IN THE CORONERS COURT

No: COR.103/05

AT IPSWICH

IN THE STATE OF QUEENSLAND

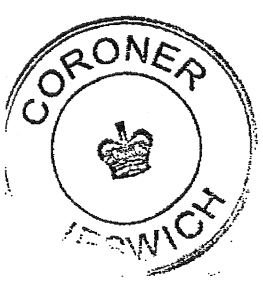
IN THE MATTER OF AN INQUEST INTO THE CAUSE AND CIRCUMSTANCES SURROUNDING THE DEATH OF **MATTHEW COLIN CASE**

FINDINGS ON INQUEST

CORONER : MR MCLAUGHLIN

HEARING DATES : 30/3/07; 24/7/07

FINDINGS DELIVERED: 24/8/07



FACTS NOT IN DISPUTE

On Saturday the 24th September 2005 at Goodna it was a hot day, with the maximum temperature recorded at nearby Amberley as 29.7 degrees. Between 1.30pm and 2.00pm Mrs Kelly Case arrived at the local public swimming pool, the Goodna Aquatic Centre. Mrs Case was accompanied by 5 children, namely her daughter Mandy aged 14; her son Michael aged 8; her son Matthew aged 3 years 11 months; her daughter Mikayla aged 18 months; and Mandy's friend Ellen Mann aged 15.

Mrs Case payed for the 5 children to enter the pool complex and she then left in her car. There were a number of signs positioned at the entrance to the complex including:

- A waist high "sandwich board" with red block letters on a white background stating

NO LIFEGUARD
ON DUTY

THIS POOL IS
OPERATING IN
LOW PATRONAGE
POOL MODE

- A head high sign with yellow background and black letters, attached to the wall stating

any person 12 years or under MUST BE accompanied and supervised by a person 18 years or older

- A waist high "sandwich board" with black block letters on a white background stating

ALL
PARENTS
MUST
SUPERVISE
THEIR OWN
CHILDREN
AT ALL TIMES

Following Mrs Case paying the fees, the 5 children entered the complex, which has 3 swimming pools. To the left of the entrance there is a hydrotherapy/learn to

swim pool with a constant depth of 1.1m. To the right of the entrance is the main, 25metre swimming pool, with a depth of 1.2m at the closest end, and 1.5 at the far end. In between those 2 pools is a shallow (40 cm deep) children's pool with 3 mushroom shaped fountains in it.

Mandy and Ellen took the 2 younger children to some chairs near the learn to swim pool, and Michael went swimming in the learn to swim pool. Matthew undressed himself and Mandy then put his swimming trunks on him. Matthew then went by himself to the children's pool and got into the water.

Mandy and Ellen then took Mikayla with them into the female dressing room, adjacent to the learn to swim pool, and changed their clothes. When they came back outside they applied sunscreen to Mikayla and shortly thereafter realised they could not see Matthew. They asked Michael who said he did not know where Matthew was, and so they started to search for him.

Two other teenage girls who were swimming in the main pool discovered Matthew lying motionless at the bottom of the shallow end of that pool, near to a disability ramp in the corner of the pool. They retrieved him and he was then removed from the pool. No person saw Matthew enter the main pool.

Kristopher Allen, an employee of the complex operator, was alerted and he, along with other persons at the pool, performed CPR on Matthew with the assistance of oxygen resuscitation equipment stored at the complex. Ambulance officers arrived and took over the resuscitation attempts, however Matthew could not be resuscitated. An autopsy revealed the cause of death as drowning.

Mr Allen was the only employee at the complex at the time and he was primarily occupied in the building at the entrance, both to charge patrons entrance fees, and to serve in the kiosk. At times he walked around the pools, especially when he needed to speak to children about their unruly behaviour. Mr Allen was qualified pursuant to the Royal Life Saving Society Australia (RLSSA) as a Pool Lifeguard, and also held Bronze Medallion and Oxygen Equipment Resuscitation qualifications. There had been other employees present earlier however only Mr Allen was present after 1.30pm.

