NSW State Coroners' Court

Inquest touching the death of: - "A"
File: Glebe 0878 of 2006.
Inquest touching the death of: - "B"
File: Glebe 2235 of 2008.
Inquest touching the death of: - "C"
File: Glebe 2239 of 2008.
Inquest touching the death of: - "D"
File: Glebe 0157 of 2009.
Inquest touching the death of: - "E"
File: Glebe 0248 of 2009.
Inquest touching the death of: - "F"
File: Glebe 0602 of 2009.
Inquest touching the death of: - "G"
File: Glebe 1179 of 2009.
Inquest touching the death of: - "H"
File: Glebe 1751 of 2009.

Section 74 Orders:

Having regard to the ages of the deceased, the circumstances in which each of them died, the issues that were the subject of investigation at Inquest and the wellbeing of other family members I consider that it is in the interest of justice that the publication of the names of the deceased, their image or any identifying features other than by the above pseudonym be prohibited.

Report Delivered:

30 April 2010 at State Coroners Court, Glebe.

Coroner:

Magistrate P. A. MacMahon
NSW Deputy State Coroner
State Coroner's Court,
44-46 Parramatta Road,
Glebe. N.S.W 2037.

Before the Court:

7-11 December 2009 at the State Coroners Court, Glebe.

Appearances:

Sgt. R. Becroft – Advocate Assisting.

Mr. K. Kelleher of Counsel - Port Macquarie Hastings Shire Council and Kempsey Shire Council.

Ms. S. Beckett of Counsel - Michael Newell.

Ms. D. Ward of Counsel – Department of Human Services-Community Services.

Mr. P. Collins, Solicitor – Mr C. Breise AO, Emeritus Professor P. Ley and Mr P Collins.

Mr. R. Collings, Solicitor – Master Builders Association.

Ms. K. Plint – Executive Officer, Hannah's Foundation.

Mr. M. Morris – Managing Director, Samuel Morris Foundation Limited

Recommendations made in accordance with Section 81(2).

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

- That a continuing media campaign be developed by the relevant NSW Government Department in conjunction with the Royal Life Saving Society and other appropriate non government bodies to emphasise the need for constant supervision of young children who are, or reside, in the vicinity of a home swimming pools.
- That a media campaign be developed by the relevant NSW Government Department, in conjunction with local government authorities within NSW, to emphasise the need for:
    - The obtaining of approval for the construction and installation of all home swimming pools whether they be in or above ground, and
    - The need for the regular maintenance of fencing and gates surrounding such pools.
    - The need to ensure that pool gates are never propped open.
- That consideration be given to the relevant NSW Government Department, in conjunction with local government authorities within NSW,
    - Developing a centralised register of private swimming pools,
    - Developing a systematic plan for the regular review of all private swimming pools in NSW so as to ensure compliance of such pools with the safety provisions of the Swimming Pools Act 1992.

- Consideration is given to an amendment of the Swimming Pools Act 1992 so as to remove all exemptions from the application of that Act.

To: The Minister responsible for the administration of the Residential Tenancies Act 1987.

- That consideration be given to providing by law that:

- Owners of residential properties that contain a private swimming pool and is the subject of a residential tenancy agreement are obliged to take all reasonable action to ensure that the pool is and remains compliant with the safety provisions of the Swimming Pools Act 1992, and
- That the owner of a property containing a private swimming pool, that is the subject of a residential tenancy agreement, should warrant at the commencement of each such agreement that the pool and the surrounding fencing and gates comply with the safety provisions of the Swimming Pools Act 1992.

To: The Minister responsible for the administration of the Fair trading Act 1987.

- That the relevant NSW Government Department in conjunction with industry associations develop systems:
  - To ensure that purchasers of aboveground swimming pools are advised at the point of sale of their obligations under the Swimming Pools Act 1992, and
  - Sellers advise the relevant local government authority of the delivery of an aboveground swimming pool to a property within the boundaries of that authority.

To: The Attorney General.

- That consideration be given to the enactment of a criminal offence, analogous to that of negligent driving causing death, to apply in circumstances where a person dies as a result of the negligence of a third party with respect to the maintenance or use of a private swimming pool.

