



OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION: Inquest into the death of **Jean-Marie Jeremie Yannick ZAZA**

TITLE OF COURT: Coroners Court

JURISDICTION: Caloundra

FILE NO: 16/08

DELIVERED ON: **21 September 2009**

DELIVERED AT: Caloundra

HEARING DATE(s): 15 June, 2009

FINDINGS OF: Coroner – Magistrate D.M. Fingleton

CATCHWORDS: CORONERS: Inquest – Infant drowning; pool safety and inspections; “Homestay” residential arrangements; residential tenancies and pool safety; review of swimming pool safety to Queensland Government.

REPRESENTATION: Counsel Assisting the Coroner:
Mr. J. Tate, Barrister-at-Law, Crown Law.

Mr G. Sheahan, Barrister-at-Law, instructed by Middletons Solicitors of Sydney, on behalf of D & D Technologies Proprietary Limited.

Ms. K. Plint of Hannah’s Foundation Drowning Prevention, Awareness and Support.

CORONER'S FINDINGS AND DECISION

1. These are my findings in relation to the death of Jean-Marie Jeremie Yannick ZAZA who died at a residence at 17 Bombala Terrace, Caloundra on 23 February 2008 while in a swimming pool. These findings seek to explain how the death occurred and consider whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future. The *Coroners Act 2003*¹ provides that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These findings will be distributed in accordance with the requirements of the Act and also placed on the website of the Office of the State Coroner.

The scope of the Coroner's inquiry and findings

2. A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-
 - a) whether a death in fact happened;
 - b) the identity of the deceased;
 - c) when, where and how the death occurred; and
 - d) what caused the person to die.
3. There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.
4. An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:- *"It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends... The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires."*²
5. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.³ However, a coroner must not include in the findings or comments or recommendations, any statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.⁴

¹ *Coroners Act 2003*, s45

² *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625

³ s46

⁴ s45(5) and 46(3)

The Admissibility of Evidence and the Standard of Proof

6. Proceedings in a coroner's court are not bound by the rules of evidence because the Act provides that the court "*may inform itself in any way it considers appropriate.*"⁵ That does not mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.
7. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.⁶
8. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw* sliding scale is applicable.⁷ This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.⁸
9. It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.⁹ This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*¹⁰ makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.
10. If, from information obtained at an inquest or during the investigation, a Coroner reasonably believes that the information may cause a disciplinary body for a person's profession or trade to inquire into or take steps in relation to the person's conduct, then the coroner may give that information to that body.¹¹

The Autopsy

11. **Dr. Peter Ellis** performed an external and full autopsy examination on 26 February, 2008 which confirmed pulmonary oedema consistent with drowning.

⁵ s35

⁶ *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625

⁷ *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J

⁸ *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

⁹ *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13

¹⁰ (1990) 65 ALJR 167 at 168

¹¹ S 48(4)

Dr. Ellis concluded that the Cause of Death was:

- 1(a) Drowning.

The Evidence

12. It is not necessary to repeat or summarise all of the information contained in the exhibits and from the oral evidence given, but I will refer to what I consider to be the more important parts of the evidence.

The Incident

13. Jean-Marie Zaza was born on 27 May 2005. He died on 23 February 2008, aged two years nine months old. The deceased child was found in the swimming pool of a residence at 17 Bombala Terrace, Caloundra at approximately 4.00pm on that day. By the time the Queensland Ambulance Service arrived to assist, the child was not breathing and he was blue in the face.
14. The child was taken by ambulance to the Caloundra Hospital, and received resuscitation treatment which was unsuccessful and Doctor Lewis-Driver of that hospital declared life extinct at 5.00pm.
15. Upon investigation by the Child Protection and Investigation Unit and by the Queensland Police Service, it was revealed that the child was at home in 17 Bombala Crescent with his father Steven Zaza and another young child, his cousin. The father of the deceased child fell asleep on the lounge inside the dwelling, a residential property with a high set house situated on the block.
16. It was not known how the children exited the rear door but they did and entered the pool area. When the father awoke, he found the children in the pool area. The deceased child was located face down in the swimming pool and the other child was playing next to the pool nearby. The father of the child removed the child and ran into the street carrying the child and screaming for someone to help. Neighbours called 000 and administered CPR to the child, which was unsuccessful.
17. The Zaza family had arrived in Australia from Mauritius some two weeks prior to the events, the subject of the inquest, leaving two children behind in Mauritius with extended family. Mrs Zaza was to study here. The family were seeking to reside permanently in Australia. They are now reunited and a new child has been born into the family.

