

IN THE CORONERS COURT)
AT CANBERRA IN THE)
AUSTRALIAN CAPITAL TERRITORY) CD 13/2005

**INQUEST INTO THE DEATH OF
KALED KANJ**

FINDINGS

Delivered on Thursday, 29 October 2009, by Chief Coroner R J Cahill

Appearances

Ms Margaret Hunter, Counsel Assisting the Chief Coroner
Mr Ian Bradfield, for Ms Jasmina Kanj (instructed by Darryl Perkins,
Solicitors)
Mr J Sabharwal for the Canberra International Sports & Aquatic
Centre (instructed by Meyer Vandenberg, Lawyers)

1. In regard to this inquest, I did indicate my views in the hearing of 17 August 2009. I am now taking the opportunity to hand down my formal findings and reasons therefor, in writing.

PART 1 – THE LEGISLATIVE SCHEME

2. I will briefly set out relevant provisions of the *Coroners Act 1997* (the Act), in accordance with which I undertook the inquest into the death of Kaled Kanj, a child of 2 years of age. Kaled died due to drowning in the swimming pool at the Canberra International Sports & Aquatic Centre (CISAC), Eastern Valley Way, Belconnen. Under section 13(1)(b), a Coroner must hold an inquest into the manner and cause of death of a person who is found drowned.
3. Section 52(1) sets the following matters on which a Coroner must make findings:
 - “(a) identity of the deceased; and

- (b) when and where the death happened; and
- (c) the manner and cause of death; and
- (d) in the case of the suspected death of a person—that the person has died.”

4. Section 52(3) of the Act provides that “At the conclusion of an inquest...., the Coroner must record his or her findings in writing”. Section 52(4) provides for the discretion of a Coroner to comment “on any matter connected with the death.....including public health or safety or the administration of justice”.

5. Section 55 of the Act sets out the procedure that a Coroner must follow if he or she is to make an adverse comment in relation to a person:

“55 Adverse comment in findings or reports

- (1) A coroner must not include in a finding or report under this Act (including an annual report) a comment adverse to a person identifiable from the finding or report unless he or she has, making the finding or report, taken all reasonable steps to give to the person a copy of the proposed comment and a written notice advising the person that, within a specified period (being not more than 28 days and not less than 14 days after the date of the notice), the person may—
 - (a) make a submission to the coroner in relation to the proposed comment; or
 - (b) give to the coroner a written statement in relation to it.
- (2) The coroner may extend, by not more than 28 days, the period of time specified in a notice under subsection (1).
- (3) If the person so requests, the coroner must include in the report the statement given under subsection (1) (b) or a fair summary of it.”

I am not proposing to make comments under section 55.

6. A Coroner may make recommendations to the Attorney-General on any matter connected with an inquest, pursuant to section 57(3) of the Act, which provides as follows:

“ 57 Report after inquest or inquiry

.....

- (3) A coroner may make recommendations to the Attorney-General on any matter connected with an inquest or inquiry, including matters relating to public health or safety or the administration of justice.”
7. Section 58 of the Act directs a Coroner with regard to processes that must be followed where the Coroner has reasonable grounds for believing that a person has committed an indictable offence. I find that in relation to this matter, I have no reason to act under section 58.
8. I will be making recommendations to the Attorney-General with respect to measures for the safety of children using public swimming pools.

PART 2 – FACTUAL FINDINGS

9. On 12 January 2005, at approximately 1:45 pm, Ms Jasmina Kanj went to the CISAC for a swim with her four children Aleksandra aged 11, Roksandra aged 9, Kaled aged 2 and Lyla aged 9 months. Kaled could not swim and did not wear any flotation devices when in the pool. The pool was crowded and noisy due to the number of people in the area.
10. The swimming centre comprises a 50 metre pool, a leisure pool which leads into a 25 metre lap pool, a water slide and a spa. The water slide and spa are situated in the southern side of the complex at the side of the leisure pool and 25 metre lap pool. The spa is fenced off from the rest of the complex.
11. The leisure pool starts at the western end of the centre near the entrance near the coffee shop area. The leisure pool consists of a beach area where the water level is at zero with the pool gradually becoming deeper until an area where there is an isthmus on peninsula which opens into the 25 metre lap pool. On the northern side of the leisure there is a circular shaped pool called the whirlpool.
12. The beach area of the leisure pool is designed for toddlers whilst the rest of the pool, which gradually becomes deeper, is designed for bigger children. The pool then has an opening from the leisure area to the lap pool where the lap pool can be accessed from the leisure pool. This area is designed for swimmers who wish to swim laps.
13. The three children entered the wading pool (leisure pool). Ms Kanj sat on the edge of the pool holding her daughter

