NEW SOUTH WALES STATE CORONER'S COURT

File Number: 3503/09

Name of Deceased: Meika Hawes

Hearing Dates: 22 – 24 August 2011

Location of Inquest: Broken Hill Local Court

Date of Finding: 24 August 2011

Coroner: Magistrate P.A. Mac Mahon
Deputy State Coroner

Representation:

- Sergeant S Kelly, Coronial Advocate assisting the Coroner

Note: Certain evidence given during this inquest is subject to a non-publication order pursuant to section 74(1)(b) of the Coroners Act 2009. See over for details of the orders made.

Non-publication order made pursuant to Section 74(1)(b) Coroners Act 2009:

The publication of photographs 19, 20, 21, 22,23 and 24 at Tab 8 of Exhibit 2 tendered in the proceedings together with any other photograph of Meika Hawes taken following her death is prohibited.

Findings made in accordance with Section 81(1) Coroners Act 2009:

Meika Hawes (born 22 June 2006) died at the Broken Hill Hospital on 30 November 2009. The cause of her death was drowning that occurred when, due to a failure of her carers to adequately supervise her and the non-compliance of a door leading to the swimming pool constructed in the backyard of her home with the provisions of the Swimming Pools Act 1992, she was able to enter into the swimming pool and because of her age, inexperience and lack of swimming ability was unable to escape there from.

Recommendations made in accordance with Section 82 Coroners Act 2009:

To: The Minister of State responsible for the administration of the Swimming Pools Act 1992

That the Swimming Pools Act 1992 be amended so as to:

- Require that all swimming pools be registered with the local government authority for the area in which they are situated,
- Require that within a specified period all swimming pools be required to be brought into compliance with Australian Standard AS1926.1 – 2007,
- Require that all owners of property on which swimming pools are constructed be required to provide a certificate of compliance with the provisions of the Swimming Pools Act 1992 to the relevant local government authority on a periodical basis,
- Provide that the right of entry to properties for the purpose of inspection of swimming pools provided to local government officers contained within the Swimming Pools Act 1992 be extended so as to allow such officers entry in order to determine whether or not a swimming pool exists on a particular property.
- Provide that where inspections of properties are undertaken by officers of a local government authority the authority be entitled to impose a fee for the purpose thereof that allows the authority to recover the actual and incidental costs of such inspection.

To the Minister of State responsible for the administration of the Conveyancing Act 1919

That the Conveyancing (Sale of Land) Regulation 2010 be amended so as to require that a certificate of compliance with the

provisions of the Swimming Pools Act 1992 be a prescribed document where the property the subject of a contract for the sale of land has erected thereon a swimming pool.

To the General Manager Broken Hill City Council

That the policies and procedures of the Broken Hill City Council be reviewed with a view to ensuring that where issues relating to compliance with the safety provisions of the Swimming Pools Act 1992 are identified, either at the initial construction stage or at a later time, effective action is taken to ensure that compliance is brought about in a timely manner.

To the proprietor L J Hooker Conveyancing

That the policies and procedures of the organisation be reviewed so as to ensure that where it is acting for a purchaser of a residential property on which is constructed a swimming pool the terms of the warning concerning swimming pools contained in Clause 15, Schedule 1 of the Conveyancing (Sale of Land) Regulation 2010 be brought to the specific attention of the purchaser and it be recommended to such purchaser that, if one is not already attached to the contract of sale, a certificate of compliance with the provisions of the Swimming Pools Act 1992 be obtained.

Introduction

1. Meika Hawes (who in these findings I will refer to as Meika) was born on 22 June 2006. In November 2009 she resided in Broken Hill with her mother, her older sister Allison Hawes and her cousin Jodie Palmer.
2. Meika was the daughter of Lorraine Underwood and Clement Smith however the relationship between her mother and father had ceased prior to her birth. There were family law arrangements in place that meant although she resided with her mother she had regular contact with her father.
3. Ms Underwood had commenced studying nursing at the Broken Hill TAFE in 2009. On 30 November 2009 she was to submit her last assignment for the year. She completed the assignment and at about 6.30 pm left for the TAFE College. When she left the family home in addition to her daughter Allison and niece Jodie there was also present Lorraine's brother David Hawes and Allison's boyfriend Jacob Verburjt.
4. At about 8.05pm Ms Palmer left the computer that she had been using and went to make a cup of coffee. She looked into the backyard and saw that the family dog was in an enclosure that contained a swimming pool. She wondered how the dog had got into the enclosure and went to find out.
5. As she approached the enclosure she noticed Meika in the pool. She quickly extracted her from the pool and commenced cardiopulmonary resuscitation (CPR). She also called for help. Ambulance officers arrived at 8.20pm. Meika was taken by ambulance to the Broken Hill Hospital and arrived there at 8.50pm.