Introduction:

1. The death of young children in home swimming pools is a significant cause of child death in Australia. Research undertaken by the Royal Life Saving Society of Australia records the number of drowning of children aged 0-4 years in home swimming pools for the period 2005-2009 was as follows:
    - 2005/2006 – 13.
    - 2006/2007 – 16.
    - 2007/2008 – 16.
    - 2008/2009 – 19.
2. The National Drowning Report for 2009 prepared by the Royal Life Saving Society also found that sixty percent of children aged zero to four years who drowned did so in a home swimming pool.
3. The same report noted that the death toll in 2008/2009 of 19 was not only an 18.75% increase on the year before but also a 26.67% increase on the five-year average of 15 deaths per year.
4. The records of the National Coroners information System also deal with this issue. Those records show that 51 children under the age of 5 years of age died as a result of drowning in private swimming pools or spa's in New South Wales in the period 2000 to 2008. Those records show that the number of deaths each year ranged from two (2) in 2000 and 2001 to eight (8) in 2002, 2003 2007 and 2008. The average number of such deaths being a little under six (6) each year.
5. Children aged 4 years of age and under are, of course, at their most vulnerable. They are completely dependent on their parents or carers for their safety. The personal and social cost associated with the death of a vulnerable child is enormous and cannot be adequately described. The cost to the child involved is also enormous. It is a lifetime that has been cut short.
6. Each death of a young child in a home pool in Australia is reported to a Coroner and police undertake an investigation of the death of that

child. In most cases, and for good reasons, an inquest into the death is dispensed with.

7. The issue of child deaths in home pools is, however, a constantly recurring theme for coroners. Between 1999 and 2007 there were a number of inquests conducted in New South Wales where the presiding coroner made recommendations.

8. In 1999, in the matter of Isaiah Andrew John Smith, the then Deputy State Coroner, Magistrate Stevenson, recommended that: *"There be an integrated approach by the Department of Local Government and other agencies to address the problems associated with backyard swimming pools."*

9. In 2002, in the matter of Emily Townsend, Magistrate Coroner Railton recommended that: *"That the rules, regulations and requirements relating to the fencing of backyard swimming pools be reviewed, particularly the requirements at point of sale to notify potential purchasers as to the necessity of compliance with the Local Government requirements."*

10. Also In 2002, in the matter of Jayden Gould-Langley, the then State Coroner, Magistrate Abernethy, made recommendations:

- *That the N.S.W. Government implements an advertising campaign directed at domestic swimming pool owners, reminding them of their obligations under the current legislation in relation to pool safety;*
- *That such campaign provide a moratorium period before enforcement by penalty;*
- *That the N.S.W. Government considers assisting all Local Councils to obtain the means to carry out inspections of all such swimming pools at the end of such moratorium period;*
- *That legislation be introduced that requires all owners of swimming pools to hold a "Certificate of Compliance" in relation to their pool; that inspections of pools/certificates of compliance be held regularly;"*

11. In 2007, in the matter of Mitchell John Porter, the then Senior Deputy State Coroner, Magistrate Milledge, recommended that: *"All properties*

offered for rent have a Local Council certificate stating that the swimming pool complies with the Australian Safety Standard and meets all other legislative requirements."

12. Notwithstanding these recommendations, and acknowledging that there has been recent legislative reform of the regulatory regime by the Parliament by the enactment of the Swimming Pools Amendment Act 2009, the number of infant deaths in home swimming pools continues to increase.
13. Because of this it was decided that a number of such deaths should be examined in a joint inquest with a view to drawing conclusions that might not be possible if such deaths were to be examined on an individual basis. In order to do this eight deaths that occurred in New South Wales between June 2006 and January 2009 were the subject of further investigation and brought to inquest.
14. It is recognised that the decision to conduct an inquest in situations where an inquest might have otherwise been dispensed with would, undoubtedly, cause additional stress and anxiety to the families of the children involved. This is inevitable even if it is regrettable. Because of this various actions were taken to minimise the pain involved however it was necessary in the public interest that the investigations be conducted and that the issues be brought before the public. In any event it is also necessary to consider the situation of the deceased children. It has long been recognised that one of the functions of a coroner is to speak for the dead. The voices of the young children, whose lives were cut short, must also be recognized and heard.

Jurisdiction and Function of the Coroner.

15. Section 81, 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.

16. 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.
17. Section 78 of the Act deals with the situation that occurs when during the course of an inquest the coroner forms the opinion that:
    - The evidence is capable of satisfying a jury beyond reasonable doubt that a known person has committed an indictable offence, and
    - There is a reasonable prospect that a jury would convict the known person of the indictable offence, and
    - The indictable offence would raise the issue of whether the known person caused the death with which the inquest is concerned.

