NEW SOUTH WALES STATE CORONER'S COURT

File Number: 1776/2010

Name of Deceased: Zane Robert HILL

Hearing Dates: 25 October 2011

Location of Inquest: Mudgee

Date of Finding: 26 October 2011

Coroner: Magistrate P.A. MacMahon
Deputy State Coroner

Representation:

- Senior Sgt D. Maddocks, 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 Coroner's Act 2009

Non-publication order

The publication of photographs 1-7 inclusive attached to the statement of Crime Scene Officer Matthew Simcock dated 31 December 2009 is prohibited.

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

Zaine Robert Hill (born 17 May 2007) died on 28 November 2009 at 262 Cypress Drive Yarrawonga in the State of New South Wales. The cause of his death was drowning that occurred when he was able to enter an aboveground swimming pool erected on the site and because of his 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 for Local Government

1. That the circumstances of the death of Zaine Robert Hill be noted.
2. That the NSW Government support the efforts by the Australian Competition and Consumer Commission to introduce a requirement of mandatory warnings on portable swimming pools and the packaging in which such pools are sold. Such warnings at a minimum should remind consumers of the need for the constant supervision of children using such products as well as the need to approach local government authorities in order to determine other requirements governing the use of such products in the area in which it is purchased.
3. That the NSW Government develop an education campaign to bring the safety requirements of the Pools Act to the attention of the community giving emphasis to the application of such requirements to products such as portable swimming pools purchased from retailers and assembled by the buyers themselves.

Introduction

1. Zaine Robert Hill (who I will call Zaine) was born on 17 May 2007. In November 2009, as an eighteen month old, he resided with his mother and father, Sarah Sproule and Richard Hill, together with his older sisters and brother, on a property at Yarrawonga in the central west of New South Wales about 40 kilometers north of Mudgee.
2. On Friday 28 November 2009 the family were at home. The day was a hot one and the children had been using a steel frame portable pool that had been erected in the back yard. At about 6pm Zaine, and the other children, got out of the pool and went inside for dinner.
3. The children were sitting on the lounge eating their dinner and watching television. Zaine's parents were also eating their dinner nearby. A few minutes later Ms Sproule noticed that Zaine was not with the other children and asked her eldest son Hayden, who was twelve years of age, where he was. Hayden went looking for Zaine and found him in the pool.
4. Hayden immediately removed Zaine from the pool and brought him inside where cardiopulmonary resuscitation (CPR) was commenced. Ambulance assistance was called for. Following the arrival of the ambulance Zaine was taken to Gulgong Health Service. Unfortunately, notwithstanding the efforts of Zaine's parents, the ambulance officers and the medical and nursing staff, Zaine could not be revived. He was pronounced deceased at 7.35pm that day.

Jurisdiction and function of a Coroner:

5. Section 6, Coroners Act 2009 (the Act) defines a *"reportable death"* as being, amongst others, a death that is *"violent or unnatural"* or under *"suspicious or unusual circumstances."*
6. Section 35 of the Act requires that all *"reportable deaths "* be reported to a coroner.
7. Section 18 of the Act gives a coroner jurisdiction to hold an inquest where the death or suspected death of an individual occurred within New South Wales or where the person who has died or is suspected to have died was ordinarily a resident of New South Wales.
8. Section 81(1) of the Act sets out the primary function of the coroner when an inquest is held. That section requires, in summary, that at the conclusion of the

inquest the coroner is 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.

9. 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.

Identity and Date of Death:

10. Zaine's identity, together with the date of his death, was not a matter of contention during the course of the investigation. His mother Sarah Sproule identified his body 8.20pm on 28 November 2009 at Gulgong Health Service. I accept that identification. I also accept the evidence of the various witnesses that confirmed Zaine was alive earlier that day.

Place of Death:

11. Registered Nurse Mark McDonnell at Gulgong Health Service assessed Zaine as life extinct at 7.35pm on 28 November 2009. I accept that assessment. I have before me the records of the ambulance officers who attended the scene. On arrival it was found that Zaine was asystole and non-responsive and although multiple efforts were made to revive him during the journey to Gulgong they were unsuccessful. I am satisfied on the evidence before me it is more likely that Zaine was deceased at the home. I am satisfied that the place of Zaine's death was 262 Cypress Drive Yarrawonga.