6. Unfortunately despite the efforts of family members, ambulance officers and the staff of the Broken Hill Hospital Meika was unable to be revived. She was declared life extinct at 9.22pm.

Jurisdiction and function of the Coroner

7. Section 81(1), Coroners Act 2009 (the Act) sets out the primary function of the Coroner. That section provides, in summary, that at the conclusion of an Inquest the coroner is required to establish, should sufficient evidence be available, the fact that a person has died, the identity of that person, the date and place of their death and the cause and manner thereof.

8. Section 82 of the Act provides that a coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths. It is not the role of the coroner to attribute blame.

Identity, Date and Place of Death:

9. The identity, date and place of death were not matters of contention in this matter. Allison Moloney, a friend of the family who had known her for about a year, identified Meika. Dr Kerrie MacDonald declared Meika deceased at the Broken Hill Hospital on 30 November 2009. I

accept the evidence of Ms Moloney and Dr Mac Donald on these matters.

Cause of Death:

10. Dr MacDonald expressed the opinion that the cause of Meika's death was drowning. Dr K Nadesan, a forensic pathologist, undertook an external examination and did not find any suspicious injuries. He found that on the basis of his examination, and the information he had available, the cause of death was consistent with drowning. I accept the evidence of Dr Mac Donald and Dr Nadesan and am satisfied that the cause of Meika's death was drowning.

Manner of Death:

11. The manner of death relates to the circumstances of, or what led to, the death of an individual.

12. Meika was said to be an intelligent and inquisitive three-year-old young girl. On 30 November 2009 she was at her home with four adults. During the investigation of Meika's death each of the persons that were present made statements they also gave evidence at the inquest.

13. Lorraine Underwood confirmed that she left the house at about 6.30pm for TAFE and left her daughter in the care of the adults who were at the house. She had done so on many previous occasions and was confident that Meika would be cared for.

14. David Hawes had been at the house for most of the day. He was using a computer playing computer games. At about the time Lorraine left for TAFE he made some noodles for Meika to eat. Mr Hawes then returned to the computer. Meika, having eaten some food, went outside to play with the dog.

15. At about 7.30pm Mr Hawes went outside and saw Meika playing in the backyard. He told her to go inside. She did not want to do so. Mr

Hawes did not push the point and left her in the backyard playing. He then left the house and returned to his own home where he had dinner that had been prepared for him.

16. Mr Hawes said in evidence, but not in a statement given at the time, that he told the other adults at the house that he was leaving to go home.

17. Ms Palmer also gave evidence. She stated that about 8pm she got up from her computer to make a coffee for herself. It was then that she saw the dog in the pool enclosure and she subsequently found Melika.

18. It was her evidence that her last memory of Meika was of her having some food that had been prepared by Mr Hawes. She said that she did not know that Mr Hawes had left the house and thought that he was caring for Meika.

19. Allison Hawes also gave evidence. After Lorraine Underwood left for TAFE she was playing on a play-station with her boyfriend Jacob Verburgt. She said that during the afternoon Meika would come into the room in which they were for a short time and then go out again. She also said that she did not know Mr Hawes had left the house. When Ms Palmer got up to make a coffee she followed her into the kitchen and noticed that Mr Hawes was not there. She then looked for Meika and shortly thereafter saw Ms Palmer carrying Meika from the pool enclosure. She phoned for an ambulance.

20. Jacob Verburjt also gave evidence he confirmed that he was playing a play-station with Allison Hawes. He followed her out to the kitchen at about 8pm and noticed that Mr Hawes was not there. He also said that he did not know that Mr Hawes had left the house. Mr Verburjt took over the CPR on Meika until the ambulance arrived.

21. All three year-old children are inquisitive and quick. It is essential that they be actively supervised so as to ensure that they do not get into situations that can cause them harm. I am satisfied that on 30 November 2009, after Mr Hawes left the house, there was no effective supervision of Meika.

