OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of a child at Rockhampton**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Rockhampton
FILE NO(s):	COR 2007/145
DELIVERED ON:	24 June 2010
DELIVERED AT:	Rockhampton
HEARING DATE(s):	25 March, 29 June – 2 July 2009
FINDINGS OF:	A. Hennessey, Coroner
CATCHWORDS:	CORONERS: Inquest – child death, drowning in public pool, adequacy of supervision, Workplace, Health and Safety investigation

REPRESENTATION:

Counsel Assisting the Coroner	Mr John Tate, Crown Law
Fun Park Pty Ltd	Mr John Clarke i/by Bressington and Partners
NSW Department of Communities	Ms Rebecca Harvey

These findings seek to explain, as far as possible, how this child's death occurred on 4th January 2007. The child drowned at a public pool after attempting to use a large inflatable device in the deep end of the pool.

Following the court hearing the evidence in this matter where learnings can be made to improve safety, changes to industry practice may be recommended with a view to reducing the likelihood of a similar incident occurring in future.

THE CORONER'S JURISDICTION

1. The coronial jurisdiction was enlivened in this case due to the death of the child falling within the category of "*a violent or otherwise unnatural death"* (drowning), under the terms of s8 of the Act. The matter was reported to a coroner in Rockhampton pursuant to s7(3) of the Act. A coroner has jurisdiction to investigate the death under Section 11(2), to inquire into the cause and the circumstances of a reportable death and an inquest can be held pursuant to s28.

2. A coroner is required under s45(2) of the Act when investigating a death, to find, if possible:-
   - the identity of the deceased,
   - how, when and where the death occurred, and
   - what caused the death.

3. An Inquest is an inquiry into the death of a person and findings in relation to each of the matters referred to in section 45 are delivered by the Coroner. The focus of an Inquest is on discovering what happened, informing the family and the public as to how the death occurred, but not on attributing blame or liability to any particular person or entity.

4. The coroner also has a responsibility to examine the evidence with a view to reducing the likelihood of similar deaths. Section 46(1) of the Act, authorises a coroner to "*comment on anything connected with a death investigated at an inquest that relates to – (c) ways to prevent deaths from happening in similar circumstances in the future."* Further, the Act prohibits findings or comments including any statement that a person is guilty of an offence or civilly liable for something.

5. Due to the proceedings in a Coroner's court being by way of inquiry rather than trial, and being focused on fact finding rather than attributing guilt, the Act provides that the Court may inform itself in any appropriate way (section 37) and is not bound by the rules of evidence. The rules of natural justice and procedural fairness apply in an Inquest. The civil standard of proof, the balance of probabilities, is applied.

6. All interested parties can be given leave to appear, examine witnesses and be heard in relation to the issues in order to ensure compliance with the rules of natural justice. In this matter, Fun Pty Ltd, NSW Department of Communities and the family of the deceased were represented at the Inquest.

7. I will summarise the evidence in this matter. All of the evidence presented during the course of the Inquest, exhibits tendered and submissions made have been thoroughly considered even though all facts may not be specifically commented upon.

THE EVIDENCE

8. About 1pm on 4/1/07, the child attended the Rock Pool Waterpark at North Rockhampton with a number of family members, adults and children. At that time, the child was subject to the care of the NSW Department of Communities and was living with his Aunt in NSW. He was visiting Rockhampton in order to see his mother over the Christmas period. The child was 9 years old.

9. Rock Pool, at the time of the incident, was owned by the Rockhampton Regional Council and leased to the operator, Fun Pty Ltd, since September 2006. It had previously been developed from a traditional swimming pool area into a waterpark in 2004, offering a number of activities in and out of the water. The park contained five pools including an Olympic size pool containing three large inflatable devices. In addition, there were two water slides, a rock climbing wall, wet and dry play areas and a mini golf course. Additional fees were paid on entry for the use of the inflatable devices and the swimmer received a coloured wristband. 652 people passed through the gates at the Rock Pool during the course of that day comprised of 365 children, 228 adults, 43 spectators and 16 concession admissions. It is unknown exactly how many people were present at the pool at the time the child was there. Two lifeguards and six pool attendants were working at the facility at the time of the incident. It is a condition of entry to RockPool that all children under 12 years be accompanied by an adult and signage appears at the entrance to the pool to this effect. Signage requiring supervision of children under 12 by parents is also displayed around the grounds.

10. The child was in the care of his Aunt. She had the full time care of her own two daughters as well as three of her sister's children, including the child. The aunt had responsibility for 6 children that day at the waterpark. She set herself up with the bags etc in the smoking area between the slides and the pool.

11. After arriving, the child was told by his aunt that he was not to go in the deep end of the pool or on the inflatables. She was aware that the child could not swim. She described him as a poor swimmer needing assistance. On all previous excursions near water, the child had always stayed where he could touch the bottom. She was also aware that the child suffered from a mild intellectual impairment which affected his speech and his ability to comprehend language. The child's school records indicated that he had difficulty in processing written and oral instructions and had poor listening skills. The aunt had been caring for him since March 2006 and was therefore used to communicating with him. She was confident that with firm and simple instruction, he was able to understand and comply. She would speak to him in terms he

could understand and she said that he always listened when they were talking about safety. The child told her that he just wanted to go on the slide with his three older brothers. All of the kids knew to keep an eye on each other.