Records indicate a total of 268 patrons attended the pool complex on the 24th September 2005. The exact number of people in attendance at the time Matthew drowned is uncertain, however estimates from different people range from 40 to 66. The number of people actually in the water at the time is also uncertain, but it seems reasonable to assume the number was less than 50, especially given that Mr Allen estimates there were about 50 people at the complex in total at the time, and obviously not every person is in the water at one time. A Ms Judy van Wyk, who was working as a learn to swim coordinator at the complex earlier in the day, separately estimated the total number of people present at 12.30pm to be 50.

The pool complex was operated by Australian Crawl Pty Ltd, who leased the facility from the Ipswich City Council. Mr Allen was employed by Australian Crawl Pty Ltd.

There is no legally enforceable protocol, code of practice or set of guidelines in place for the operation of public swimming pools in Queensland. The RLSS has however published a document titled "*Guidelines for Safe Pool Operation*" which states as its purpose "*To establish the minimum safety content of Swimming Pool Operations Manuals*", and these guidelines are commonly adopted by the operators of public pools. Australian Crawl had voluntarily adopted these guidelines. In addition, the lease agreement for the premises required the lessee to meet various "*performance requirements*", including at least 10 random quality inspections by the lessor each year which must not result in "*2 consecutive unsatisfactory assessments of the same criteria*".

The RLSS guidelines contain requirements for "*bather supervision*" in public pools and also have a specific set of supervision requirements for "*Low Patronage Pools'*. In essence, the requirements are relaxed for low patronage pools, no doubt for practical reasons including costs. A Low Patronage Pool is defined in the guidelines as "*A venue that consistently has fewer than 50 patrons in the water at any one time*". Attendance records indicate the Goodna Aquatic Centre fits this definition, even though attendances on the day in question were somewhat higher than usual for a Saturday, perhaps because of the hot weather.

The general RLSS guidelines provide for at least 2 people to be on duty at a public pool, including a qualified lifeguard who should be "*supervising, facing and watching the people in the water at all times*", and dressed in "*distinctive*", preferably red and yellow, clothing. The recommended minimum ratio of lifeguards to people in the water is one lifeguard for up to 100 people. In contrast, the Low Patronage Pool guidelines provide for a "*responsible*" and "*mature*" person who is an RLSS qualified Pool Lifeguard to "*be in attendance at all times*".

A section of the guidelines titled Parental Supervision applies to all pools including Low Patronage. It provides:

4.1 Children under 10 years should not be allowed entry unless under supervision of a person 16 years or older.

4.2 Parents or guardians (including those persons described in section 4.1 above) should supervise their charges at all times and as such should be dressed ready for action including unexpected entry to a pool.

4.3 Signage or literature indicating the parental supervision policy of the pool is recommended.

FACTS IN DISPUTE

The only factual matter of any real significance which is in dispute is relation to what happened when Mrs Case left the children at the pool complex.

In an interview with police on the day in question, Mrs Case said :

"*Well we arranged to go and take and - go to the pool with the kids and then we didn't have enough room in the car so I left my eldest one at home, the two girls and the kids went to the pool and I said to the guy behind the counter the attendant 'I'll be back soon', he said 'Yep righto I will keep an eye on them for ya', and I was "Mandy please you know... ', '...yep yep not a problem', she's looked after them heaps of times before never a problem.*"

At the inquest she gave further evidence :

"*...the whole day was planned to – so I could go to the hairdresser's which was changed when my son was meant to come with us in the car, but then he was with his girlfriend having a fight and we left and he rung me and said ' You know, I've just missed you, can you come back and get me', and so by the time I dropped the kids off, the hairdressing appointment was already there so I just went back, got my son, said 'We're going back to the pool', and I, you know, and by the time I got to the pool, I'd spoken to the guy and said I would be back, 'I'm going to get my eldest son and we're coming back'.*"