22. I am satisfied that the last person to see Melika alive was Mr Hawes. It was Mr Hawes's evidence that he told the other adults that he was leaving the house. I am not satisfied that he did so.

23. In the statements given at the time, and in their evidence at the inquest, all the other adults stated that they did not know he had left. They, by implication, thought he was looking after Meika. It was only some two years later that Mr Hawes said that he told them he was leaving. I am satisfied that he either did not tell them he was leaving or if he did he did not say it in a way that communicated the message in a way that was heard. Either way once he left the house at about 7.30pm Meika was in the backyard without supervision.

24. It is accepted that no matter how vigilant carers of children are there will be times or circumstances in which the supervision of children is not effective. Governments have recognised this and where swimming pools are constructed in residential properties they are required to be fenced in a manner that meets the requirements of the Australian Standard applicable at the time of construction. This requirement is to be found in the Swimming Pools Act 1992 (the Pools Act).

25. In the case of Ms Underwood's property in April 2000 the then owners applied to the Broken Hill City Council (BHCC) for approval to construct the swimming pool. The pool was subsequently constructed.

26. There was some delay on the part of the BHCC in ensuring that the swimming pool was compliant with the provisions of the Pools Act.

27. In June 2004 a review of BHCC records found that a final inspection had not taken place. An inspection of the pool enclosure occurred on 1 July 2004 and found that *"the fitted glass doors need to be self-latching."* The then owner was advised to bring about compliance.

28. There was a further inspection on 21 July 2004 and the enclosure doors were then found to be compliant with the Pools Act.

29. In 2007 Ms Underwood purchased the property. She did so through L J Hooker Conveyancing. It was her evidence that at the time of the purchase, although she knew there was a pool on the property, there was no discussion about whether or not it complied with the provisions of the Pools Act.

30. She said that she was not advised to obtain a compliance certificate nor was she advised what was required in respect of pool fencing for it to comply with the safety requirements of the legislation.

31. It was Ms Underwood's evidence that*:*

> *"When we had to shut the pool doors I had to manually twist the handle to latch them together and lock them. It had been like this since the day I bought the home."*

32. The Australian Standard for pool safety fencing requires that gates or doors in pool fencing must be self-locking. This was not the case at the time of her purchase nor was it the case on 1 December 2009 when police inspected the property. Thus prior to the death of Meika the door was not compliant at all times during Ms Underwood's ownership of the property.

33. On 14 July 2001 at my request police arranged for the property to be reinspected by a BHCC officer. The pool at that time had been drained however the door was still not self-latching.

34. Ms Underwood gave evidence that she regularly checked the doors to ensure that it was locked but conceded that if the door was not manually latched *"Meika could have easily pushed the doors open."*

35. Following Meika's death police examined the pool enclosure. A walk through video and still photographs of the enclosure were available as exhibits during the inquest. The examination established to my satisfaction that the only way Meika could have entered the pool enclosure was through the doors. It was Ms Underwood's evidence that if the door was latched it could not be opened without the use of the door handle. That handle was too high for Meika to reach.

36. Ms Underwood did not think that rattling the doors would open the latch however during the walk through on 1 December 2009 DSC Crowley showed that it could be done with little effort. The fact that a adult could do so does not mean however that a three year-old child could.

37. I am however satisfied that the latch was in fact not on the door on 30 November 2009 and that Meika was able to enter the pool enclosure by pushing the sliding door open.

38. Ms Underwood said that she checked that the latch was on the day before Meika drowned. This may be the case however on 30 November 2009 the evidence was that at about 6pm Scott Palmer, the brother of Jodie Palmer, came to the house to collect some boxes to assist him in moving house. He said that he opened the door to the pool enclosure and commented to his sister about the dirty water in the pool. He then let the doors close and thought that they locked when they closed. He did not manually apply the latch. Mr Palmer said that he did not have to unlatch the door to open it.

39. It is not necessary for me to determine if the door was latched prior to Mr Palmer opening it. I am however satisfied that when he closed the door he did not latch it.

40. I am therefore satisfied that from the time Mr Palmer left the area the door to the pool enclosure was able to be opened by Meika. She had been left in the backyard unsupervised and was able to enter the pool enclosure and then the pool. Once in the pool she was unable to extricate herself and subsequently drowned.