Layla. Ms Kanj indicated that she observed the children wading further into the pool towards a tiled wall area, at this point the water was approximately waist high on Kaled.

14. Ms Kanj then entered into the pool, whilst holding onto Layla, to follow the children. She said that she was closely following a child whom she believed to be Kaled. As she followed the child, she heard a woman screaming at a male person whom Ms Kanj believed to be a life guard. She further stated that at that time she observed a child being removed from the bottom of the pool to her right.
15. Then only she realised that she had lost sight of Kaled. She immediately started screaming out for children. Ms Kanj watched as Kaled was placed on his back by the life guard on the island (the peninsula) and saw the life guard and two women commence cardiopulmonary resuscitation (CPR). Mr Scott Gruber was the life guard, and the women who were helping him were Ms Belinda Hurdis, a general trained paediatric nurse and Ms Christine Mead, another nurse.
16. Kaled was taken to the Calvary Hospital where he was pronounced dead at 2:25 pm.
17. Mr Gruber is a qualified and experienced lifeguard. He was on duty to patrol set areas – namely, the leisure pool. Mr Gruber was stationed on the southern side near the beach area and the water slide whilst another lifeguard, called Pete, was watching the whirlpool area.
18. Mr Gruger, in his evidence, indicated that people were everywhere in the pool so that it was difficult to see what was going on and was also difficult to keep an eye on everybody. He estimated that there were about 100 people in the leisure pool and the 25 metre lap pool area. He also said that there were a lot of kids jumping around the pool, like little kids jumping in and out of the area, especially the area around where the spa area is.¹
19. During this time two girls came up to him and told him something that he could not quite hear and they then got out of the water and informed him that there was a boy floating and not moving. He looked but had difficulty seeing Kaled as there was a lot of people in the water. When he saw the boy he tried to alert the other life guard, Pete, and then he jumped into the pool at the peninsular area, retrieved Kaled turned him over, gave him 2 quick breaths, checked for a

¹ Transcript (t/s) p 105.35

pulse, and could not find one. He then took Kaled to the side of the pool at the peninsular area where the leisure pool goes into the 25 metre lap pool, placed him onto the peninsular deck and commenced CPR. Mr Gruber noticed that Kaled appeared to be pale at that time.

20. Shortly afterwards two ladies came to assist him. Ms Hurdis heard someone yell out “little boy” and saw the boy being pulled from the pool. She said that the boy was blue, had no femoral pulse or heart beat and it appeared that he had aspirated water. The lifeguards retrieved oxygen, a Gudels airway and an ambu bag to aid the resuscitation. Ms Hurdis continued to assist Kalid and later assisted the paramedics in intubating Kaled.
21. Ms Mead, a nursing sister with experience in Emergency, ICU and paediatric and neonatal intensive care, heard a female scream. She looked up and saw something being lifted onto the island area of the leisure pool near the 25-metre pool where the water cannon was situated, and made her way through the pool to where the boy had been placed. She remained in the pool and said the water was about waist height.²
22. Ms Mead observed Ms Hurdis, had commenced mouth-to-mouth and found out that no one had checked for a pulse. Ms Mead then checked and upon finding none commenced cardiac compressions. She also observed that Kaled was centrally and peripherally cyanotic [blue], flaccid and unresponsive.
23. As the women said they were nurses, Mr Gruber handed over the resuscitation to them and alerted Pete who then called for an ambulance. Aquatics co-ordinators Mr Andrew Hankin, Mr Owen Peter Watson and Mr Graham Shaw were also assisting in the CPR effort. Mr Gruber evacuated the pool so that it would be easier for the paramedics to come in. Whilst he was assisting with CPR he said that he saw a woman who stated that Kaled was her child and that she was standing about 3 metres away from the child in shallower water toward the beach area of the pool.
24. The lifeguards arrived with an ‘air-vivor bag’ and Ms Mead placed the mask over Kaled’s face and squeezed the bag to blow air into his lungs. Ms Mead also placed a Guedel’s