And later she said

'*...and I told him (sic. – the attendant) there and then that I would be leaving to – and be back within half an hour to pick – of picking my son up..... He just took my money for the kids, and he just kept standing there. I turned around to my daughter, told her to keep an eye on the kids, 'I'm not going to be long'. He was still standing there. I yelled out to my youngest 'cause he started walking away, told him to come back. Mandy took a few steps away, I took a few steps away. I stood there. Mandy turned back around to me and goes 'What's the matter?' I said 'Oh you know 'cause I haven't left them before', and she goes 'It'll be alright mum. We've done it before', and the guy behind the counter goes 'Look, it's okay. I'll keep an eye on them for you', and she turns around and goes 'See mum, it'll be okay'.*"

Later still she said

" *'I will keep an eye on them' – they're the actual words that he – that I clearly remember, because that was the point where I thought, well okay you know, that sort of give me the – not assurance, but a bit more comfortable when – and then I actually left whereas I was hesitant and I just kept standing there.....That was, everyone was still behind me. Mandy was holding Michaela..... I turned back to Mandy and I said 'Just make sure you keep an eye on them' and she goes ' Yes, it'll be alright' and I said 'Just make sure'.*"

She was asked :
"*When did you make up your mind that you weren't going to go to the hairdressers?*"
To which she replied
"*Oh, as soon as I left this place here.....as soon as I got in the car I just thought, 'No, I'm just going to get Mark and I'm coming straight back'.*"

This last answer is clearly in conflict with her earlier evidence, since she could not have told the attendant she would be back after collecting her eldest son if the decision to collect him was not made until she returned to her car. The "eldest son" was not called at the inquest and has not provided any statement.

She was asked if Mandy knew of the change of plan and she said
"*Oh, she knew I was going back to pick Mark up and coming back to the pool.*"

Mandy Case was also interviewed on the day in question. When asked if she knew what time Mrs Case dropped her and the children at the pool she said :

"*About twenty to two....yeah, because she was in the car and she had a hair appointment at a quarter to and I said she's going to be five minutes late, it takes ten minutes to get back.*"

Mandy made no mention of the attendant saying he would keep an eye on the children, and also made no mention of any knowledge of any change of plan whereby instead of going to the hairdresser, Mrs Case was going to pick up her son Mark and return to the pool. She was not called to give evidence at the inquest.

Ellen Mann was also interviewed on the day in question. She said

"*.....after she dropped us off, she was going to get her hair done and it's like the main reason we were taking them so she could get her hair done because like they annoy her, like.*"

Again there was no mention of the attendant saying he would keep an eye on the children, or of any change in plans to pick up the son and return. Again Ms Mann was not called to give evidence at the inquest.

A patron at the pool, Tania Tainui gave a statement to police in which she said

"*I recall seeing a woman arrive with two females who appeared to be in their early teens, a younger male, a toddler and a baby. I observed the woman pay at the reception. I recall thinking due to the way she was dressed that she was going to drop her kids at the pool and leave (she was wearing a strapless blue dress and dressy high heel platform shoes). I saw her walk to the front of the canteen, then turn around and walk out.*"

The attendant, Kristopher Allen provided a handwritten statement on the day in question to an inspector from the Division of Workplace Health and Safety, and in

that statement made no mention of any conversation with Mrs Case. On 28th August 2006 he was interviewed by the same inspector, and the interview was recorded. He was asked
"*Do you recall Mrs Case telling you that she had to leave and that she would be back soon*?"
He replied
"*No.*"
He was asked
"*Did you say 'Righteo, I'll keep an eye on them for you*?"
He replied
"*No.*"
He was asked
"*Do you think that that statement concerning those words 'Righteo, I'll keep an eye on them for you' would be common for you to say something like that*?"
He replied
"*No.*"
He was asked
"*Have you ever given any guarantees to anyone at the complex that you'd do that*?"
He replied
"*No, I can't guarantee.*"

At the inquest he gave further evidence. When asked if he agreed to keep an eye on the children, he was adamant he did not do so and said
"*That's not my responsibility.*"
He also said
"*Well, our main goal isn't to supervise kids as to, as such, baby sit them, but supervising as in to save a life if they're in the water.*"
He was asked
"*So you say you would never, ever volunteer to keep an eye on someone's children*?"
He replied
"*No.*"
He was asked
"*It would just never happen at all*?"
He replied
"*No.*"

He also agreed he would not allow children without an adult to enter the complex and could offer no explanation for how the Case children were allowed in without their mother.

