QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of T a child aged 15 months**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2015/1080
DELIVERED ON:	18 December 2015
DELIVERED AT:	Brisbane
HEARING DATE(s):	16 November 2015, 16 December 2015
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, child drowning, swimming pool, gate propped open, supervision

REPRESENTATION:

Counsel Assisting:	Ms M Jarvis, Office of State Coroner
Hannah's Foundation:	Ms K Plint

Contents

Introduction

1. T was 15 months of age when he died after falling unnoticed into a partially filled swimming pool in a family member's backyard.

2. At around 5.30pm on Friday 20 March 2015, T and his mother were visiting his uncle at his property in Regency Downs, 45km west of Ipswich in Queensland.

3. T was playing with a plastic lawn mower in his uncle's yard whilst his mother was getting help to change a flat tyre on her car, which was parked next to the yard. This was twenty metres away from the pool area.

4. At some time, T's mother looked up and could not see T. She immediately began looking for him.

5. Also in the yard where T had been playing was an in-ground swimming pool. T's uncle was in the process of draining the pool and it was only about a third full with untreated, dirty water.

6. The pool gate was propped open with a length of wood.

7. Tragically, this is where T's mother found T, floating face down in the partially filled pool. He had no pulse, no heartbeat, and was limp and unconscious.

8. Following CPR attempts and emergency medical treatment by ambulance and hospital staff, T regained heart and lung function but remained unconscious and in a critical condition. The following day, 21 March 2015, T's life support was turned off and he died shortly afterwards.

9. A pathologist determined T's cause of death as 'hypoxic ischaemic encephalopathy following a near drowning event'. T's family agreed to organ donation, which took place.

10. This inquest followed an inquest held into the drowning-related death of another young child, William Corben in similar circumstances where issues concerning the propping open of a gate and supervision were raised. I determined that an inquest be held into T's death to help raise awareness of the risks to young children when they are playing in and around water.

11. As with William, it is hoped that upon hearing T's story, a pool owner may decide to take that one extra step that ends up being critical in preventing a tragedy such as the one experienced by T's family.

12. I gave leave to Ms K Plint of Hannah's Foundation to appear to make submissions and otherwise examine witnesses (subject to leave being granted), pursuant to s. 36(3) of the *Coroners Act 2003*.

13. Due to the distressing nature of the death and family dynamics, on 16 November I ordered that the surname of the deceased and deceased's family not be published. I was satisfied that the material that had been gathered during the investigation was sufficient to enable me to make my findings without directly hearing from the family members. Accordingly the only witnesses called were the QPS Investigating Officer Detective Sergeant Bronagh Gillespie of the Laidley Child Protection and Investigation Unit, and Mr Gary Shum, pool inspector of Lockyer Valley Regional Council.

List of Issues

14. At a Pre-Inquest conference held on 16 November 2015 the following issues were determined to be considered at the inquest:

- The findings required by s. 45 (2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death; and

- To discover what happened so as to inform the family and the public of how the death occurred, with a view to raising awareness and reducing the likelihood of similar deaths, including by way of preventive recommendations if appropriate.

The investigation

15. DS Gillespie prepared a comprehensive report for the coroner. She attended shortly after the incident. Unfortunately this was the second child drowning case she was investigating within days of each other. The other case involved a drowning in a dam, of which there have been a number recently.

16. During the coronial investigation into T's death, statements were obtained from T's uncle, the owner of the pool, as well as T's mother and all other adults present on that day. Scenes of Crime officers attended and photographs were taken.

17. T's mother stated that he was a healthy happy little boy. She had started him on swimming lessons around the age of six months and that had continued for some period. She believed he could swim to save himself; he knew how to get out of the pool and how to swim straight to the side.

18. T's uncle was renting the property from his father. In his statement, T's uncle explained that he had been in the process of draining the pool over a period of a few months. It seems he had not been using the pool and rather than expending money on chemicals decided to drain it, but this was taking some time. The pump was stopping and starting so about three weeks previously he started to prop open the gate to enable him quick and easy access should a blockage occur or the water level drop too low. It is evident the pool water was green and grimy and had a depth of only 31cm approximately.

19. T's uncle admitted that he had been lazy leaving the gate propped open and he regrets his actions. He was very distressed immediately after the immersion event and continues to be.

20. T's mother stated she had not visited the residence very often and T had only been in the pool once when he was a couple of months old. She was aware the pool was not maintained and they were draining the pool because they could not keep up the maintenance.