12. All of the adults in the group were communicating with each other as to where the children were in the waterpark. All of the children were excited as it was a new experience for them and they were all running around. All of the adults were moving around with them. The aunt stayed with the 2 little girls in the little pool. At one stage, she swapped positions with one of the other adults in going to the little pool and she to the slides with the children.

13. One of the adults and the children went down the slides and the aunt watched the child in that area. The aunt knew that the child was enjoying the slides and made some friends there. Then she joined two of the group in the little pool. After about 30 minutes she commented on not seeing the child for a while and one of the adults noticed a crowd near the big pool. He stated that it was not long between them all being on the slides and noticing the crowd which was around the child as he was being attended to. One of the older children was told by the aunt to stick together with the child and the child's brother and for all the kids to stay together. After the first slide, the older child lost sight of the child and went looking for him. He found his brother and sent him back to the aunt and then got in line for the inflatables. He was on the Rocket when he saw the child being attended to. One of the child's brothers was playing on the slides with his brothers and cousins and then played in the little pool. The child and his 10 year old brother left the slides together and the brother showed the child how to do bombs in the shallow end and told him to get off the obstacle inflatable. He did not see the child after that but knew they were to stay in the shallow end as the child couldn't swim. He did not go near the Rocket as it was in the deep end of the pool. Whilst he had a wristband to use all facilities, the aunt did not understand why he ended up at the inflatables. Her opinion was that the lifeguards were there to prevent an accident from happening.

14. The Rocket inflatable had been purchased by Fun Pty Ltd 4 months prior to the incident from A-flex Technology (NZ) Ltd. Operating and safety information relating to the inflatable usually accompanied the object and was located on the company's website. Mr Flintoff, the pool manager, confirmed that no manual was received with the rocket. This had happened on previous occasions as well, both before and after the incident. In fact, Mr Stephens, the owner, stated in evidence that if it had not been for the WPHS prosecution in relation to the incident, he would not have been aware that a manual existed. No risk assessment was performed on the inflatable before it was commissioned. The rocket was a replacement for a previous piece of equipment so the previous practices were applied to it. The manufacturer recommends that 2-3 people supervise the inflatable when in use. The manual provides that "a trained attendant controls access onto the unit with other attendants

positioned where necessary for a clear view of users on the inflatable at all times, from when users enter the water until they are clear of the pool". Further, "given the restricted visibility under the inflatable, staff must be alert to the possibility of a user experiencing difficulties in an obscured part of the pool, either underneath the structure or on the pool bottom."

15. The Rocket is a large inflated rocket-shaped object, 20.8 meters long, which was located in one corner of the Olympic size swimming pool at the deep end. The water depth varied from 1.7 meters to 2.1 metres along the length of the device. It was secured at the base (2 meters wide) to a starting block and was positioned between lanes 2 and 3, sufficiently away from the side of the pool (4.4 meters to 2.9 meters when in use and moving in the pool) such that the side of the pool would not cause an obstruction to swimmers falling off the rocket. A lane rope was placed in the centre of the pool between lanes 4 and 5 which would be a potential anchor point for swimmers in trouble on that side of the rocket. In order to use the rocket, swimmers line up at the end of the pool next to the lifeguard and step onto the device from the edge of the pool, running along until they get to the end or fall into the water to either side of the device before reaching the end.

16. At the time of the child using the inflatable, it was being supervised by one person, Neal Barram who was 18 years of age. He had been employed at Rock Pool for 4-5 months in a part time capacity, 25-30 hours per week. Lifeguard Ben Young was supervising the obstacle inflatable in the shallow end of the pool. Mr Barram held a Senior First Aid certificate but did not hold any formal qualifications relating to the supervision of swimmers. He had done his lifeguard training but not the competency assessment. He had been unable to do his Bronze medallion testing due to a sporting injury.

17. His general duties at the inflatable on this day was to keep an eye on the pool, if a swimmer was struggling they would be assisted and then told to move to the shallow end of the pool. He also had to keep watch on the sides of the pool and ensure that no-one jumped in (towards the inflatable). His duties also included checking swimmer's wrist bands (to ensure they had paid to use the device), hosing down the inflatable (from the ladder area), and ensuring that one swimmer at a time used the inflatable. The next person would not be released from the line until the inflatable was clear of the previous swimmer. One of the duties of the supervisor was to add challenge to the swimmers on the inflatable by hosing it to make it slippery and to move the rocket around so that users slipped off. It was also hosed so that it would not get too hot to walk on. The supervisor would also move the inflatable with the ropes to make staying on more difficult.

18. Mr Barram was positioned at the end of the pool (the base of the rocket) in accordance with instructions to him. He would also sit on the starting block from time to time. There was no line of sight to the bottom of the

pool and the area under the rocket from either of those positions. In addition, reflection from the water and the disruption to the water surface by hosing all interfered with what vision there was.