Mr Justin Lemberg gave evidence that he was a director of Australian Crawl Pty Ltd from 2000 until late 2006. He is a qualified Bronze Medallion pool lifeguard and is a current surf club president. He has represented Australia as a swimmer at Olympic Games, Commonwealth Games and Pan Pacific Games. He did not believe that any pool lifeguard would agree to personally supervise any swimmer as that is not correct lifesaving policy.

Having regard to the evidence I have referred to, I am unable to accept the evidence of Mrs Case as to the events at the time she dropped the children at the complex. There is no evidence to support her version. If her version was correct, surely Mandy would have been aware Mrs Case was returning shortly rather than going to the hairdresser. Indeed, Mrs Case said Mandy was aware of this. Presumably Ellen Mann would have also been aware. Both girls indicated they believed Mrs Case was still going to the hairdresser, and neither mentioned Mandy saying "See Mum, it'll be okay" after Mr Allen allegedly said he would keep an eye on the children. The son Mark could have been called to confirm his mother had agreed to return and collect him. The various versions of Mrs Case given at the inquest became more embellished and self serving as they went on, and of course all of those versions were inconsistent with her making the decision to collect her son "as soon as I got in the car".

I accept the evidence of Mr Allen that he did not, and would not, agree to "keep an eye" on any children at the complex. He is a trained lifeguard and it is not correct policy to do so. Such an undertaking would be in clear conflict with the signs at the entrance advising no lifeguard was on duty, and that parents must supervise their own children. Further, it is obvious that he would simply be unable to do so having regard to him being largely occupied working behind the counter.

I am therefore satisfied that Mrs Case left the younger children under the supervision of the older children only, and that she intended to be gone for a considerable time to attend at a hairdressing appointment. I am also satisfied that, on that basis, the younger children should not have been granted entry to the pool complex, as this was in breach of the RLSS guidelines, Australian Crawl policy, and the signage at the entrance.

SAFETY ISSUES

A number of safety issues were raised concerning the design of the Goodna Aquatic Centre.

Firstly, there were concerns as to the design of the disability ramp in the main pool where Mathew drowned. The ramp commenced in a corner of the shallow end of the pool and ran along the side of the pool for some distance, continually sloping deeper into the water. On one side of the ramp there was therefore the side of the pool. On the other side there was a railing which sloped into the water, parallel with the ramp. Concerns were raised that the railing could be used by children to swing and play on, which was dangerous, and also that a child walking down the ramp might slip and go under the rail and off the edge of the ramp, thereby falling suddenly into deeper water.

Both concerns were rectified subsequent to the day in question by the installation of a series of vertical bars under the railing. The original railing complied with the applicable Australian Standard, and in hindsight the rectification seems a sensible step which merits consideration in the Australian Standards. It should be mentioned that

there is no evidence that Matthew Case did walk on the disability ramp, or pass under the railing. He was found near the ramp and therefore the ramp may have contributed into him getting into difficulty, although this is really no more than speculation.

Secondly, there were concerns raised about a raised edge around the main pool which in effect created a "blind spot" in part of the pool for a person observing the pool from the ticket office/kiosk. It was suggested that if a child did fall off the disability ramp into deeper water, that the raised edge would prevent a person in the office/kiosk from observing this. Again, there is no evidence that this is what happened with Matthew Case, however the issue should be considered from a general safety point of view.

The first observation I make on this matter is that the RLSS guidelines require lifeguards to have "*regular rotations or changes in duty or supervision area to assist in avoiding lapses in attention or occasional involuntary rest periods*" and "*Ideally a lifeguard should change his or her point of supervision or duty activity every fifteen minutes, and no longer than every thirty minutes*". Mr Lemberg gave evidence that even if a lifeguard was sitting in a raised tower it would be difficult to observe all parts of all pools at the Goodna Aquatic Centre. He said that the preferable method for a lifeguard to keep a pool under observation is to regularly move around, as provided in the guidelines.