Recommendations:

41. As previously mentioned the role of the coroner is to investigate the circumstances of an individual death, to find out what happened and why and having done so try to learn from the circumstances of the death.

42. Meika's death was a tragedy for both the family and the community. The death of a young child is always a tragedy as their life and potential is taken from them. In this case, as is the case in every backyard swimming pool drowning of a child, the death was preventable.

43. Once again, as has been found to be the case in most coronial investigations of such matters, the failure of supervision and the failure to comply with the safety requirements of the Pools Act were the matters that contributed to the death. In this case, as is often also the case, lack of understanding of the requirements of the Pools Act appears to have been a factor.

44. In this case as I have already found there were long periods of non-compliance. The construction appears to have occurred in about April 2000. It was non compliant on 1July 2004. It was found to be compliant on 21 July 2004 but by January 2007 was again non-compliant and remained so until 30 November 2009. On this

calculation it would seem that the maximum period of compliance between 2000 and the date of Meika's death was some three and a half of almost ten years.

45. I have made recommendations in other matters that there be mandatory periodic inspection of backyard swimming pools. This matter once again draws attention to the need for such inspections. I propose to repeat the recommendations that I have previously made in this regard.

46. Mr Geoff Laan, the Building and Environmental Health Manager of BHCC gave evidence during the course of the inquest. He estimated that there were some 250 to 300 swimming pools within the jurisdiction of BHCC. The BHCC was however not in a position to know exactly how many pools actually existed.

47. Mr Laan's evidence was that he could not advise how many of the pools that exist were compliant with the Pools Act. There was no statutory requirement for regular inspection and the BHCC did not have the resources to conduct such inspections on a voluntary basis itself. The BHCC would, however, react to requests for inspections and complaints that they received.

48. Notwithstanding the evidence that the BHCC would react to complaints it appears that it did not do so in this case. Mr Laan inspected the property on 1 December 2009 and identified non-compliance with the Pools Act. The BHCC did not take any action after that to ensure that compliance was brought about.

49. It would have been appropriate for a sensitive approach to have been adopted given the circumstances however the non-compliance having been identified it was necessary for the danger to be removed. Had I not requested the site be reinspected in July 2011 it would appear that there would not have been any further inspection

and the non-compliance would have continued to exist. It is fortunate that the pool was found to have been drained. I propose to make a recommendation to the BHCC that it examine its systems so as to ensure that matters such as this are followed up on a systemic basis.

50. Ms Underwood contracted with L J Hooker Conveyancing to assist her on the purchase of her property. I have already found that at the time of the purchase there existed a non-compliance with the Pools Act. Ms Underwood gave evidence that at the time of purchase the matter of compliance with the Pools Act was not raised with her by those who were assisting her.

51. L J Hooker Conveyancing was not a party to the inquest and their file was not before the court. Those who assisted Ms Underwood from that organisation have not given a statement. Although I have no reason to disbelieve Ms Underwood on this matter I cannot make a determination one way or another concerning what advice was or was not given to her as to do so would not afford L J Hooker Conveyancing procedural fairness.

52. The matter may, however, raise an issue in relation to training within that organisation. Since the events that have given rise to this inquest the Conveyancing (Sale of Land) Regulation 2010 (the Regulation) has also commenced.

53. In the circumstances I propose to make a recommendation to L J Hooker Conveyancing that they examine their policies and procedures so as to ensure that when they are assisting a client in the purchase of a residential property on which is constructed a swimming pool the warning required by the Regulation be brought to the attention of their client and it be recommended that a certificate of compliance with the provisions of the Pools Act be obtained.

54. In this case I have found that at the time Ms Underwood purchased her property there was a non-compliance with the Pools Act. Had there been a requirement at the point of her purchase that the matter be brought into compliance Meika's death may not have been prevented. That would have depended on the maintenance of the latching device during the period of Ms Underwood's ownership. Had it been corrected at that time however it may remained effective during the following period and if so might have prevented Meika's death.

55. I propose to repeat my previous recommendation that the Conveyancing (Sale of Land) Regulation 2010 be amended to require that a certificate of compliance with the provisions of the Pools Act be attached to all contracts for the sale of properties on which a swimming pool is constructed.

Magistrate P A Mac Mahon
Deputy State Coroner
24 August 2011