Cause of Death:

12. Following Zaine's death his body was transported to the Department of forensic medicine at Newcastle. At the direction of the Assistant Coroner at Mudgee Dr Kasinathan Nadesan, a forensic pathologist undertook a limited examination of the body. Dr Nadesan reported that on the basis of his limited examination the cause of Zaine's death was "consistent with drowning".
13. Neither Dr Nadesan's examination of Zaine's body nor the subsequent police investigation of his death have identified any matters that would suggest the cause

of Zaine's death was anything other than drowning. In the circumstances I am satisfied that the direct cause of Zaine's death was "drowning."

Manner of Death:

14. The manner of a persons death relate to the circumstances thereof or the answer to the question what factual circumstances resulted in the death.
15. When a death is reported to the coroner a police investigation of the death may be ordered. In Zaine's case such an investigation was ordered and Detective Senior Constable Joshua Holgate of the Mudgee Detective office was appointed as officer in charge of that investigation. He prepared a brief of evidence that became an exhibit in the inquest.
16. DSC Holgate attended the scene on the night and found that in the backyard of the property on which Zaine lived was a "Bestway " brand "Steel Pro Frame" portable pool. The pool walls were constructed of a plastic/vinyl/material, which was held upright by a round metal frame connected to a series of metal vertical poles. The manufacturers estimate of the capacity of the pool when 90% full was in excess of four thousand two hundred liters. There was no fencing or barrier of any sort surrounding the pool.
17. DSC Holgate also found that on the western side of the pool a child's slippery dip had been converted to fit over the wall of the pool. The ladder part of the slippery dip had three rungs and was on the ground outside of the wall. The slide part of the slippery dip had been placed over the pool wall so that the slide went into the pool water. DSC Holgate also found a black steel framed chair on the northern side of the pool, which was next to the wall of the pool.
18. Police undertook measurements of the pool and it was found to have a diameter of 285cm, a height of 85cm and the water in the pool was 53cm deep.
19. At the conclusion of his investigation DSC Holgate, having considered the interviews with Zaine's mother, father and brother and the other evidence collected formed the opinion that:

> *"After the family came in to have dinner at sometime around 6pm on 28 November 2009 Zaine wandered back into the pool from which he and his family had just got out of. At the time his siblings were watching TV and eating their dinner and his parents were at the front of the house eating theirs. As a result no one saw Zaine go beck to the pool. Once at the pool it seems likely that Zaine used either the slippery dip, which was over the wall of the pool or the chair, which was next to the pool to access the water. It*

cannot be known exactly what occurred in those moments after Zaine went to the pool."

20. DSC Holgate estimated that Zaine had been in the pool for no longer than around 5 minutes until his brother, who removed him from the pool and sought help, located him.
21. DSC Holgate was also of the opinion that there was no evidence to suggest any general lack of supervision on the part of Zaine's parents that contributed to his death nor was there any evidence to suggest any alcohol consumption by them contributed to the events of the day either.
22. Having reviewed the evidence available and considered the evidence given during the course of the inquest I accept the evidence of Zaine's parents and brother and agree that DSC Holgate's conclusion is more likely than not what occurred on the afternoon of 28 November 2009. I also agree that the evidence suggests that Mr. Hill and Ms Sproule were generally caring and responsible parents and that Zaine's ability to enter the pool was not due to any gross neglect of their responsibilities towards him.