The second observation I make is that Mr Allen was not acting as a lifeguard at the time as the pool was in low patronage mode and there was in fact no lifeguard on duty. Mr Allen was therefore not expected to be able to observe all of the pools from his position in the office/kiosk, and neither could he be expected to keep the pools under observation while he was busy with other duties.

In my view therefore, the issue of the "blind spot" is missing the point that when a lifeguard is on duty, he or she should be moving around regularly, so that all parts of the pool can be regularly monitored, regardless of the fact that from some points of observation some parts of a pool may not be fully visible. In the present case I see little, if any, significance in the fact that a person serving in the office/kiosk, who is not acting as a lifeguard, may not be able to view the entire swimming pool.

The third safety concern raised was that there was no physical barrier between the shallow children's pool and the main pool, which made it all too easy for a child to quickly travel, unnoticed, between the two pools. Evidence was given that at some similar pool complexes a hedge or a fence line had been placed between pools to address this issue. The Ipswich City Council has now erected a straight line fence between the pools at the Goodna Aquatic Centre. This obviously does not prevent a child walking from one pool to the other, but makes the trip slower as they must now walk around the end of the fence. Clearly, unless the child is being kept under observation the fence will have little impact, since a child arriving at the deeper pool a few seconds later than would otherwise be the case can still drown once in the deeper pool.

Some discussion was had as to whether it would be advisable to fully fence the children's pool to make it impossible for a child to get to the deeper pool. I agree with

the submissions made that the purpose of a pool fence is to keep children out of a pool unless they are supervised by an adult who can open the gate in the fence. To put a fence around the children's pool would invite supervising adults to consider the child was somehow protected and therefore in less need of observation, whereas experience shows that a child can drown in very shallow water when not properly supervised. Put simply, the whole pool complex has a fence around it and it is the responsibility of parents to ensure their children are constantly under observation while they are inside that fence, regardless of which particular pool they are in.

RLSS GUIDELINES

The guidelines state that their object is to "establish minimum safety content" of pools. That is, they are not intended as a rigid code of practice. As Mr Lemberg said in a written statement

"*I should say that I regard such Guidelines as being precisely that – guidelines. It is quite impossible to be so arbitrary where the safety of swimmers is concerned. For example, it may be that, although fewer than 25 people are in the water, a lifeguard should nevertheless be present because the swimming group is comprised of mainly young children. On the other hand, there may be 60 people in the water, all of whom are adults who are undertaking advanced swimming training, and none of whom will be likely to require a lifeguard.*

In the case of all management staff, they are directed to make judgments about staffing levels on a day by day and hour by hour basis. If they feel there is a need to have more lifeguards on duty, they are told to err on the side of caution."

The safest policy of course would be to not have special requirements for Low Patronage Pools and therefore expect every public pool to have a lifeguard on duty at all times. I accept however that if this was mandated, the practical effect would be that pools with low attendances would become uneconomical to operate, and they would close. The places most likely to be affected would be small and remote towns, where presumably the public pool would be one of the few public facilities available for the enjoyment of the residents.

This public policy consideration must be weighed against the desire to achieve maximum safety. A sensible balance needs to be found. While the number of 50 people in the water which has been chosen for the "cut-off" for a Low Patronage Pool is arbitrary, some figure must be chosen if there is to be a relaxation of requirements for Low Patronage Pools. Evidence was given that at one stage the number of people was reduced to 25, but after considering submissions from pool operators the original figure of 50 was reinstated. Considering these are minimum requirements, I see no need to interfere with the current guidelines.

There is an obvious advantage to making the guidelines compulsory, otherwise there is no obligation on a pool operator to achieve any minimum safety standard at all. I agree with Mr Lemberg though, that the guidelines are simply a guide as to minimum standards, and that in some circumstances additional measures are warranted. It would be impossible to create an exhaustive code of practice to suit every situation, and the operators must use their discretion from time to time as circumstances vary.

OTHER SIGNIFICANT INCIDENTS

Evidence was given about a number of other significant incidents at the Goodna Aquatic Centre.