18. Where Section 78 applies the coroner is required to suspend the inquest and refer the matter to the Director of Public Prosecutions.

19. In respect of each of the matters that were the subject of these inquests having reviewed the evidence available in each case I am satisfied that the evidence did not activate the provisions of Section 78. I will however return to the general issue of the role of the criminal law in these situations later in these findings.

Findings of Fact.

20. The names of the child and the identifying features of each case selected for inquest was the subject of non-publication orders. Each child was allocated a pseudonym by which they were to be referred.

Each child died as a result of drowning, or the effects of drowning, in a home pool. It is now necessary to record the circumstances of each death in order to determine what, if any, conclusions might be drawn that could give rise to recommendations in accordance with Section 82**.**

Child "A."

21. "A" was a little under two and a half years old at the time of his death. He resided with an older sibling, his mother and her partner together with her mother's parents. Some eleven years previously an above ground pool had been installed at the rear of the property. A homemade fence was constructed at the time of the installation of the pool. Council approval for the installation of the pool had never been sought and as such the pool and the fence had never been inspected for compliance with relevant building and safety standards.

22. The police officer responsible for the investigation of the death of "A" concluded that the cause of his death was as follows:

> *"It appears that the deceased has been left unsupervised for a period of time in the backyard. The exact length of time is unknown given the differing versions of the witnesses regarding the time. In any case during this period of being unsupervised, the deceased has been able to access the pool area due to a combination of factors resulting in the deceased falling into the pool and drowning. The first of these factors was (his grandfather) working (in the area) and obtaining paint from a shed located in the pool enclosure. This required him to walk through the access gate leading to the pool enclosure. Secondly, the fact that (the grandfather) believed everybody was inside the main house whilst he was undertaking his work, possibly leading him to be less vigilant with the gate as he usually was when the deceased was in the vicinity. Thirdly, inadequacies relating to the pool fence structure meant that the pool gate did not automatically latch in the closed position due to the spring attached to the gate not being secured to the fence itself. The gate also opened inwards giving easy access if unlatched. Lastly, it appears as though the deceased could not swim being only two and a half years of age"*

23. Following the death of "A" an officer of the relevant local government authority examined the pool and its surrounds. That officer concluded

that the pool and its fencing did not comply with relevant building and safety standards for, among other reasons, the following:

- There were numerous climbable objects surrounding the pool that provided direct access to the pool area,
- The fence height was deficient,
- The vertical timber railings exceeded the width specified by the Australian Standard (AS),
- The gap beneath the pool fence was greater than that allowed by the AS,
- The gate swung in an inwards direction and was not self latching and closing as required by the AS,
- There were no sufficient barriers surrounding the latching mechanism, which allowed access to open the latch unrestricted,
- To the front of the pool fence gate was a metal garden arch that acted as a climbable object and would have provided direct access to the pool area.

24. The local government authority inspector confirmed that the records of the council showed that there was no approval for the aboveground pool.

Child "B"&"C."

25. "B" & "C" were twenty one month old twin brothers at the time of their death. They had been picked up from day care by their grandparents and taken to their grandparent's home to care for them until their mother was able to collect them.
26. The grandparent's family home had an in-ground pool that was surrounded by a five (5) foot barrier fence and gate. The evidence was that the fence and gate complied with the required legislative obligations. I accept that they did.

27. On returning home the boys were playing on their bikes inside the home. The evidence was, and I accept, that the door from the house to enable access to the yard was closed. I accept that, unknown to the boys' grandfather who was looking after them; the boys' had learned to open the back door by standing on their bikes. The boys, and their bikes, were subsequently found in the pool.
28. Evidence was that the family had a practice of propping open the gate of the pool with a tent peg when the boys were not at the house. This was to allow the family dog to have access to the pool area as well as the backyard.
29. Police testing of the pool gate after the incident showed that it was in working order, was self-closing and secure once closed. I accept this evidence. I also accept that if the gate had been closed the boys' could not have opened it themselves.
30. Having regard to the evidence I am satisfied that the boys' opened the back door by one of them stranding on their bike. They then rode their bikes into the backyard and into the pool area the gate of which was propped open in accordance with the usual practice of the family. I do not accept the evidence that suggested the pool gate was closed at the time. I am satisfied that it was open. I am also satisfied that when riding in the pool area each boy rode or fell into the pool by accident. This resulted in them sustaining the injuries that subsequently led to their deaths.