The Investigation

18. Following an investigation by both the Queensland Police Service and the Department of Child Safety, no suspicious circumstances surrounded the tragic death of the child.
19. The investigation found that the pool was located at the rear of the house, amid a thick, tropical style garden. A check of windows and doors, found that the lock of the security door to the outside of the lower part of the

house, where the Zazas were living, was in working order. However, the key was in the lock on the internal side. From this door a garden path led to the pool area.

20. The in-ground pool is surrounded by standard pool fencing, which was in good condition with no signs of failure present. However, the pool gate fitted to this fence and connected by two hinges, failed to automatically close when tested. The gate would close and latch when pushed; however, when open 5mm past the fully closed position, the gate would self close but not latch in the locked position. Multiple other trials with the gate found this was the same up to about 20cm open. After this point, the gate failed to return to the closed position and would stay open up to 25cm wide.
21. This situation was shown in both photographs of the gate and its locking device, (Exhs. 6, 7 and 8) which showed the pin mechanism had no visible damage. In a video played to the court (Exh. 9), it was shown that the gate did not automatically latch in the locked position from where the latch physically touched the locking pin to almost fully open. When locked, the gate would not come open under force, without causing damage to the locking device.
22. Evidence of a certification that the pool fence complied with Local Council Regulations showed that the pool fence and latch was last inspected four years and nine months previously to the drowning of the deceased but not since.
23. Although the owner of the residence did not herself attend the inquest, evidence was given that Mrs Barnard (the owner) had, since the date of the child's death, had the gate locking device repaired and it was now in working order.

“Homestays”

24. Ms Ann Jacobson, who runs a business known as “Connect Relocate” informed the inquest as to the way in which her business and other similar businesses operate, to provide accommodation to international students coming to Australia to attend tertiary or other institutions.
25. Part of the Australian Homestay Network, she is approached by schools and colleges to arrange accommodation for incoming students. The purpose of the placements is so that the students can live in a home with Australian “host” families and become accustomed to the culture of Australia. In the case of families and individuals, this arrangement is appropriate for situations where the newly arrived students and their families cannot obtain residential tenancies because they do not have the “100 point” requirement necessary. After a stay at these homestays, they can begin to accumulate the necessary points.
26. Bookings are made either by the students themselves or by a migration agent. In the case of the Zazas’ impending arrival in Australia from

Mauritius, the arrangement was made by their migration agent. Ms Jacobson had difficulty in locating suitable accommodation but the situation was urgent. Usually, in such an urgent situation, the student/s would be placed at backpackers' accommodation. The Zazas being a family with children, this was impossible.

27. It was unusual that Ms Jacobson would place a person, group or family at a residence where the host was absent. However, in this case, the situation was so urgent, that the approval of Ms Barnard was obtained and the Zazas were taken to the house and shown through. The arrangement was that the Zazas would live in the lower part of the house, with access to the kitchen upstairs. They were also to have the use of the outside areas and the pool in the downstairs area.
28. Ms Jacobson went through various procedures to do with the house with the Zazas. A form was completed (Exh. 12), which went through various issues. Notably, safety in relation to the pool was noted as "pool gate secure". Ms Jacobson said that she leant against the pool gate and considered it secure. She had had no training in being able to establish whether or not pool fencing and gates were secure and safe, through the Homestay Network. She left her mobile phone number with the Zazas, in case they required anything but did not leave any emergency numbers with them, such as the "000" details.
29. Ms Jacobson did not go into pool safety techniques with the Zazas. She said that it was usual for the relevant schools or educational institutions to instruct in such matters as water safety. She saw no evidence of the "CPR" signage which has been a requirement for pool owners to have displayed for some time.
30. For Ms Jacobson, a number of lessons have been learned from this highly unfortunate experience. Still, however, she has had no training in assessing the safety of pool gates or fences and none is offered by the Homestay Network.
31. Other issues which arose in relation to the Homestay situation are that, as such homes are being used as businesses for profit, local councils should be investigating whether or not such houses should be rezoned as commercial. In relation to families being placed in residences, the issue of the necessity for blue cards for host families needs consideration.