² t/s p 63

airway to assist in keeping a clear airway. A lifeguard had attempted to incorrectly insert it and she had to take over.³

25. During the resuscitation process Kaled made no response to her efforts. Once the ambulance arrived Ms Mead continued to perform cardiac compressions and assist the paramedics in getting Kaled ready for transportation to hospital.⁴ When the ambulance officers checked Kaled's pupils they were fixed and dilated.⁵
26. Ms Mead said that she heard Kaled's mother say words to the effect of 'Oh my God, that's my boy or son or something like that'. Ms Mead said in the proceedings as follows: 'She [*the mother*] said, "I only left him for a minute" and I think something about "I left him with the girls" or "The girls were looking after him" or something like that' (*words within square brackets added*). Ms Mead then heard her say something about "I went to get a towel"⁶
27. Ms Mead said that there were many people in the pool and that where the mushroom was in the whirlpool it was difficult to keep track of children and that they could loose their feet.⁷ She also considered that the number of people in the pool could create a danger in not being able to see into the pool as well as when the spa operated which created bubbles making it even harder.
28. Mr Gruber said that he had been on pool deck for about 15-25 minutes when he was alerted about Kaled. He also said that he had rescued several small babies who had fallen whilst their parents were talking and also several children getting out of their depth.

PART 3 – ISSUES

29. With the tragic death of Kaled surfaced some issues of concern about the management and structure of the swimming pool at the CISAC.
30. Mr Hankin was concerned that there were no instructions about the maximum number of swimmers and children possible in the pool and about how many people should or should not be in the leisure area was left to the lifeguards to

³ t/s p 60

⁴ t/s p 62

⁵ t/s p 59

⁶ t/s p 65.15

⁷ t/s p 63

decide.⁸ He also said that the leisure area used to get overcrowded and that it was a stressful environment and had not been addressed.⁹

31. Mr Gruber in his evidence that in a congested pool it was difficult to see what was going on and, on the day of Kaled's death it was difficult to keep an eye on everybody that was in the pool.¹⁰ He also said that when a lot of kids were jumping around the pool, especially the area around the spa, it was more difficult for him to see if any child was face down in the water.¹¹ It appeared that assessment of how many swimmers was done visually. From the evidence of Mr Gruber and Mr Hankin, there were 6-8 or 7-9 life guards on duty during holiday sessions.
32. Mr Hankin was of the view that in the leisure area, which goes from very shallow to a little deeper and then deeper again, one could see children having trouble getting back when it got about to their depth and said that indeed there had been incidents of that type in the past.¹² He said, "We'd get the kid out and move them across and let them know that they've got to stay in the leisure area, not in the 25m pool because it's too deep".¹³ In those cases an incident report would be filed.
33. Mr Hankin also that there was signage of the rules of entry in the entrance to the aquatics centre and that the sign set out what parent's responsibility were, including that they must accompany their children at all times.
34. He considered,
 - (a) that guard towers would have assisted in better visualising swimmers; and
 - (b) that it would have also been better to block off the area where the 25-metre pool leads into the leisure pool. He said, "Well, obviously a pool that's open, people are going to swim in that area. They're not going to think that pool's blocked off. They're obviously going to swim over that area, regardless of how old they are."¹⁴

⁸ t/s p.211-212

⁹ t/s p.213

¹⁰ t/s p.95.

¹¹ t/s p.110.