At about 11.45am on Monday the 20th December 2004 Ezra Little, aged 2 years, was found floating face down in the main pool near the disability ramp. The information about this incident is brief and vague, however it appears that while the mother of the child was at the pool complex, she was not aware of the situation until the child had been removed from the pool by a lifeguard who was on duty at the time, and who noticed the child was in trouble. The child was initially unconscious and not breathing, but coughed and began breathing when placed into the recovery position. There were 3 employees at the complex at the time, including the lifeguard.

As with Matthew Case, no person has said they saw the child get into the pool, and as with Matthew, this again seems to be a case where the parent of a young child was not properly supervising their child. Given that Ezra was found near the disability ramp, there is again a suspicion that he may have been on the ramp and slipped under the railing. Again this is really speculation, and again the railing has been modified to prevent such a possibility occurring again.

On the 14th May 2005 between 7.30am and 11.45am, Emma McConnell, aged 16 years, was apparently found by friends at the bottom of the pool, not breathing. The friends retrieved her and successfully performed resuscitation on her. No staff at the pool were aware of the incident, and it only came to light when her mother reported it by telephone 2 days later to Ken Chandler, Pools Superintendent with the Ipswich City Council. Three learn to swim teachers at the pool at the time knew nothing of the alleged incident. Despite repeated attempts to obtain information from Emma's mother, the mother failed to provide any contact details for the friends who allegedly rescued Emma, and any further investigation was therefore frustrated. Her mother indicated Emma had been on a "power walk" before going to the pool and that she suspected Emma had "pushed herself too hard" and as a result had "blacked out". She was said to be undergoing tests with her doctor.

Given the lack of information with this incident, it is impossible to make any comment on how it may have been prevented.

On Wednesday the 19th October 2005 two boys apparently had a collision in the water and as a result one of them, Ben Roydhouse, was rendered nconscious. The boy's parents performed CPR while a lifeguard prepared oxygen resuscitation equipment, but before the equipment was used he was revived. This is thankfully a case where clearly the parents were supervising their child and that supervision paid off.

At 3.55pm on the 4th October 2006, Baxter McFadzean, aged 4 years, was pulled unconscious from the learn to swim pool by his mother. Diana Lipke, who was conducting a learn to swim class at the other end of that pool, noticed the mother with the child. She and other staff used oxygen resuscitation equipment to successfully

revive the child. Again this is a case where proper supervision by a parent was rewarded with a positive outcome.

Apart from the obvious evidence that parental supervision is the key to safety of children in swimming pools, there was another issue of real concern in relation to all of these incidents.

Mr Les Mole gave evidence as an expert on public swimming pools, lifesaving, and safety issues. He was the executive director of the Royal Life Saving Society of Queensland from 1994 until 2005. He is a highly qualified pool lifeguard and has wide experience in the design and management of public pools.

Mr Mole gave evidence that there is no official database which keeps track of "near drownings" or "major incidents" at public pools, unless the person actually drowns or is hospitalised. While individual pool operators have their own records and often report such matters to a lessor of the premises, there is no central record where the entire state can be monitored. Clearly, if lessons are to be learned from near tragedies, hospitalisation should not be the criteria by which records are or are not kept. Surely if a child is found unconscious in a pool and is revived at the pool without being hospitalised, this is an important matter. This is precisely the sort of information which would, for instance, assist the RLSS in deciding whether the "cut – off" figures for a Low Patronage Pool should be revised, and whether other safety measures are considered necessary.

Mr Mole advised that drownings in public pools are quite uncommon, and that in the last two years in Queensland, there have been two drownings, including Matthew Case. Statistics on drownings alone will therefore be minimal and this further justifies keeping statistics of all significant incidents, to get a true indication of the effectiveness of existing safety measures.

WORKPLACE HEALTH AND SAFETY

Officers from the Workplace Health and Safety division of the Queensland Department of Industrial Relations were involved in the investigation of the death of Matthew Case.

Two inspectors from WHS attended the complex late in the afternoon of the 24th September 2005. They issued a "*Prohibition Notice*" to the management which had the effect of shutting down the complex until management had ensured there were "*adequate controls in place to ensure public safety*". In the part of the standardised notice where the inspectors were required to "*Describe briefly the circumstances that have caused the risk or are likely to cause a risk*", they simply indicated that a person had drowned in the main pool. There was absolutely no mention in the notice of what the inspectors considered was unacceptable from a safety point of view, or what controls they considered needed to be implemented to address their concerns.