19. A Senior Lifeguard was employed to supervise all of the water activities in a roaming sense. On this day, that person was Cameron Jennings. He was 27 years of age and held Senior First Aid, Bronze Medallion and a Pool Lifeguard Certificate as well as a Degree in Human Movement. At the time of the incident he was supervising the rock climbing wall activities, some distance away from the inflatable devices. Mr Jennings had a lot of other duties and was responsible for overseeing all supervisors around the waterpark. A lifeguard tower was situated near the pool but the line of sight difficulties especially around the inflatables were addressed by requiring the lifeguard to keep moving around the premises on ground level whilst supervising. Working under the direction of the Head Lifeguard, the staff worked 40 minute rotations between the various stations at different activities in the waterpark. One reason Mr Barram understood for this practice was to keep alert on each station. Mr Jennings would speak to parents if their child needed assistance in the water. He said some people laughed it off, some made excuses and some became aggressive. He was not sure if other staff did that.

20. About 2.30pm two young children saw the child lying on the bottom of the pool, between the side of the pool and the inflatable. Those children had seem him on the inflatable shortly before. It was not able to be determined how long the child had been playing on the inflatable. They got into the pool and touched him but he did not move. They left the pool and immediately notified Mr Barram. He looked into the pool but could not see anything as he had just been hosing and the hose spray had disturbed the surface of the water. After turning the hose off, he saw the child on the bottom of the pool. He was in 1.87 meters of water and was 11.1 meters from the end of the pool.

21. Mr Barram dove into the pool and retrieved the child. Mr Barram was assisted by another staff member to lift him from the water. He was not breathing and had no pulse. Resuscitation efforts commenced immediately and the Queensland Ambulance Service attended within ten minutes. A nurse, Mrs Chalmers, assisted with the resuscitation efforts. The child was taken to Rockhampton Hospital where he was unable to be revived. The cause of death was drowning. He had a small bruise on his head but it was not thought to have contributed to his death.

22. The aunt was very upset by the events and understandably felt that the effects would be with her for life. She was very angry with the waterpark owners as she felt that there was no lifeguard at the top of the slides and no-one near the rocket. Her comment was that they were all too busy standing around talking to watch. She estimated there were 500-600 people at the waterpark at the time of the incident. She felt that the inflatables looked dangerous when she got there and was concerned about the number of children on them, diving underneath them and

falling off around them. She would not have let the child go on the inflatable. There were no questions asked of the aunt of swimming ability of children on entry. She did not notice any signs. She purchased a wristband for the child so that he could go on the slides. She did not ask whether that pass allowed access to deep water areas.

23. Mr Patrick O'Connor, a TAFE teacher, gave evidence that most of the staff at the pool seemed to be teenagers with a high level of responsibility on them. There was a lot of activity going on with a lot of children and young adults in some areas of the waterpark, especially around the inflatables, and there were a large amount of things to observe as well as attending to administrative jobs like checking armbands. He had concerns as a parent regarding these issues. Whilst some parents were seated in the grandstands, there did not seem to be any parents standing on the side of the pool watching children on the inflatables. Mr O'Connor was keeping a keen eye on his children but he noticed some parents reading or doing other tasks. He could not recall seeing signage around the pool and the lifeguard's role in supervising was not clear to him.

24. Another patron, Mr Brian Chalmers, also had concerns regarding safety matters that day. He considered that there was a need for more people to supervise the inflatables after a risk assessment was done to identify the danger points. He considered there were too many people on the inflatables at one time and the people jumping in from the side could have been controlled more. He considered that parental responsibility was paramount and he did not let his children out of his sight at the waterpark.

25. Police were called and arrived soon after 3.30pm. The Pool was closed and names taken of the persons present but some patrons had been allowed to leave in the intervening period. Sgt Buxton took statements from the direct witnesses, none of whom saw the incident itself. A version was given to Police that an older child may have fallen onto the child while he was in the water. It was not able to be confirmed whether this was correct. Another child stated seeing the child fall off the rocket when the lifeguard pulled on the rope of the rocket. The child was underwater for 2-3 minutes. Police attempted to contact WPHS from 4pm on the afternoon of the incident but were only able to leave a message.

26. Sgt Buxton's conclusion after reviewing all of the material he gathered was that parents always retain a high level of responsibility for the supervision of children and ultimately one person has to be responsible for the supervision to avoid this situation of thinking others were supervising. Lifeguards were there to ensure correct behaviour and respond to distress and to perform administrative duties. The presence of a lifeguard does not subrogate the parent's responsibility for the child.

Risk Assessment at Rockpool

27. On taking over the facility, Mr Stephens was provided with a risk assessment document compiled by Australian Amusement, Leisure & Recreation Association (AALARA, now known as WorkLaw) and conducted an audit of the Rockpool at the request of the previous owner in early 2006. The audit addressed infrastructure risks and recommendations were made for the improvement of some signage at the business. The issues of water hazards, supervision, staffing levels or competencies of lifeguards and the inflatable devices were not discussed in any detail.