¹² t/s p 206

¹³ ibid

¹⁴ t/s p 206

35. Mr Peter Hunt of Peter Hunt and Partners, Perth, WA, was the architect who designed the CISAC pool complex. He provided helpful evidence about the structure and design of the pool. His evidence was as follows:

The pool was built to the appropriate guidelines as set out in the Royal Life Saving Society, Australia's Guidelines for Safe Pool Operation.¹⁵ As suggested by the name the leisure pool was designed for the purposes of play rather than lap swimming. The design features a 'beach area' which starts with zero depth of water to simulate the waves lapping on the sand and gradually with a gradient of 1:15 becomes deeper as would happen at the beach with the depth of 900mm at the point where the leisure pool goes into the 25metre lap pool.

The pool is meant to represent the beach and has a whirlpool to simulate waves. The whirlpool area is surrounded by plantar boxes of foliage and a green and red spotted mushroom as a central feature. This design is said to give the impression of a tropical paradise. The beach area is behind the whirlpool area.

36. Mr Hunt considered that the plantar boxes and foliage would not hamper vision of lifeguards because lifeguards and attendants supervise from all sides of the pool and, when walking around, should have good vision of the pool.
37. Mr Hunt suggested that the peninsular area with the water cannon, which is the area where the leisure pool opens into the 25-metre lap pool, is designed to be a point where static lifeguard monitoring can be achieved. This is said to have been the area Ms Hannah Haggarty-Steiface saw Kaled lying face down. It was Ms Haggarty-Steiface and her friend Ms Rachel Carn who got the life guard's attention to Kaled.
38. Mr Steven Eccelston, National Manager of Aquatic Industry Services for the Royal Life Saving Society of Australia, who attended the CISAC pool with the Chief Coroner and Counsel Assisting, also indicated that this is the good position where a life guard to be in but they should not be static.¹⁶
39. Mr Hunt was of the view that the younger children would splash and play in the very shallow beach area and the older children would play in the area where the depth increases. The tile colour changes to indicate change in depth and to

¹⁵ Exhibit 54

¹⁶ t/s p.3

indicate change in use of the pool.¹⁷ The leisure pool as it gets deeper goes into a narrow isthmus with the peninsular area where the water cannon is situated. Mr Hunt said that the reason why the area between the leisure pool and the lap pool is not separate is for reasons of heating the pools and cost and also greater flexibility of use in that area.

40. In Mr Hunter's view, supervision is the key to addressing this issue of children moving from the shallower area to the deeper area of the pool. He also said that it is possible for temporary floating barriers to be placed to separate the two areas.
41. Mr Eccleston noted that there was an observation tower which would be a good viewing point. In his report, he indicated that there were blind spots in the leisure pool area and he noted at the pool visit that the point where the whirlpool is obstructed by planter boxes would be an area that could have some problems.
42. Mr Eccleston suggested the following:
 - (a) the level of trees created a blind spot in the spa area and should be removed or trimmed;
 - (b) the facility should apply a risk assessment approach when determining how many life guards should be on duty so that it is important to have good vision at all times;
 - (c) the mushroom in the centre of the whirlpool should be removed as it is an area where children may wish to congregate;
 - (d) there needs to be more prominent signage at the entrance to CISAC and on the pool deck, especially the leisure pool area, setting out parents' responsibility for their children;
 - (e) there needs to be signage to indicate that parents should keep children at arm's reach at the point the depth increases;
 - (f) any closed off area should have signage that no life guard is in attendance;
 - (g) it is good management to keep a log of all incidents that occur in the pool and the incidents should be reviewed and risk assessments undertaken; and
 - (h) all pools should have an audit from the Royal Life Saving Association and any audit recommendations should be implemented.

¹⁷ t/s p 236

PART 4 – FORMAL FINDINGS UNDER SECTION 52 OF THE ACT

43. Pursuant to section 52 of the Act, my formal findings are as follows:

- Kaled Kanj, aged two years, died in the Emergency Department of the Calvary Hospital, Belconnen on 12 January 2005. The death occurred most probably between 13:50 and 14:00, and the life was pronounced extinct at 14:25 hours.
- The manner of his death was that he attended the swimming pool at Canberra International Sports & Aquatic Centre, Belconnen in the afternoon of 12 January 2005, along with his sisters and mother, Ms Jasmina Kanj. Not long after, Ms Kanj lost sight of Kaled as she also had responsibility of her 9-month-old baby. Soon thereafter, Kaled was observed floating face down in the water. The life guard retrieved Kaled and commenced cardiopulmonary resuscitation (CPR) which was then continued by two nurses who happened to be present at the pool at the time. Kaled was then taken to the Calvary Hospital Emergency Department where, even after efforts to resuscitate him, he succumbed to death.
- The cause of Kaled Kanj's death was drowning (immersion).