Tenancies Generally

32. The issue was raised as to whether tenancy arrangements generally take care in relation to the safety of pools and surrounding areas. The homestay arrangements are not tenancies and are not governed by the *Residential Tenancies Act 1994*.
33. However, the issue as to whether pool safety should be considered in the same category as other safety issues such as smoke alarms was considered. The appropriate time at which the issue of pool safety –

fences and gates – should be taken into consideration, was when “entry” and “exit” procedures were produced. Issue of training for agents to adequately assess any failings in pool safety features was discussed. Certainly at the moment, real estate agents would be in no better position than any other unqualified person to assess such safety features.

The Mechanism

34. Mr John Clarke, a Director of the company which manufactured the latch and hinges of the pool gate in question, gave evidence. Mr Clarke was able to explain at the Inquest why a pool gate would fail to self close four to five years after installation. The typical reasons, it was suggested, are that a gate sags due to wear and tear. Children swinging on gates and natural ground movement are some of the issues involved. Alternatively, the fence or fence panels can move or collapse such that they fail to adequately support the gate. This causes misalignment, jamming and friction which may prevent or impair normal gate closure. Other problems that would prevent a gate from closing or latching include broken or faulty latches or hinges that have not been adjusted to counter the aforementioned closing speed, sag and misalignment issues.
35. D & D Technologies, Mr Clarke's company produces the “Magna Latch” gate latch and the “TruClose” gate hinge, which were found on the faulty gate, the subject of the relevant investigation. The “TruClose” hinge product, offers a degree of adjustment after installation which is designed to ensure ongoing performance, because hinges and other gate-closing springs can fatigue somewhat over time. The ability to readily re-adjust tension during and after installation – at the turn of the screwdriver – allows for simple and quick re-adjustment.
36. The hinges must also be always kept free of sand, ice and other debris which could impair the operation of the latch. A “how to adjust” sticker is supplied with each hinge and a list of maintenance requirements is located on the installation instructions and catalogues, as well as on D&D Technologies' website. Although it is understandable that the sticker may be taken off upon installation, regular checks of the gates should discover any inadequacies and steps could be taken to remedy the default.
37. Magna Latch latches and TruClose hinges comply with the requirements of Australian Standards. By the use of a small gate sample, Mr Clarke was able to show the Inquest the effect of a hinge being wrongly adjusted. A gate can be adjusted to stay open, which would be dangerous but may have a possible use, or the tension can be closed up to ensure that it closes as it should.
38. Mr Clarke was supportive of regular advertising by authorities to urge pool owners to check on the adequacy of pool fence gates,

emphasising that regular adjustment of hinges, for example, is a simple and effective safety precaution.

39. It was noted that at the present time, building inspections do not contain a pool compliance certification module. The cost of this specific inspection is in the range of an extra \$400 to the prospective purchaser of a property. Mr Clarke saw the benefit of a “certificate of safety” or “certificate of compliance” being required by local authorities at point of sale or rental, in relation to pool fencing, including gates.
40. The issue of horizontal, as well as vertical locks was discussed with Mr Clarke, by way of a “backup” for children ingenious enough to climb up to release a vertical lock and enter a pool through a gate. Hannah’s Foundation, an advocacy group for pool safety, is particularly keen for such a development.
41. Another issue, that of possible alarms being fitted to gates, was considered as not universally popular with pool owners and it was generally conceded that it is a suggestion that would not work, as the annoying nature of the alarm means they are turned off.