Matters contributing to Zaine's death:

23. At the time of his death Zaine was a little over 18 months of age. Children at this age are inquisitive yet exceedingly vulnerable. In Zaine's case the evidence was that he was a very active child and generally confident child who loved to roam about the property on which they lived. Notwithstanding their level of confidence and capabilities children of this age depend on those in whose care they are for their protection from harm. Where a child of this age dies it is important to examine the circumstances closely with a view to determining what matters contributed to the death not for the purpose of attributing blame but to determine whether or not changes in systems or procedures might be developed to prevent such tragedies occurring in the future.
24. The problem of child drowning is a significant one. Drowning is a leading cause of death among children under the age of five years of age. On average 11 children under the age of 5 drown each year in NSW. According to the NSW Injury Risk Management and Research Centre a further 62 children in this category are hospitalized for near drowning.

25. In 2010 the Children's Hospital at Westmead treated 38 children as a result of drowning or near drowning. That number was an increase on the number that have presented to that hospital in any of the previous 10 years.
26. From one perspective Zaine is part of these statistics however for his family and the community that knew and loved him his death is a tragedy of immense proportions and will have long lasting consequences.
27. A review of the evidence available makes it clear that there were three matters of significance that contributed to the death of Zaine. They were firstly his ability to travel to the pool area without the supervision of a responsible adult, secondly once he was there his ability to access the pool area and thirdly the existence of a slippery dip or chair that allowed him to get into the water contained in the pool.
28. The first of these contributing factors is well recognized. A breakdown in the supervision of active and inquisitive children is always a contributing factor in drowning deaths. The manufacturers of the pool that was on the property also recognized this as shown by the warning that was on the pool itself. That warning read, in part:

> *"Warning! Use only under competent supervision. Potential drowning hazard. Do not leave young children unattended."*

29. In this case there was a breakdown in the supervision of Zaine and that allowed him to access on his own the dangerous environment of the pool.
30. It has to be accepted that young children cannot be observed every minute of the day. Parents are invariably required to undertake numerous other activities and even where they are caring and responsible breakdowns in supervision do occur. That appears to be what has happened in this case.
31. Because this situation is recognized legislative requirements have tried to put into place a number of protections or what might be described as being a second line of defense. These protections are to be found in the Swimming Pools Act 1992 (the Pools Act).
32. In short the Pools Act requires that where a swimming pool, which is defined as being an excavation, structure or vessel that is capable of being filled with water to a depth of 300 millimeters or more and that is solely or principally used, or is designed, manufactured or adapted to be solely or principally used for the purpose of swimming, wading, paddling or any other human aquatic activity, is constructed

on a residential property it must be fenced in accordance with the provisions of the Pools Act.

33. The pool that was observed on the property by DSC Holgate was a pool to which the provisions of the Pools Act applied and it was required to be fenced. Having regard to the evidence before me I am satisfied that the pool was not fenced in accordance with the requirements of the Pools Act. I am also satisfied that had it been so fenced that would most likely have prevented Zaine's death.

34. The third matter that was a contributing factor to Zaine's death was the existence of a slippery dip that was located so that a child could climb up the steps and then slide down into the pool. In addition there was also a chair located next to the wall of the pool that could assist a child to enter the pool. The evidence, which I accept, was that it was likely Zaine entered the pool by one of these means. One can understand the thinking of those who placed these items next to the pool however without the protection of a fence or other barrier surrounding the pool once Zaine had left the area of supervision there was the ready means of entering the pool available to him.

Knowledge of requirements of Pools Act

35. Mr. Hill gave evidence at the inquest. He said that he had observed the pool when he was at an Aldi Store whilst he was there shopping. He discussed the purchase with Ms Sproule and they decided to purchase it. This occurred about three weeks before Zaine's death. Mr. Hill put the pool together himself a task that took about an hour. A small amount of water was put into it until they were able to get a water delivery when it was filled to a little over half way.

36. Mr. Hill was asked about his understanding of the Pools Act and local government regulations that require the construction of a pool be certified. He stated that as he was able to purchase it at a retailer he did not think they applied, He thought that if it had to be constructed he would have to get permission however that was not the case here.

37. I accept Mr. Hill's evidence in this regard. It is similar to the evidence given in other inquests. The knowledge of the requirements of the Pools Act in the community appears to be very poor.

38. There were a number of warnings on the pool itself together with the packaging in which it was sold but none of those warnings mentioned that the requirement of

local government approval for construction nor did they mention the need for barrier fencing that complied with the Pools Act.