Accreditations and Training of Lifeguards

28. The Director of Fun Pty Ltd is Mr John Stephens. On acquiring the Rock Pool in September 2006, Mr Stephens sought appropriate pool safety credentials and in January 2007 he received Statements of Attainment from RLSSQ in supervising an aquatic facility; Respond to Aquatic emergency, resuscitation, Administer Oxygen, Bronze medallion, Oxygen Equipment Resuscitation, and Pool Lifeguard. Mr Stephens (prior to and after the incident) makes arrangements for assessors to fly to Rockhampton twice a year to conduct courses for employees for them to stay current and upgrade their skills. Mr Jennings stated that after Mr Stephens took over there was a definite improvement in safety especially through signage at the pool. Staff were constantly on the public address system reminding parents to be aware of where their children are.

29. A staff handbook was presented to all staff at the time of employment, containing operational information regarding staff roles and safety matters. The handbook was 'inherited' from the previous owner of the facility. It did not make reference to water hazards or supervision issues in any way. Inductions and refreshers with staff were conducted mostly through mentoring and on the job training and by starting staff in easier to supervise areas of the waterpark. Induction on inflatables and scenario training would benefit staff in Mr Jennings view.

30. Mr Dave Flintoff was the Pool Manager at the time of the incident. He stated that the lifeguard duties included supervision of the water at all times and crowd control. Many of the staff were lifesavers from Emu Park. Mr Flintoff said that whilst the lifeguards were there to assist, the responsibility lay with the parents. It should be noted that there are varying levels of "lifeguard" training, skills and competencies and not all of the staff described as lifeguards at the Rockpool held the highest level of qualification warranting that name. The safeguards put in place by the management against non-swimmer injury included the signs, gates, and lifeguard supervision. Sgt Buxton gave evidence that there were signs at the pool reminding parents that they needed to supervise their children and condition of entry signs in the foyer containing this requirement. Staff with supervisory responsibility will always retain the obligation of identifying a patron in distress and rendering assistance however.

31. Mr Flintoff said that there was a problem at the waterpark with people treating the facility as babysitting, dropping children from as young as 5 years old off and returning hours later. Unaccompanied children were not permitted entry. Most incidents at the pool involved grazes from slips, bloody noses from hitting heads on waterslides and the occasional bee sting.

32. Cameron Jennings indicated that he often wanted more training for the staff at the pool and to have a controlled environment in which to conduct the training through scenarios, he especially wanted to do some training around the inflatables, but it was tough to arrange training with the pool opened seven days etc.

Workplace Health and Safety Investigation

33. Inspector Peckover was the investigator of this incident for WPHS. He described the duties and role of the investigator for WPHS. He stated that the primary task of the investigator on attending the site was to ensure that the risk identified by the incident was controlled to avoid any further incidents. Then evidence is collected for the purpose of a prosecution under the WPHS Act. He was not aware of any training or information which detailed the investigator's role vis-à-vis the coronial jurisdiction. No thought (or departmental direction) was given to investigating matters of interest under the Coroners Act by WPHS during the training course for investigators. Operational Inspectors conduct proactive inspections with a preventative focus and conduct community consultations and education. At the time of this incident there was 1 investigator and 6 operations inspectors in Rockhampton regional office.

34. Inspector Peckover commenced his investigations of the incident on the 5th January 2010. The Police had conducted the initial investigations on the day before. Ordinarily WPHS would take statements from witnesses for the purpose of their investigation but the Police had already attended to that task. The Inspector gave his attention to the inflatable itself and identified that a clear line of sight was available under the inflatable from the side of the pool. Formal risk assessments and other documentation were required to be provided, and Notices of Prohibition and Improvement given to the operator. It was determined that no commissioning risk assessment of the rocket inflatable had been done. Investigations were made regarding the manufacturer of the inflatable, the website was inspected and enquiries made as to the supply of the inflatable. It was established that no manual for the inflatable was at the waterpark. WPHS ensured that the operator did complete risk assessments in relation to the use of the inflatable after the incident and obtained a copy of the manual, turning their mind to the supervisory recommendations and risks associated with the use of the inflatables. A copy of the RLSSA Guidelines were

also obtained and provided to the operator. A copy of the ALARA Audit was provided by Fun Pty Ltd and inspected.

35. A prompt request (11/1/07) was made by the WPHS Inspector to the Police to provide a copy of the material gathered by Police relating to the matter. That request was followed up but no information was forthcoming for a long period of time. WPHS were informed that the release of material under the Memorandum of Understanding (MOU) between the Departments required a lengthy process of authorisations from Brisbane. Eventually WPHS were provided a copy of the Police material by the Rockhampton Coroner's Office in November 2007 when it was received by the Coroner from the Police. No material was provided directly from the Police to WPHS.

36. By that stage, 10 months after the incident, it was very difficult for WPHS to pick up the details of the investigation and advance the issues they were interested in further, in particular, to obtain versions from witnesses not interviewed by the police at the time of the incident. WPHS would have also conducted investigation into the qualifications and competence of the lifeguards but were unable to do so as they did not inform themselves of who was present on the day of the incident and their versions of events, expecting to be in receipt of that information from the Police in the short term.