21. T's mother was dropping her other brother back to the residence. In total there were four adults present. She spoke to her older brother about the mechanical issues she had with her motor vehicle and he stated he might be able to help. They decided to switch the spare tyre and were jacking up the car to do so.

22. At the time T was running around the yard playing with a little plastic toy mower. He was racing backwards and forwards waving to her. She asked her brother's girlfriend to 'watch him for a sec'. She then went over to her brother to speak to him where he was at the motor vehicle. Later when she could not see T she yelled out to the others as to where he was.

23. The brother's girlfriend does not state that she was specifically asked to look after T. She had been talking to T's mother and had seen T walk between the pool fence and the shed and towards the trampoline. Two other children were playing on the trampoline. She specifically turned around to face the front gate to make sure none of the children went out the front gate. A few minutes later she heard T's mother asking where T was. She stated he had gone down to the trampoline with the other boys. They went looking there.

24. T's mother then went up the road towards the garage and then down to the shed. She asked one of the brothers to go down to the dam. She then went to walk past the pool and looked in and could see T's little red shirt floating on the top. She screamed and then ran around to the gate and tripped on the edge of the pool and landed on the pool steps. There was no water at the depth of the steps. She estimated the time frame from when she last saw T with the mower to when she found him in the pool was between 5 and 10 minutes. She could not recall whether the gate was open or shut although it was usually shut. I accept she is likely not to have realised the pool gate had been propped open.

25. T's mother started CPR. A neighbour with some hospital experience attended and took over. He was unresponsive, had no pulse and was not breathing. Queensland Ambulance Services were called and attended. T was taken to Ipswich Hospital and it is apparent that advanced resuscitation enabled them to obtain a heart-beat and he was breathing but not doing well. Down time without oxygen to the brain was calculated at just over 60 minutes.

26. T was stabilised and taken to the Lady Cilento Children's Hospital. He was GCS 3 on arrival and a CT scan found features consistent with hypoxic ischaemic injury to the brain. There was no evidence of cranial or facial fractures.

27. It is accepted that T's uncle had not intended to allow T this access to the pool. Rather, it appears that the adults present that day were not particularly alert to the fact that the pool gate was propped open, and the risk this posed for T. T and his mother did not visit his uncle's house on a regular basis. The visit that day had been unplanned. It is also apparent the adults' attention appears to have been focussed on changing the tyre on T's mother's car.

Autopsy examination

28. An external only autopsy examination was completed. This showed a well-nourished male toddler with growth parameters within the expected range. There was evidence of medical intervention and of post-mortem tissue donation.

29. There were several minor injuries to the face. It was considered that some of these may have been sustained as a result of falling into the pool and some may have been due to handling during resuscitation efforts. There was no evidence of skeletal trauma or other significant natural disease.

Council Pool Inspections

30. Lockyer Valley Regional Council records indicate a final pool inspection was approved in 1997.

31. It is evident that the pool had some history as three Pool Safety Nonconformity Notices were issued in 2011 although a pool safety certificate was finally issued later that year.

32. The LVRC inspection of the pool fencing and surrounds following T's death revealed a number of additional safety issues, including an ineffective self-closing mechanism on the pool gate, inadequate resuscitation signage, and climbing aids fixed to and near the pool fence that could assist a child to climb over and gain access to the pool.

33. Mr Shum who carried out the inspection on 24 March 2015 stated that he considered his inspection was for the purpose of preparing a report for the benefit of the coroner and initially did not consider he was carrying out a pool safety inspection per se. He passed this information on to his supervisor who told him he would follow-up any compliance issues. He was unaware as to whether there had been any consequences. He did not issue a nonconformity notice or on-the-spot fine. On questioning by Mrs Plint from Hannah's Foundation he stated that their current procedure was not to issue a Nonconformity Notice or on-the-spot fine but rather to talk to the land owners to obtain some voluntary compliance. He was unsure if the pool was currently compliant.

34. Nevertheless, even if all these safety issues had not been present, the very act of propping the pool gate open was enough. T, a fifteen-month-old child unaware of the danger, was able to walk freely into the pool area and enter the water.

Conclusions

35. In reaching my conclusions it should be kept in mind that a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.[1] 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.

