors to undertake the necessary searches. A proper reading of the clause reveals the words – "*conditional upon the buyers satisfying themselves".* It is clear that the clause requires some action to be taken by the Plints. This action was not taken whether due to limited finances or otherwise.

The conveyance was affected in accordance with Queensland Law Society protocol and in accordance with the wishes and express instructions of Mr & Mrs Plint.

Mrs Liddy denied that she had discussions with the building and pest inspector about a problem with the pool fence, stating that during the inspection she and Mrs Plint were in the kitchen discussing the house.

Evidence was given by David Kaye, the Director of Planning, Building & Environment with the Lockyer Regional Council with regard to the application made by the Liddys to, first, build the house and second, undertake alterations.

Mr Kaye is also an Accredited Pool Certifier. He carried out two inspections at the property. The first was in about September 2006 when he made a final inspection of the garage and additions to the house; the second was at the request of the Plints following Hannah's death with regard to the pool fencing. He did not inspect the pool at the first inspection as his task was to inspect the extension and the garage. He did not see the pool. He advised that the pool fence and gate were compliant, but that the positioning of the pool too close to the fence would then make the gate and fence non-compliant.

He was unable to say why pool compliance checks had not been done when inspections were undertaken by his predecessor following completion of the dwelling house.

Jason Smith an Executive Director with the Building Services Authority provided information with regard to the Liddys' application for an owner/builder permit to build the original dwelling. One permit will remain valid for 6 years. The original permit was granted on 30 November 1993 and the Liddys should have applied for a further permit to erect the pool and deck if indeed they were erected after 1999.

Dr Robert Pitt provided the following information for my assistance:-

(a) Supervision

Supervision is the first line of defence in drowning prevention. Children move very quickly and when a child is in the house (as in Hannah's case) and not near a hazard, there is no reason to be watching them at all times. Children can slip from sight quickly and sometimes it is not possible to keep them in direct line of sight.

(b) Barrier

The Australian Standard calls for a **child resistant** barrier, not a child proof barrier. Most children understand why the barrier is there. Less than 5% of children who drown in pools scale the fence, with 80% going through the gate. The gate should self-close and latch, with the gate to swing outward. Historically where a pool is fenced on three sides, and the house forms the fourth side, this is more hazardous.

New technology with regard to child safety catches is being developed by pool gate manufacturers. A lock incorporating a horizontal lock being operated at the same time as a vertical lock may minimize the risk that a child will be able to gain access through the pool gate.

However, any new technology must be (in Dr Pitt's words) "doable, inspectable and acceptable" and not cause public backlash.

(c) Water Familiarisation and Swimming Lessons
The vast majority of child drownings involve children less than 5 years old. Whilst parents should encourage water survival skills, early swimming lessons are not necessarily going to assist in lessening the numbers of drownings.

9. Findings

In accordance with the *Coroner's Act 2003*, I find

(a) The identity of the deceased person is Hannah Isabella Alyson Plint

(b) Hannah died from drowning in an aboveground pool

(c) Hannah died on 4 October 2007

(d) Hannah died at her home located in the Laidley district

(e) Hannah's death was caused by her dragging a plastic chair around the side verandah of the house, climbing on the chair and opening the pool gate to gain access to the pool.

Whilst no application for construction of the pool gate and fence was made to the local council, and therefore no compliance certificate had been issued, I find that the pool gate and fence erected at the property did, by themselves, comply with the relevant Australian Standard. The positioning of the pool behind the fence was the factor which then made the pool gate and fence non-compliant.

I find that the erection of a timber deck linking the house to the pool, whilst not causing Hannah's death, contributed to it.

(f) I find that the fact that the swimming pool and deck were erected by an owner/builder did not contribute to Hannah's death.

(g) The care provided at the Laidley Hospital was provided to a standard expected. Dr Yee was experienced in paediatric trauma and a perusal of the medical notes regarding treatment reveal that proper protocols were followed.

It has been submitted that Dr Yee ceased efforts to revive Hannah too soon. However, I find that no actions taken by any of the persons involved in Hannah's treatment, including that provided by her mother, would have made any difference to the outcome.

(h) With regard to the level of assistance given to Mrs Plint at the hospital, I find that the versions of the events given by witnesses should be viewed in light of the distress and confusion suffered at that time. All

available hospital staff were attending to Hannah in an attempt to save her life. Mrs Plint was ultimately not prevented from holding her daughter at the hospital following the pronouncement of her death.

(i) The ambulance response to Hannah Plint on 4 October 2007 was timely, the assessment and treatment provided by the paramedics was appropriate and accorded with recognised standards of practice, and there was nothing further that could or should have been offered by the QAS which may have altered the outcome.

10. Recommendations

(a) That the Australian Standard pertaining to swimming pools and especially swimming pool gates and fences be reviewed, upgraded and inspected, to include a child resistant lock incorporating a vertical and horizontal locking mechanism.

(b) That all local authorities adopt a system to identify all properties in their local authority areas which have both inground and above ground swimming pools installed.

(c) That all local authorities be required by legislation to institute a regular system of inspection of swimming pools and surrounding structures to ensure compliance by pool owners.

(d) That the Real Estate Institute of Queensland and the Queensland Law Society review the standard contract of sale to provide a mandatory condition that a certificate of compliance and clearance be received from the local authority before settlement of a property at which a swimming pool has been constructed.

I would like to thank my clerk Dan Darlington and Constable Dearling for their assistance at this inquest. I also take this opportunity of congratulating all the parties and their legal advisers for their contribution to this inquest.

The Inquest is closed.

Kay Ryan
Coroner
Toowoomba
22 December 2008