37. The investigation of a pool drowning was considered to be out of the ordinary for the Rockhampton WPHS office and so there was an impression on the part of the Inspector that as the Police had attended first and taken statements that they were the lead agency and the prosecution investigation would "piggyback" on the Police investigation. This was the first occasion in which the inspector had been involved in an investigation in which the Police were also involved. In hindsight, conducting their own investigation from the outset would have been wiser.

Safety Alerts

38. Safety Alerts are documents released by WPHS to industry which are intended to be timely responses to serious safety issues which obligation holders (or operators in the industry) are unlikely to foresee. Immediate consideration of the safety alerts by obligation holders is expected. An information sheet is sometimes published with the alert to detail to those using it the requirements of WPHS in relation to the issue.

39. Inspector Peckover did not prepare a safety alert in this matter though he had in previous investigations. Due to the complications in the progress of the investigation, and WPHS not being aware of how the incident occurred until at least November 2007, the Inspector was of the view that there was no concrete information on which to base a safety alert. Further, the Inspector did not inform himself as to whether

the use of inflatables in commercial pools was extensive and therefore did not gauge the extent of the potential risk across the industry. The Inquest was informed that in addition to RockPool, at least ten other pools in the Central Queensland region alone had inflatable devices for use in commercial or public pools, indicating that the supervision issue would be of broad interest. The Inspector left WPHS during the course of the investigation and it seems that the preparation of a safety alert (which he had intended) was missed in the changeover.

40. In hindsight, Inspector Peckover was of the opinion that WPHS should have put out an alert straight away to of all those operators using inflatables and then audit them for compliance with the alert. Further, he felt they could have placed a Notice of Requirement on A-flex to provide manuals with all inflatables.

41. Inspector Peckover, who now works for the Rockhampton Regional Council in a Safety role, stated that Safety Alerts are relatively easy to disseminate to Council owned pools through LGAQ's existing network. Inspector Peckover was of the opinion that it was more difficult and time-consuming to prepare a safety alert at WPHS than it is in the local government system due to all of the levels of approval required within the Department before information is sent into the public arena. In 2007, he said, it was extremely difficult to have a safety alert approved, particularly in a timely fashion.

WPHS Report to Coroner

42. Inspector Sara Swift prepared the WPHS report dated 27/10/08. She had not conducted the primary investigation but had come to the matter after entering the Department some time after the departure of Inspector Peckover. On giving evidence in June 2009, Inspector Swift was aware that there was a duality to the Inspector's role which included assistance to the Coroner.

43. Inspector Swift "inherited" folders with information relating to this matter. She did not know where some of the information came from. She was not with WPHS at the time of the investigation but had attended the waterpark with another inspector to see what measures had been taken in relation to this incident. She was tasked with preparing the report to the Coroner which had been requested. She was given a very brief template amounting to a number of general headings from which to prepare the report. She found that the template was not very helpful. She largely drew on her experience in the Police to prepare the report. Sgt Buxton advised that a detailed template for Police Coronial reports is contained in QPS procedures manuals.

44. Shortly after the incident, Workplace Health and Safety Qld issued Prohibition and Improvement notices to the pool operator in this matter in relation to the use of the inflatable devices. Those notices were complied with and Fun Pty Ltd co-operated with the WPHSQ

investigation. Monitoring and compliance checks continued to be conducted by WPHSQ inspectors over a period of time with Rock Pool. A prosecution by WPHSQ was conducted and was the subject of a plea of guilty with a fine being imposed on 12/8/08.

45. Ms Letiticia Robinson, the Coronial Liaison Officer for WPHS also gave evidence (1/7/09). The CLO role was created as part of the Regional Services Manager role in an effort to provide central management of coronial matters in relation to both the provision of investigation reports to assist coroners and organisationally respond to recommendations made by coroners. The CLO role represents 25% of the positional duties and oversees matters for the entire State, about 30 deaths per year. WPHS were (at the time of the Inquest) looking at ways to improve the information provided to coroners and to undertake consultation with the State Coroner regarding those issues. I have in recent times received a questionnaire on this topic, indicating that the process spoken of in July is still continuing.

46. WPHS were asked to provide information to the Inquest regarding actions taken by them on the recommendations made in two previous coronial decisions involving the drowning of young children in public pools (Case and Rouse, both in 2005). Whilst a plan was developed to take certain actions on the recommendations, it seems that in the intervening years, one meeting with various stakeholders had occurred in late 2008 and an enforcement note and information sheet (drawing reference to the RLSSA Guidelines) were drafted but not issued. Prosecution summaries were also being posted on the website for the access of pool operators. WPHS had not met with RLSSA since the stakeholders meeting as no need to do so was identified. Safety Alerts on those two cases had not been issued as recommended.