Remarkably, the senior inspector, Mr Kickbush, gave evidence at the inquest that "*It is policy that we do not tell them what to do.*" He said that an operator could be

prosecuted for not complying with the notice, but that it was entirely up to the operator to decide what were "adequate controls", and that they could resume operations as soon as they believed they had complied with the notice. It hardly needs to be said that this approach is absurd.

If the Prohibition Notice is to be of any benefit, then the inspectors, aided by suitable experts if necessary, should list the measures they require to be taken, and the prohibition should not be lifted until they have certified there has been compliance with the notice. As it presently stands, the Prohibition Notice seems to be no more than a self serving document designed to protect WHS from any suggestion they have failed to take appropriate action.

In the present case the inspectors indicated at the inquest that the primary basis for their concerns was that they suspected there was insufficient supervision of swimmers by staff, and they were particularly concerned that Mr Allen was largely occupied in the office/kiosk rather than acting as a lifeguard. It is apparent that at the time of issuing the Prohibition Notice they were unaware of the RLSS guidelines, and particularly the Low Patronage provisions.

In a written report prepared in 2006 WHS set out a number of failures they identified on the part of Australian Crawl Pty Ltd. They quite rightly identified that the operator failed to stop the unaccompanied Case children entering the complex. They also quite rightly, in my view, noted that there were inadequate practices in place to ensure the operator remained aware of the total number of persons present and the number in the pool at any one time. The management gave evidence at the inquest that they have now implemented a practice of regular head counts of people in the water, so that additional staff can be called to duty if necessary. As discussed earlier, these head counts also must take account not only of the number of people, but the age of the people, their swimming skills, how many parents are present and so on.

There were a number of other alleged failures set out in the report which demonstrate to me a lack of understanding of the Low Patronage guidelines. Apart from general assertions that Australian Crawl had " failed to .....identify hazards" and "failed to identify and assess what level of supervision was required", they alleged specific failures to

- *"Provide sufficient lifeguards to effectively supervise....."*
- *"Provide lifeguards with distinctive coloured clothing."*
- *"Ensure the lifeguard on duty at the Goodna Aquatic Centre on 24 September 2005 carried with him the minimum protective equipment."*
- *"Provide lifeguards with appropriate breaks from duty, or the ability to change points of supervision or duty activities to ensure maximum effectiveness of supervision."*

They also alleged

- *"The Australian Crawl Pty Ltd lifeguard on duty at the Goodna Aquatic Centre on Saturday 24 September 2005 failed to provide adequate supervision of the swimming facility to ensure the safety of patrons."*
- *"On Saturday 24 September 2005 Australian Crawl Pty Ltd lifeguard on duty at the Goodna Aquatic centre failed to maintain concentrated observation of the pools, in order to anticipate problems."*

Remarkably again, these comments were included in the report even though the report also acknowledged the RLSS guidelines, including the Low Patronage guidelines. The report also acknowledged the various signs at the entrance to the complex.

Plainly, there was no lifeguard on duty on the 24 September 2005 because the pool was operating in Low Patronage mode, and those matters were clearly stated in signs at the entrance. In low patronage mode a qualified lifeguard must "be in attendance at all times" however that person is not required to "supervise" swimmers; wear "distinctive coloured clothing"; carry "protective equipment"; have "breaks from duty, or the ability to change points of supervision", or "maintain concentrated observation of the pools".

Regrettably, the WHS Prohibition Notice, and subsequent investigation, appear largely to be a waste of time, carried out by ill informed staff who persisted with their findings even in the face of the QLSS guidelines. At the inquest Mr Kickbush belatedly accepted that Australian Crawl Pty Ltd did comply with the Low Patronage guidelines.