Local Councils and Pools

42. Mr Richard Prout, a building certifier with the Sunshine Coast Regional Council, (newly amalgamated to cover the Noosa and Maroochy areas as well as Caloundra), gave evidence about the obligations on pool owners to maintain safe pool gates and fences. There is an obligation under the *Building Act* for pool owners to maintain their pool fences in a good condition. One of the things that has to be ensured is that the pool gate is self closing. If a non-compliance is found with a particular pool, a \$700 on-the-spot fine can be imposed.
43. The approach taken by the Council could be labelled “softly-softly”, in that prosecutions for non-compliance are rarely pursued. Instead, further fines and show cause and enforcement processes are used as a means to obtain compliance. Mr Prout said that the subject pool gate was subject to a final inspection on 8 May 2003 and was not inspected again until 25 October 2008, after the subject incident, when the gate was found to be compliant.
44. The estimate of the number of pools in the Council’s area is 35,000. All new pools are recorded and this has been the case since the early 1990’s but existing pools are not recorded, as there is no obligation on owners to register existing pools with the Council.

45. In relation to auditing requirements, Mr Prout informed the Inquest that in both the Noosa and Maroochy area, random audit programs are in existence but not in the Caloundra area. These inspections are not carried out by building certifiers but by officers of the council and upon being satisfied as to compliance, a “compliance certificate” is issued. If not an on the spot fine is given. However, in view of the amalgamation, it is possible that such a random audit program will be adopted across the new amalgamated Council area but the matter is yet to be decided.
46. Mr Prout gave evidence of a certain resistance to compliance by some pool owners, which is an attitudinal block, which is best countered by advertising, by random checks and by prosecution.
47. In relation to the issue of “short term occupancy” of premises, such as is possible with “Homestays”, Mr Prout informed the Inquest that a stay of less than six weeks would not require the reclassification of a building, into say, that of a boarding house. Mr Prout felt that training would be required if real estate agents were required to vouch for the safety of a pool fence or gate, at the stage of an occupier entering into a contract to rent a property. It was noted that out of 14 pool deaths in Queensland, recorded with Hannah’s Foundation over three years, ten have been in rental properties.
48. It was noted that it is difficult for councils to be aware of when a property becomes a rental property but if there were a requirement in legislation requiring anyone who is about to rent a dwelling out or part of a dwelling which has a pool, to register that fact, then the council could do an inspection as to the safety of a pool fence or gate.

The Review of Queensland’s Swimming Pool Safety Laws

49. Mr Glen Brumby, the Executive Director of the Department of Building Codes, Queensland in the Department of Infrastructure and Planning, gave evidence in relation to the current Review of Queensland’s Swimming Pool Safety Laws. Mr Brumby is in charge of the current departmental project, which has seen a committee made up of high level persons, including relevant experts, interested parties from the building industry, child safety organisations and the royal lifesavers’ organisation. In consultation with relevant stakeholders, the committee has produced a “Swimming Pool Safety Review Committee Report to the Queensland Government”, dated April 2009.

50. Mr Brumby also produced a “Report for the Coroner-Caloundra” – “Review of Queensland’s swimming pool safety laws (Exh. No. 17) for the coroner’s attention. The committee recommended:
- Mandatory point of sale and point of lease swimming pool fencing inspections.
 - The 11 different sets of pool laws to be simplified down to a single standard.
 - Strengthening of powers of entry for local governments to inspect outdoor swimming pools.
 - Local governments to establish a register of Queensland swimming pools.
 - Adopting the existing standard used in other states that portable pools must be fenced if they are deeper than 300mm instead of the current 450mm in Queensland.
 - Compliant temporary swimming pool fencing should be required while swimming pools are being constructed and until a permanent pool fence is installed.
 - That pool safety laws apply to indoor pools, hotels, motels and caretaker residences for the first time.
 - More funding to supplement the \$100,000 spent on the current pool safety education campaign, which last summer featured The Wiggles.
51. An important feature missing from the recommendations of the committee is a mandatory ongoing periodic inspection system such as that operating in Western Australia. Indeed, the committee, it was said, felt that the mandatory inspections would be too expensive and that such inspections did not target the risks. The committee felt that the “risk profile” related more to the change of dwellings and that it would be more cost effective to inspect pools at change of dwellings, rather than every pool being regularly inspected.
52. It was noted that the committee did not propose (or cost) the alternative recommendation for regular, say, every four years, inspections (as is the case in Western Australia), currently set at \$55. The Committee, it was said, considered the cost would be more like \$150 per inspection. This was not costed out, though.
53. Although the committee’s recommendations have not yet been adopted by government, it is hoped that the measures, once adopted, will be in place by this summer, in which case, urgent action is required. The Committee currently considers that the most important recommendation is in relation to rationalising the standards.