47. In relation to the WPHS response to the needs of the coronial system, Ms Robinson stated that WPHS were considering a "complete realignment of the way that information for fatality investigations is considered" in part by providing central oversight of regional investigations and including in coronial reports "some conclusions about the endemic nature of the issue across industry whereby the regions will in fact conduct multiple assessments around the issues that have been identified" in order to assist the coronial decision making process. Further, coroners in the future will be informed what WPHS "organisationally are either doing to respond to the issues from the investigation or believe may be appropriate for the coroner to consider." An internal governance group is developing a new template for investigator reports to coroners. It was anticipated that the State Coroner would have the opportunity to comment on that document.

48. It became evident during the evidence of Ms Robinson that there was additional material which could have been of assistance to the Inquest which had not been provided to the Coroner, including a statement from the regional manager involved in this investigation.

Royal Life Saving Society of Australia

49. RLSSA targets reduction in drowning incidents and conducts public awareness and education programs including the Swim and Survive program for schools and lifeguard training courses. They are able to provide to owners a Pool Safety Audit checklist to assist them in identifying safety issues for consideration.

50. RLSSA has access to various sets of statistics on drownings and Michael Darben, Qld CEO, gave evidence that incidents of drowning and near drowning in commercial pools are low in number, primarily due to the supervision provided and the fact that those pools are more controlled environments than rivers and creeks etc. Despite that, drowning remains the number one priority for lifeguards.

51. RLSSA has produced "Guidelines for Safe Pool Operation" (1/4/06) which are an advisory standard. Adoption by more pools of the Guidelines would, in Mr Darben's opinion, lead to standardisation and provide less ambiguity around safety at pools. The Guidelines stress that the primary responsibility for supervision of children remains with parents at all times.

52. The major components of the Guidelines include:

- one qualified Pool Lifeguard supervising to be facing and watching the water at all times
- a second supervisor should hold Bronze Medallion
- at least one supervisor should have Senior First Aid
- there should be sufficient (qualified) lifeguards to ensure the bodies of water and people in them are supervised effectively
- a clear line of sight must be established for the surface and floor of the pool by the supervisor
- the minimum ratio of lifeguards is 1 to 100 people in the water
- responsible behaviour should be encouraged at all times

53. The Guidelines contain a section on "Inflatable Play Equipment" (Supervision no.13) which requires a detailed risk assessment for the use of the equipment and specifies factors to be included in the risk assessment including supervision of the inflatable and general area including line of sight issues. Inflatable devices are becoming more popular in recent years as they are becoming more affordable and are portable from one pool to another if the operator moves to another venue.

54. Mr Darben confirmed that all activities should have commissioning risk assessment documented and staff trained on it. The operator had not been aware that another hazard which required control was created when the inflatable was introduced into pool.

55. Mr Flintoff had never looked at the RLSSA guidelines as he found that he had no time to do anything above the day to day tasks he was responsible for. Management looked after all of the risk assessments and procedures. Documentation of those was required to be provided to Council every 6 months. He was working at the pool when ALARA conducted the safety audit.

56. Sgt Buxton confirmed that the pool operator had shown substantial compliance with the RLSSA guidelines.

57. In relation to the engagement of RLSSA in action on the recommendations made by Coroners in the Rouse and Case matters, Mr Darben (who came to his position in October 2008) had attempted follow up with the Local Government Association to no avail. He made the valid point that neither the Local Government Association nor WPHS are experts in the aquatic field and as RLSSA has significant expertise in the area, they could be of vital importance in advancing safety issues across the industry through government. In the past there have been various pool/water safety committees but they generally fizzle out. Mr Darben was of the view that a government sponsored water safety committee including all elements of the sector would help progress issues in a co-ordinated fashion. He believed that the current action taken on those recommendations needed to go further.

58. RLSSA have a self audit tool available for pools which would be an aid to improving safety for pool users.

Australian Standard

59. The Australian Standards AS3533.1 and AS3533.2 and the standard regarding water amusement devices (water slides and on-ground jumping castles) have no provision relating to in-pool obstacles or inflatables.

Court Appointed Expert – Dr Ruth Barker

60. Dr Barker, the Court Appointed Expert in this matter, is qualified and experienced in Paediatrics and Emergency Medicine. She is the Acting Director of the Queensland Injury Surveillance Unit and a Staff Specialist Emergency Paediatrician at the Mater Childrens' Hospital in Brisbane. Dr Barker has an advisory role on the Queensland Government Swimming Pool Safety Committee which examines the current domestic swimming pool legislation but does not address public pool safety. Dr Barker also gave evidence that researchers, including the QISU, do not have access to appropriate information in a timely fashion regarding drownings and immersion events to enable them to quickly analyse events and formulate prevention strategies.

61. Dr Barker identified the following issues as contributing factors in the child's death:

(i) *His lack of swimming competency*

Dr Barker stated in her report that there is an expectation that children swimming in a public pool unsupervised have a certain level of swimming competency when it is not uncommon for a child of the child's age to be unable to swim;

(ii) *Failure on the part of the carer to designate an adult supervisor*

The child was accompanied by multiple adults, none of whom had the sole responsibility of supervising him. Dr Barker stated that this is a frequent thread in pool deaths and immersions. The RLSSA "Keep Watch" campaign seeks to set workable guidelines for pool patrons in terms of supervision of children of certain ages (it is not addressed to swimming ability levels). Further, it may have been unrealistic to expect the child to comply with the direction not to enter the deep end of the pool as it is obvious that he either misunderstood the direction or the temptation of the Rocket proved too great.