FINDINGS

I make the following findings

- The person who died was Matthew Colin Case, born 18 October 2001.
- Matthew died when he got into an adult public pool while unsupervised. Unnoticed, he sank to the bottom of the pool where he was later discovered lying motionless. Attempts at resuscitation were unsuccessful.
- Matthew died on the 24th September 2005.
- Matthew died at the Goodna Aquatic Centre, 135 Brisbane Tce., Goodna.
- The cause of death was drowning.

COMMENTS

Pursuant to the Coroners Act, I may make comments which I believe may help to avoid similar deaths in the future.

I am mindful of the grief and guilt which will no doubt haunt Mrs Case for the rest of her life following her decision to leave the children at the pool. I accept that she is a loving and caring parent and that this decision was a tragic error of judgement on her behalf.

Even so, there is no escaping that the starting point with this drowning is that if Matthew had been properly supervised by an adult he would in all probability not have drowned. Whether the drowning occurred at a public pool, a private suburban back yard pool, at the beach, in a river, or even in a bathtub, the same comment would apply. Young children in and around water deep enough to pose a threat must be kept under constant adult supervision.

Certainly, lifeguards at a pool or at a beach can make swimming for children (and adults) safer. They are trained in rescue and resuscitation to assist in emergencies, and they can help to maintain order when numerous people are swimming together. It has never been a function of lifeguards, however, to act as a baby sitter for young children in the water. That is the parents' responsibility. How can any lifeguard be expected to keep any individual under constant observation while supervising a group of people? He can at best keep a general observation on the group so that if anyone gets into obvious distress he can assist, as for example where a parent calls out that their child is in trouble.

There is a need for minimum safety standards at public pools to be regulated. Paying patrons are entitled to at least expect that there will be a person on hand who is able to perform CPR and other resuscitation in the event of an emergency. While the RLSS guidelines are helpful in that regard, they are not mandatory. An unscrupulous operator could legally implement no safety procedures at all, and even if WHS served a Prohibition Notice there would be no assurance that acceptable measures were implemented, as it is up to the operator to decide what those measures should be.

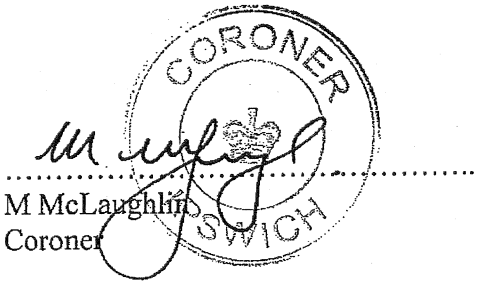
While the cut off for Low Patronage Pools which do not require a lifeguard to be watching the water at all times is arbitrary, there are sound public policy reasons for having some cut off. The alternative is that pools with low attendances would close because they were uneconomical to operate. The cut off figure should be regularly reviewed taking into account all matters including financial concerns, and statistics to reflect the effectiveness or otherwise of the current cut off figure. Regardless of what guidelines are in place, and whether or nor they are mandatory, there will always be a need for pool operators to continue to monitor the situation and to make adjustments as they become necessary.

Bearing these matters in mind, I make the following recommendations

1. Minimum safety standards at public pools should be made enforceable by The Department of Industrial Relations implementing an appropriate code of practice or set of protocols. The RLSS guidelines would appear to be a good starting point.
2. The guidelines, whether enforceable or not, should be regularly reviewed, and in this regard it is essential that a central data base be established to collate statistics of all significant safety related incidents. A mandatory reporting system for such incidents is also necessary.
3. Workplace Health and Safety need to redefine their involvement in such matters. If they are to have any meaningful function they need to spell out what operators need to do to achieve acceptable safety standards and they also need to conduct reviews to ensure compliance with their directions.
4. The Australian Standards for the railing on a disability ramp in a public pool should be amended to require vertical bars to prevent a person slipping under the rail into deeper water off the edge of the ramp.
5. The minimum safety standards should include a requirement to regularly make a head count of people in the water and to also note the proportion of small children or other people who might be considered not to be likely to be a

strong swimmer. This information should then be used to make a judgement as to whether a lifeguard or further lifeguards should be on duty.

I offer my condolences to the family of Matthew Case and now close this inquest.



.....

M McLaughlin
Coroner