Findings required by s45

54. I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with the last of these issues, being the circumstances of Jean-Marie Geremie Yannick Zaza's death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the death.

- (a) The identity of the deceased was Jean-Marie Geremie Yannick Zaza.
- (b) The place of death was 17 Bombala Terrace, Caloundra, Queensland.
- (c) The date of death was 23 February 2008.
- (d) The formal cause of death was:
Drowning.
- (d) Yannick's death was accidental, though preventable, with the Police and Department of Child Safety concluding that there were no suspicious circumstances involved in the death.
- (e) I find that, while it cannot be said conclusively that the failed hinge in the pool gate contributed to the accessibility of the pool at the residence to the children involved, such pool gate was found to be faulty and has now been rectified.
- (f) That, given the lack of information available to the father of the deceased child to deal with the emergent situation in the best way possible, he received as much help as humanly possible from neighbours in the street, that the QAS responded as quickly as possible and that the medical staff at the Caloundra Hospital also provided expert assistance but could not save Yannick.

Concerns, Comments and Recommendations

- a. Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.
- b. In making my recommendations, I take into account, those of previous coroners who have also had the responsibility of making findings and recommendations in relation to other deaths of children by drowning. I

refer specifically to the recommendations of two coroners. Firstly, His Honour, Coroner Spencer of Cairns, who handed down findings in the Inquest into the death of *Phillip Tognola* on 15 July 2005; secondly, those of Her Honour, Coroner Ryan, Coroner at Toowoomba who delivered findings in relation to the death of *Hannah Isabella Alyson Plint*, on 22 December 2008.

- c. I attach to these findings a copy of the recommendations in both of those matters for two purposes. Firstly, I agree with those recommendations to the extent that the issues overlap with the facts of this particular inquest. Secondly, that those agencies to whom these findings are sent and who have responsibility in relation to any matters raised in these findings and the two previous matters, can review what, if any, progress they have made in relation to those recommendations.

Referral of Information

- d. The facts in this case do not warrant the referral of information to a prosecuting authority or a professional disciplinary body.

Recommendations

- e. That the Queensland Government, as part of its response to its “Review of Queensland’s Swimming Pool Safety Laws”, implement a mandatory ongoing periodic inspection system, so that pools are inspected at least once every four years for safety compliance.
- f. That the Queensland Government embark on an immediate advertising blitz as summer fast approaches, urging pool owners to check that their fences and gates are safe and compliant with building regulations and that such checks should be made by owners several times each year. Advertisements should focus on the major risk factors – gates/latches/hinges/gaps in fences. Pool owners should be referred to the Royal Lifesaving Association of Australia’s checklist for pool safety.
- g. That the Queensland Government ensures that there is a viable monitoring process in place for pools to be inspected upon sale or upon leases being entered into, as this provides a good opportunity for such inspections.
- h. That building certifiers be forced to follow up on pool fencing approvals, as opposed to owners being obliged to call for final inspections.
- i. In relation to para. 61, real estate agents be obliged to ensure that a Council officer inspects a pool for safety at the beginning of each new lease and once a year for existing long leases. This arrangement should also apply to “Homestay” operators, who regularly place persons and families in residential premises with pools.
- j. That “entry” and “exit” conditions reports completed by real estate agents at the beginning and end of tenancies, focus on pool safety as well as other safety issues, such as smoke alarms.