PART 5 – SUBMISSIONS FROM THE FAMILY AND CISAC

44. It is evident that the CISAC pool management and staff acted appropriately in dealing with Kaled's drowning. The pool had more than twice the number of recommended life guards per swimmer ratio (which is 1:100.) in that they had between 6-8 guards patrolling on deck to approximately 350 patrons. [Mr Richard Shaw, acting Aquatics Manager at the CISAC, estimated that there were 350 patrons, with approximately 150 patrons in the whole of the pool area, which consists of the 25-metre pool and the leisure pool.] Counsel for the family, Mr Ian Bradfield, submitted, however, that "there was no clear evidence as to how the extra staff were allocated to alleviate the overcrowding".
45. The lifeguard Mr Gruber acted immediately and appropriately when informed that Kaled was found floating. It was extraordinary that two highly trained paediatric nurses were in attendance from the time Kaled was brought out of the pool.

46. Certainly the resuscitation was done in a professional and competent manner. As submitted by Counsel Assisting, it is most likely that Kaled had been dead for some minutes prior to his being noticed floating face down in the pool. Dr Sanjiv Jain, pathologist at the Canberra Hospital, said, in his evidence, that Kaled could have died longer than 5 minutes before he was pulled out of the pool.¹⁸
47. It is clear that Kaled could not swim and was not wearing any flotation device. It was difficult for his mother, Ms Kanj, to monitor all four children and this was exacerbated because of the crowded pool making it difficult for her to keep an eye on Kaled. Her confusion is evident from what she said that she was looking at another little boy thinking he was Kaled – it was at this time Kaled was found face down. I agree with Counsel Assisting that it would have been very difficult for Ms Kanj to keep track of the three children in the pool as well as attend to a 9 month old baby. Again, I agree with Counsel Assisting that “[i]t may have been prudent to have a flotation device on Kaled but even then the responsibility still lies on the adult supervising to keep them at arms length.”
48. Evidence of Mr Gruber and Mr Hankin indicates that there were previous incidents of children getting into difficulties in regard to the leisure area where children had walked down to a certain depth and could not walk back.¹⁹
49. Counsel for the family submitted that such incidents indicated that the CISAC had knowledge that the incline in the pool “had previously (*caused*) and continued to cause problems at the time of Kaled’s death to small children as they couldn’t turn around and go back to the safety area” (*the word in italics added*). However, evidence does not indicate that the incline in the pool contributed to Kaled’s death. It appears from the evidence of Mr Geoffrey Ninnis, a consulting engineer, that the slope gradient at the pool conformed to the guidelines of Royal Life Saving Society of Australia.²⁰
50. The first life guard to be in action to save Kaled was Mr Gruber. From the position he stood he could not see Kaled floating face down. This could be due to the combination of factors such as overcrowding of the pool, noise, several kids jumping in the area in which Kaled was

¹⁸ t/s p. 73.42

¹⁹ t/s p.110 and p.206

²⁰ t/s 14

floating and bubbles. Mr Eccleston suggested the positioning of a life guard near the slide in the leisure area. It is not clear to what extent it would have been possible for a life guard in that position to promptly detect a 2 year old boy drowning in the condition of the pool at the time Kaled died. The only way, I believe, the attention of a life guard in that position could have been drawn was by someone shouting or showing signs that the child was in trouble. From the position Mr Gruber stood, I note, he was not able to hear two girls calling out to him that a boy was floating. Then they had to go up to him. It does not seem that the result would have been different if he was able to hear them and moved into action immediately.