(iii) *Failure on the part of Rockpool owner to adequately assess the risk associated with aquatic hazards*

Dr Barker considered that the organisational requirements for water safety supervision were not clear. Further, the staff handbook failed to address procedures for the most likely adverse event at a pool – an immersion. The manual for the Rocket was not provided with the equipment. If so, from the guidelines for supervision (particularly the clear line of sight of the floor of the pool), Rockpool management should have identified that more than one person would be required to properly supervise the Rocket.

(iv) *Inadequate number of pool supervising staff to adequately supervise the aquatic hazards and dilution of aquatic supervision by requiring staff to multitask*

Dr Barker considered that the supervision requirements of the various amenities at the RockPool clearly exceeded the six 'lifeguard' staff who were assigned to them on the day. The performance of additional tasks such as maintenance of equipment and checking wristbands diluted the ability of the staff to identify patrons in distress. The staff handbook instructed staff to accommodate patrons rather than direct them in safe behaviour.

(v) *Inadequate number of qualified lifeguards to adequately supervise the aquatic hazards*

The RLSSA requirement is for 1 qualified lifeguard per 100 patrons in the water. Lifeguard qualification contains a component of aquatic supervision which is not included in other qualifications. 'Lifeguard'

tends to be used as a generic term in the industry for a supervisor but actually should reflect the specific skills of that qualification. Other staff should be referred to as Pool Attendants. Not all of the six staff were qualified to Pool Lifeguard standard.

62. Dr Barker considered that despite the failure of the management to identify and manage the aquatic risks, there was a clear intention to do so. The assistance of the assessment tool available from RLSSA would have helped identify the risks in a more appropriate way than reliance on the AALARA audit achieved in relation to this particular issue.

Investigation Issues

63. The incident was reported to the Police who attended the scene and commenced investigating the matter. They established that they would need to involve the Division of Workplace Health and Safety in the matter but had difficulty in contacting WPHS after hours to notify of the incident. WPHS did not become officially involved until the following day.

64. The Police had established that there were no suspicious circumstances in the matter and the bulk of the investigation fell to WPHS. However, as the Police were on scene, they had interviewed the witnesses who were still present shortly after the incident. WPHS determined that they needed to access those witness statements in relation to their investigation. The QPS Operational Procedure Manual (OPMs) prohibits the disclosure of information to external bodies without the authority of the Commissioner of Police. This procedure was followed by the investigating Police officer but substantial delay was occasioned (some months) in WPHS gaining access to the material that the police officers had gathered relating to the incident.

65. Further delays were caused when the officer responsible for the WPHS investigation left the employ of the Division and issues which should have been followed up on, including the issuing of a Safety Alert to industry, were overlooked in the internal changeover of the file. There is a need to ensure the delivery of timely safety warning information out to industry following an incident, within days of event being preferable.

66. There was little communication between WPHS and investigating Police especially regarding safety issues such as risk assessments undertaken by the pool operator. The investigating Police officer was not notified of breach proceedings taken by WPHS against the pool operator. There was no liaison between QPS and WPHS regarding the provision of a report to the Coroner. The report which was furnished by the Police was quite complete but the WPHS report effectively regurgitated the Police material and added little substance regarding the substantive issues in the matter. This was largely due to the paucity of direction to officers in the material which should be included in such a report and the loss of relevant momentum and attention to detail occasioned by the internal handover referred to earlier.

SINCE THE INCIDENT

67. Since the incident, the pool operator has taken significant steps to address the safety issues which arose as a result of this tragic incident. Those steps include but are not limited to undertaking a risk assessment in relation to the use of the inflatables, reallocation of positioning of lifeguards around the inflatables (one on the starting block and one on the side of the pool to ensure line of sight for the area surrounding the inflatable), and improvements to signage.

FINDINGS

68. I am required to find, so far as has been proved on the evidence, who the deceased person was and when, where and how he came by his death. After consideration of all of the evidence and exhibited material, I make the following findings:

Identity of the deceased person– The deceased person was the child born on 31st October 1997.

Place of death – He died at the RockPool waterpark, Rockhampton.

Date of death – He died on the 4th January 2007.

Cause of death – The child attended the RockPool, a leisure park centred around pools and water activities, in Rockhampton on the day of his death with family members including his aunt/carer. He was not a swimmer and had some difficulties understanding and following instructions. He was not properly supervised by the adults who attended the pool with him. After playing happily with his brothers and other family members for a time, he was unsupervised for a period of time. Despite being instructed not to go to the deep end of the pool, he has entered onto the inflatable rocket in the deep end of the pool which was being supervised by one pool attendant. He was discovered lying on the bottom of the pool under the inflatable device and was retrieved and CPR administered. He died from drowning. Contributing factors in the death were inadequate supervision of the child by the adults responsible for him, inadequate supervision of the inflatable device he was using, inadequate identification of the risks and hazards associated with the use of the inflatable device by the pool operator, and the child's lack of swimming competency and to a lesser extent his ability to comply with instructions.