- k. That, until such time as the Queensland Government considers the implementation of Recommendation 59 (above), that, in the meantime, the Sunshine Coast Regional Council implement a random audit program, similar to that carried out by the previous Maroochy and Noosa councils, to ensure that pool owners are more inclined to ensure that their pool fences and gates are compliant with safety regulations.
- l. That the Regional Council compile a register of all pools in its area, in both owned and rented residential properties, including those in existing properties, with a view to regular inspections being carried out.

I close this inquest. The sympathies of the court are once again extended to Mr and Mrs Zaza and their family for the sad loss of their son, Yannick.

D.M. Fingleton
Caloundra Coroner

21 September 2009

Inquest into the death of Hannah Isabella Alyson PLINT

Recommendations delivered 22 December 2008 by Coroner Ryan, Toowoomba

- (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.

Inquest into the Death of Phillip Allan Walter Tognola

Recommendations delivered 15 July 2005 by Coroner Spencer, Cairns

I make the following recommendations and request that such recommendations be provided to all Federal, State and Local Government departments responsible for swimming pool construction and fencing in the hope that each and every recommendation will be taken positively and acted upon with a view to preventing any further waste of life and further distress to families and friends.

These recommendations are as follows:

(1) Different regulations apply to pool fences, depending on whether it was built before the 1st of February 1991; between the 1st of February 1991 and the 29th of April 1998; between the 30th of April 1998 and the 30th of September 2003; and on or after the 1st of October 2003. Different legislation applies to each of these periods. Full details are set out in a document produced by the Department of Local Government and Planning entitled "Guidelines for the Interpretation of Swimming Pool Fencing Requirements." Although the document is extensive, it highlights the maze and complexity of legislation that intending pool owners must comply with, for example, the Local Government Act, the Building Act, the Building Act Amendment Act, the Local Government Swimming Pool Fencing Amendment Act, the Standard Building By-laws, the Standard Building Regulations, the Integrated Planning Act and various Australian standards.

I recommend that the Queensland Parliament consider providing a single piece of legislation containing a uniform set of rules and requirements relating to the construction and fencing of pools, irrespective of their date of construction. I appreciate that this might require retrospective legislation, but I believe it is justified to protect the life of children.

(2) That local authorities institute a system to identify all properties in their local authority areas which have swimming pools, both in ground and above ground. For example, a highlighted tick box on rate notices requiring each rate payer to identify if a swimming pool is on that particular property to which the rate notice relates, which may ensure an accurate or a better database than currently exists.

(3) As previously recommended by the Deputy State Coroner in 2002, legislation to require a compulsory inspection of all properties and issue of a certificate of compliance with pool fencing legislation prior to settlement of all properties.

(4) I recommend that the Queensland Law Society and the Real Estate Institute of Queensland 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 any premises having a swimming pool be settled and that settlement is not able to be effected until there has been full compliance. In respect of this aspect, I also recommend that this be reinforced by legislation, requiring the certificate to be produced to the Department of Natural Resources before registration of a transfer is perfected.

(5) That the Australian Standards which relate to swimming pools be updated and upgraded.

(6) That all local authorities be required by legislation to institute a regular system of inspection of swimming pools (whether they be random or not) to ensure compliance by pool owners.

(7) Legislation giving local authorities appropriate powers to have serious defects attended to immediately as the current legislation allowing 24 hours to rectify defects allows a dangerous situation, when a swimming pool is full of water, to remain as an unacceptable risk.

(8) That all local authorities, and in this matter the Cairns City Council, be required to compile policies, practices and procedures and inspections regarding applications for the approval of domestic swimming pools and implement the same.

(9) That all local authorities implement a more proactive inspection campaign on existing swimming pools and their compliance with all legislation.

(10) An awareness campaign be undertaken by all authorities, both State and local, to promote training on resuscitation techniques, and an awareness to home owners of the extreme dangers of swimming pools and young children.

(11) That all local authority websites provide information or links to the relevant information relating to the swimming pool legislation and requirements.

(12) That legislation clearly sets out the right of enforcement officers to enter private properties to monitor compliance.

(13) That the local authorities utilise their powers to issue on the spot fines in order to create an awareness by property owners of their obligations to comply with fencing legislation.