36. If, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed a criminal offence, the coroner must give the information to the Director of Public Prosecutions in the case of an indictable offence, and to the chief executive of the department which administers legislation creating an offence which is not indictable.[2]

37. In this case submissions were made that it was not in the public interest to make any such referral and I agree.

38. Mrs Plint on behalf of Hannah's Foundation stated that since 2013 there had been 13 deaths in backyard pools and all related to some extent to the propping open of pool gates. Supervision or a lapse in supervision of course is always an issue in swimming pool child deaths. Hannah's Foundation, in conjunction with the Corben family, launched an awareness campaign 'STOP! DON'T PROP'. They are also advocating for changes to the law making it a criminal offence for breaching swimming pool legislation when a drowning occurs.

39. What this statistic says is that the enhanced pool safety and fencing laws that have been introduced into Queensland have been very successful. But deaths have continued to occur because of deliberate breaches of the pool safety laws by placing obstacles in front of gates, which effectively renders useless the safety features intended by pool fencing and compliant gates in the first place.

40. After T's death, T's mother issued this message for other parents [The Toowoomba Chronicle, 26 March 2015]:

> *Always make sure your pool gate is shut, check that it has closed correctly and never prop it open. Tragedies happen in a second; don't believe it can't happen to you.*

[1] s 45(5) *Coroners Act 2003*
[2] S 48(2)

41. That message is particularly pertinent to the events that occurred and is essentially the safety message that needs to be impressed on all pool owners over this summer holiday period.

42. T was apparently capable of swimming to save himself. However it is likely he fell and in the process hit his head and became unconscious. He was in the water for a 5 to 10 minute period, long enough to suffer the effects of drowning.

43. The capability to swim to save oneself is of course a significant prevention strategy, but is no substitute for compliant barriers to prevent unnoticed entry to pool areas or adequate supervision.

44. In this case T's mother thought she had asked another adult to look out for T. It is unclear if this was communicated with the degree of importance that may be expected. T's mother would not have noticed the pool gate had been propped open. In those few minutes where there had been a lapse in direct supervision and particularly because access to the pool was enabled by propping open the gate, T was able to enter, probably fell, hit his head and became unconscious and drowned in 31cm of water.

45. T's death was preventable. The circumstances of T's death highlight that even when a swimming pool is in a state of disuse or it is not expected that children will be visiting or using the pool, vigilance in preventing access by children to the pool must be maintained at all times.

Findings required by s. 45

Identity of the deceased – T

How he died – T drowned in a home swimming pool. Of particular significance was the fact that the pool entrance gate had been propped open enabling T to have easy access to the pool. A lapse in supervision was also contributory.

Place of death – Lady Cilento Children's Hospital, South Brisbane Qld 4101

Date of death– 21 March 2015

Cause of death – Hypoxic ischaemic encephalopathy due to drowning.

Comments and recommendations

At the conclusion of this inquest and the inquest in respect to the death of William Corben, I received submissions on a number of proposed recommendations. Those recommendations included proposals to introduce new legislation (Williams Law) making it a criminal offence where a death or serious harm occurs in a swimming pool where there are intentional breaches to pool safety. Such laws have been recommended by coroners in New South Wales but as far as I am aware have not been introduced. Such laws are the subject of some controversy as it may be argued that current laws relating to offences in the Criminal Code are sufficient.[3]

The evidence in this inquest as well as that of William Corben also suggests some concerns with respect to efficacy of the regime of pool inspections and training of inspectors.

I am also aware that a State Government Inter-departmental Committee for Pool Safety convened by the Department of Housing and Public Works is reviewing a number of aspects of pool safety including:

- Immersion Incident Reporting
- Pool safety Management Plans for Category 3 building such as resorts and hotels
- Pool Safety Inspectors and training
- Dam Drownings
- Whether there should be new offences for people who commit intentional breaches of pool safety and death or serious harm occurs.

I am informed that the committee's deliberations are nearing completion and may be released early in 2016. Accordingly it is my intention to postpone finalisation of any recommendations until such time as the committee's report has been received and my findings in relation to the death of William Corben have also been given.

What I can say at this time, given we are in the midst of summer holidays, is that I endorse the efforts of Hannah's Foundation and its attempts to raise public awareness about all aspects of pool safety. In particular, the message of not propping the gate open and to supervise vigilantly, will save lives.

I close the inquest.

John Lock
Deputy State Coroner
Brisbane
18 December 2015

[3] s 364A – Leaving a child under 12 unattended, s 289 – Persons in charge of dangerous things