51. The family pointed the evidence - that bushy areas, mushrooms and the general presentation of the area restricted the view of life guards, that there was a lack of any distinction or clear markings of depth from the entrance area to the deeper area abutting the 25-metre pool, that the pool was overcrowded, and that confusion in the pool was aggravated when the jets were on – as indicating lack of care on the part of the CISAC. The family argued that the overcrowding and lack of observation causally contributed to Kaled’s death, and that not having an observation platform in the peninsula area was partly causative of the death of Kaled.
52. The family further contended “contributing factors included not just the overcrowding but the aggravating factors of: loss of view because of the bubbles; the presentation of bushes and other objects impeding the sight of lifeguards; and the construction of the pool causing problems for young person to turn around and return to the safe area, {particularly in a crowded environment}”.
53. The family also submitted that that “there was no effective or safe procedure in place for assessing the whirlpool and the leisure pool to take into account the age of the user, the use of the spa area and the activities undertaken in the area”.
54. The matters that the family contend are important for me to consider with a view to making recommendations under section 57 of the Act, and for the CISAC to address with a view to enhancing the safety of children who use the pool. Nevertheless, within the perspective of the coronial jurisdiction, I am unable to regard those matters as directly causative or contributing to the death of Kaled.

55. I agree with Counsel for the CISAC that there is no basis for finding that there exists a duty incumbent on a life guard to supervise children at the pool. They are there to save any one encountering difficulties while using the facility. Kaled's drowning would not probably have been noticeable to Ms Kanj as she was she was looking after other three children, including her baby of 9 months old. As a parent, and as notified in signage at the entrance to the facility, she would have known that she had to primarily and closely care for her son who did not know swimming and had no flotation device. She would not have expected Kaled to move away from her arm's reach. In fact, she was looking at the wrong child thinking he was Kaled.
56. No doubt, the overcrowding of the pool, noise, a number of kids jumping in the pool and bubbles – all would have contributed to her slight distraction.
57. Indeed, her parental responsibility to each of her children would have increased with her undertaking to enter the pool with all of her children, in particular, including her 9 month old baby and a child who could not swim and who did not have a flotation device. The CISAC signage of allowing entry to the pool was for children less than 10 years of age to be supervised by adults.
58. Counsel for the family submitted that the payment of entry fee increased “the duty of care on the proprietors for the safety of the area including the provision of facilities which would prevent overcrowding of specific areas, particularly those accessible to young children who couldn't swim”. I reiterate my finding that from the perspective of the coronial inquest the issues that this inquest notes that the CISAC would need to address to enhance the safety of children at the swimming pool did not appear to have directly or indirectly causally contributed to the death of Kaled. I do not agree that the payment of entry fee had shifted to the CISAC the parent's responsibility to keep the child, who could not swim, at arm's length, or diminished that responsibility.
59. Counsel for the CISAC referred to the High Court decision of *Roman Catholic Church Trustees for the Diocese of Canberra & Goulburn v Hadba* [2002-05] 221 CLR 161 as authority for the proposition that “in order to succeed on a claim for breach of a duty to supervise, it is incumbent to demonstrate that there was some system of alternative supervision to that being used at the CISAC at the time of the incident that was free of all the risk complained of and which was available in

a practical sense”, and submitted that there is no evidence that there was an alternative method available.

60. *Hadba* decision concerned a primary school playground incident in which an eight year old student suffered injuries after being pulled off a flying fox apparatus by a fellow student. The supervising teacher had momentarily turned her back on the flying fox. The High Court took into account several factors including that there was no previous incident and concluded that the school was not in breach of duty of care given the magnitude of the risk of injury was not high, nor was the degree of probability of its occurrence.
61. There was no previous incident of a child accompanied by a parent drowning in the CISAC pool. If there was a compliance with the parental supervision, the risk of death by drowning of a child or the probability of drowning would not be high. My views are expressed from the point of this inquest, the aim of which is to establish the manner and cause of the death. Therefore, my observations on the issue of duty of care would not be determinative if the matter was pursued in another forum.
62. I am pleased to understand that there was a complete audit of the safety of the pool at the CISAC and it came through with good results.
63. Counsel for the CISAC submitted that the CISAC had implemented many of the recommendations of the Royal Life Saving Society, Australia, noted in the report by Mr Eccleston dated 5 June 2007, including:
 - (a) the removal and reduction in plants located in the planter boxes to enable greater visual supervision of the pools;
 - (b) the removal and reduction in trees and plants separating the spa and sauna area from the pool concourse;
 - (c) the removal of the mushroom feature located in the children’s water area;
 - (d) continued and ongoing lifeguard training;
 - (e) the implementation of the “Keep Watch @ Public Pools” program, which includes Royal Life Saving Society of Australia-accredited information signage and information cards handed out to parents whose children are further than reaching distance from parents; and
 - (f) the completion of voluntary, annual safety audits.