RECOMMENDATIONS

In an effort to avoid similar deaths occurring in the future, I recommend:

Recommendation 1

That when items such as inflatable devices are in use in commercial or public pools, pool operators are to conduct a risk assessment on the use of the inflatable before commissioning it. The risk assessment should be conducted in accordance with RLSSA guidelines and take into account all information regarding the inflatable provided by the manufacturer. Following the risk assessment, the pool operator should develop staff training on the issues raised in and procedures developed from the risk assessment and assess staff competency in the procedures. Those procedures should include scenario training relevant to the inflatable device in use. The Division of Workplace Health and Safety is to supervise the implementation of this recommendation.

Recommendation 2

That AFlex Technology Ltd, the manufacturer of the inflatable device in this matter, ensure that the user manual for each device more fully and prominently explain the risks associated with the use of the inflatable device, especially the risk of users drowning, and ensure the manual is provided to the purchaser with the product.

Recommendation 3

That the Division of Workplace Health and Safety consult with industry and RLSSA and give consideration to establishing a Pool Industry Code of Practice as a Standard under the Workplace Health and Safety Act to provide a guide for commercial and public pool owners and operators on issues including risk management and which includes provision for effective monitoring and enforcement of the guideline.

Recommendation 4

That Royal Lifesaving Society of Australia [RLSSA] conduct a review and produce guidelines, to be incorporated into the RLSSA Guidelines for Safe Pool Operation relating specifically to:

(i) the appropriate level of qualification and accreditation of lifeguards, and the required number of lifeguards providing supervision at public pools and "pay for entry" pools;

(ii) that specific reference be made to pools where obstructions including inflatable devices are used as part of the pool business of undertaking.

Recommendation 5

That the Committee responsible for review of Australian Standards AS3533.1 and AS3533.2 review these and other appropriate standards

with regard to inclusion of issues around the use of in-water inflatable amusement devices not currently addressed in the standards.

Recommendation 6

That the Department of Health, Local Government Association and RLSSA consider conducting a public awareness campaign, reinforcing the need for continued supervision of children swimming at public pools, by parents, carers, guardians, or responsible adults.

Recommendation 7

That the Department of Health and RLSSA develop a program to promote and encourage parents and guardians to enrol children and other non-swimmers in learn to swim instruction including skills to survive a sudden immersion event.

Recommendation 8

That RLSSA review the 'Keep Watch' program with a view to tying the recommendations for supervision not only to age but also to swimming ability levels and require significant enforcement of recommendations by pool staff/owners.

Recommendation 9

That WPHS consider legislating a requirement for all operators of public pools in Queensland to hold membership of RLSSA to ensure operator compliance with safety guidelines offered by RLSSA and to promote greater safety awareness in the industry.

Recommendation 10

That the Queensland Government reconvene a Queensland Water Safety Council including representation from Division of Workplace Health and Safety, Local Government Association, RLSSA, Qld Injury Surveillance Unit and other interested parties, perhaps under the auspices of the Commissioner for Children and Young People, in order to monitor issues and advise government on issues connected with public water safety.

Recommendation 11

That the Local Government Association of Qld and WPHSQ provide access to data involving public pools to RLSSA and approved researchers.

Recommendation 12

That the State Coroner improve the availability of appropriate information regarding drownings to approved researchers at an early stage of the coronial investigation, allowing a more timely review of the event by experts and the development of prevention strategies. It is noted that section 53(2) Coroners Act makes provision for the supply of information in certain circumstances. Timing is the thrust of this recommendation.

Recommendation 13

That WPHS improve the efficiency of the system for the issuing of Safety Alerts or other safety information to industry within a short period of time after an incident in order to protect public safety.

Recommendation 14

That WPHS and QPS:

(i) **develop a protocol for QPS officers to contact WPHS inspectors out of office hours in relation to incidents;**

(ii) **clarify the QPS Memorandum of Understanding with WPHS regarding the investigation of coronial matters and consider modification of the Operations Procedure Manual provisions which prohibit disclosure of information to external bodies without the authority of the Commissioner of Police in this regard;**

(iii) **Improve communication between WPHS inspectors and investigating Police when investigating a coronial incident.**

Recommendation 15

That WPHS ensure that there is continuity of knowledge within the organisation when an Inspector responsible for an investigation leaves before it is complete, so that a report prepared by a subsequent investigator represents the entire details of the incident, and issues such as safety alerts or the dissemination of other safety information are advanced in a timely fashion.

Recommendation 16

That WPHS develop, in conjunction with the State Coroner a more instructive and complete template or instructions to investigators to assist in preparation of coronial reports (reference might be had to the current QPS practice).

I close this inquest.

A M Hennessy
Coroner
Rockhampton
24 June 2010