39. In the circumstances Mr. Hill could be forgiven for not thinking that he was required to get approval for the erection of the pool or to erect barrier fencing. What he would have done had he known is a matter of speculation however the absence of the barrier fencing, as I have already said, was a major contributing factor to Zaine's death.

Aldi Stores

40. As has been mentioned the pool was purchased by Mr. Hill from the Aldi store in Mudgee. The price was about $149. Aldi assisted DSC Holgate in the preparation of his brief of evidence. Mr. Shane Aitkin, the buying manager responsible for such products also gave evidence. Having regard to the evidence given I am satisfied that Aldi undertook an appropriate due diligence prior to placing the product on sale.

41. The difficulty that is faced by Aldi, and no doubt other similar retailers, is that such products are sold at Aldi stores in every State and Territory in which there are Aldi stores. The warnings and other matters that are recorded on the pools and packaging must therefore necessarily be of a generic nature that will be suitable for all jurisdictions. In this case the requirements of the Pools Act, which are limited to New South Wales, are not mentioned.

42. The evidence is that Aldi sold some two thousand five hundred such pools across Australia at about the time Mr. Hill purchased his pool. All such pools sold in NSW were required to be fenced. It is reasonable to infer, having regard to the evidence given in this inquest as well as that given in other inquests dealing with similar matters, that most, if not all such pools, were unlikely to have been appropriately fenced.

43. The evidence given at inquest was that there is some effort being made by the Australian Competition and Consumer Commission (ACCC) to introduce mandatory labeling on portable swimming pools. This effort is to be commended. Such warnings however need to be supported by a regulatory environment that is consistent across each State and Territory.

44. It is however pleasing to note that Aldi supported the ACCC proposal to introduce mandatory labeling on packaging for portable swimming pools. Aldi also supported the printing of a warning on the pools itself to remind users of potential dangers

even after the packaging is disposed of. Each of these proposals are to be commended and should be supported. I propose to make a recommendation concerning this matter.

Mid Western Regional Council (MWRC)

45. The MWRC is the relevant local government authority. The evidence produced by it to the inquest showed that no application had been made to it by Mr. Hill to erect the pool.

46. John Nelson Russell, the team leader responsible for health and building matters at the NWRC, gave evidence to the inquest. He confirmed the regulatory requirements for the subject pool. He also confirmed that in his experience, of over more than a quarter of a century in two local government authorities, the lack of knowledge displayed my Mr. Hill was not unusual. In Mr. Russell's experience that lack of knowledge was more the norm than the exception.

47. Mr. Russell explained that the MWRC was trying to educate the public as to their obligations and a number of examples of such efforts were tendered to the inquest. The efforts made are of course to be commended however, as Mr. Russell effectively acknowledged; such efforts are of limited effectiveness. For such an education campaign to be effective it must be a concerted one and aimed at persons who are responsible for home swimming pools and not simply limited to a single local government area. I propose to make a recommendation dealing with this matter.

A Commendation:

48. In the conclusion in his statement and in giving evidence DSC Holgate commended Hayden for his efforts to save his brother. Hayden was twelve at the time of the incident and although the situation would have no doubt been confronting to him he immediately went to the assistance of his brother. He acted quickly and bravely putting fear aside to try and save Zaine.

49. I agree with DSC Holgate assessment and would also like to add my personal commendation of Hayden for his efforts on the day.

Review of the Pools Act:

50. As a consequence of the response of Government to recommendations made in a number of previous inquests I am aware that a review of the provisions of the Pools

Act is currently the subject of Government consideration. In the circumstances I do not propose to make detailed recommendations arising out of the circumstances of the death that this inquest has examined. There are, however, a number of matters that are unique to this matter that I propose to bring to the attention of Government by way of recommendation. Such matters may already be the subjects of consideration however as the detail of the matters being considered by Government has not been released I consider that it is appropriate to make the recommendations that I do.

Magistrate P A MacMahon
Deputy State Coroner
26 October 2011