PART 6 – MY RECOMMENDATIONS

64. I make the following recommendations arising from the Eccleston report, some of which may have already been covered by the recommendations implemented by the CISAC:
- (a) All public pools in the ACT must have an audit by the Royal Life Saving Society of Australia and implement any recommendations in respect of that audit.
 - (b) Risk assessments should be done especially when there is large numbers in the CISAC swimming pool and the assessments should be recorded. Recommended minimum ratio of lifeguards to people in the water is 1:100, but a risk assessment should be completed to vary this ratio taking into consideration a range of factors such as weather, holidays, size, number and layout of pools, surface reflection, average attendance, anticipated attendance, swimming capabilities, special needs individuals and groups, the number and distribution of users, and recreational activities (programmed or spontaneous). All areas of the pool, including the pool floor must be scanned and scrutinised on a regular basis.
 - (c) Signage in relation to parental or adult supervisor responsibility must be well signposted in large lettering. It should be posted prominently in areas of danger to encourage adults to keep their children at arms length, and posted at reception on the “Conditions of entry” and then, on entry to the aquatics area on the “Aquatic Rules”. It should state that “Children under 10 must be supervised by an adult at all times when in the aquatics area”.
 - (d) Signage in relation to pool behaviour should also be prominent and should be in an area where it is able to be well visualised such as the entry turnstiles and also on the pool deck.
 - (e) Educational pamphlets should be available at the entry to the pool.
 - (f) Depth indicators should be displayed in the area where depth is changing with signage such as ‘DEPTH INCREASES – 0.6 TO 1.2M PARENTS KEEP CHILDREN AT ARMS LENGTH’.

- (g) Sufficient lifeguards should be provided to ensure that all the areas of water and people therein can be supervised easily without obstruction from any object. Blind spots and areas where there is sun glare must be considered when deploying lifeguards.
- (h) Where the whirlpool entry is restricted by a lane rope, there should be a sign posted to indicate that the area is closed. Preferably, the sign can read as “No Access beyond this point. Whirlpool Closed to Public: No Swimming in this area”
- (i) Consideration should be given to
- (i) recording every incident which resulted in the intervention of a lifeguard;
 - (ii) setting a limit to the number of users of different areas of the pool and that limit be effectively monitored by staff;
 - (iii) having at least two lifeguards constantly moving in the area between the shallower and deeper area of the pool, giving particular attention to children who cannot swim;
 - (iv) highlighting changes in gradient of the pool floor with a contrasting colour, in particular area between the toddler/leisure pool and the area outside of it; and
 - (v) providing a minimum of four training sessions per year to lifeguards at quarterly intervals, directly related to the aquatic facility of which the lifeguard is employed, and the training should include, but not limited to,
 - revision and practice of emergency procedures
 - practice of initiative assessment of and response to simulated incidents
 - revision of lifesaving skills
 - resuscitation
 - oxygen equipment
 - first aid
 - retrieving a person from the deepest part of the pool
 - special needs populations;
 - public relations; and
 - practical water work.

65. Even if all safety arrangements are in place, it is important for a parent accompanying a child who cannot swim to know that the result of momentarily losing sight of the child could be fatal, as had happened in this case.
66. I note with approval that, subsequent to the tragedy that led to this inquest, the CISAC management had already made substantial improvements to the facility in the interests of user safety.
67. Finally, I express my personal sympathy to the parents and siblings of Kaled Kanj for the untimely loss of their loved son and brother.