Child "D."

31. "D" was fourteen months old the time of his death. He resided with his mother and her father in rented accommodation. The property had a pool in the backyard that was surrounded by a metal fence.
32. The officer in charge of the investigation of the death of "D" came to the conclusion that:

> *"From the limited information supplied to the police, in conjunction with the crime scene examination, it appears that the child was left unattended for a short period of time, whilst the mother of the child went to the bathroom. It appears that the*

child has exited the house via the glass sliding door that leads to the rear of the property. It is then suspected that the child has crawled down the pathway towards the gate of the pool area, which had been wedged ajar by broken gyprock. It could have been that the child was following the two dogs. It is the opinion of the police that the child has fallen in, or been pushed in by one of the animals, into the pool, where he has drowned. From the information available to the police, the child was not in the water for a long period before (his mother) has discovered him submerged in the water, however it was a time period long enough for him not to be resuscitated."

33. At inquest it was suggested that the gate to the pool area was not wedged open as suggested by the officer in charge of the investigation. Having regard to the evidence available however I am satisfied that the gate was wedged open and that it is more likely than not that it had been so for some time.

34. An officer of the local government authority for the area in which the property was located inspected the pool fencing following the death of "D". The report of that inspection was that:

- The pool had been the subject of a building approval prior to construction,
- At the time of the inspection the gate within the pool safety barrier was neither self-closing nor self-latching as required by the AS, and that
- The construction of a dog kennel, adjacent to the rear boundary of the allotment, and the storage of household goods beneath the carport had reduced the effectiveness of the non-climbable zone of the pool fence.

35. As previously mentioned the property that "D" and his family resided in was rented accommodation. The evidence was that the property had undergone a periodic inspection by the managing real estate agent a short time before the death of "D". It is not unreasonable to infer that at the time of the inspection the non-compliance of the pool fencing would have existed. The evidence of the mother was that during the course of the inspection little or no attention was paid to the pool, and the fencing surrounding it, by the agent involved. This raises a question as to what responsibilities owners and managing agents of rented accommodation

have in respect of the maintenance and repair of pool fencing so as to ensure that such fencing is compliant and, more importantly, safe. I will return to this issue later in these Findings.

Child "E."

36. "E" was approaching her third birthday when she died. She lived with her mother and father in the family home, which included an inground pool. The pool was partially fenced as the fence was in the process of being erected. The gate was not attached and there were other gaps in the fence that were yet to be filled.
37. "E" was in the house and her mother was vacuuming. Her mother noticed that "E" was not where she had previously been and went looking for her. "E" was found floating face down in the pool. "E" was quickly removed from the pool and CPR was undertaken and ambulance help sought unfortunately to no avail.

Child "F."

38. "F" was almost two years and four months when he died. He lived with his parents and older siblings in the family home. Erected on the property was an 8m by 4m aboveground swimming pool that was 1.8m deep. The erection of the pool, and its filling with water, had been completed the day "F" died. There was some temporary fencing but the pool was not completely fenced and access could be gained to the pool from the backyard.
39. On the day of his death "F" had been in the pool with his brother. He then exited the pool, was given dinner and then taken to an upstairs bedroom to play with his toys by his father. His parents and aunt commenced dinner.
40. About twenty-five minutes after "F" was taken to his room he was observed to be inside the house by his aunt. A short time later as his father passed the lounge room window that overlooked the pool he observed "F" to be face down in the pool. His father quickly retrieved

"F" from the pool, commenced CPR and called for ambulance help. Unfortunately to no avail.

41. The evidence established that no approval had been sought for the construction of the pool from the relevant local government authority.

Child "G."

42. "G" was two years and nine months old when she died. On the day she died "G" was taken by her mother and father to visit friends at their home. The friends lived in rented accommodation with three foster children. The home included an in-ground swimming pool of fibreglass construction. The pool was surrounded by a metal fence consisting of vertical bars with metal cross section at the bottom and towards the top. The fence did not have a locking mechanism fitted to the gate. In addition there was a pile of timber and other debris at one end of the pool fence that could allow climbable access to the pool.
43. On the day of her death "G" was playing with the other children in the backyard. Their respective mothers, who were sitting at the rear of the premises and talking, were supervising the children. Their fathers were inside accessing a computer. After a while the two women went inside and joined the men.
44. Some time later, estimated as being about fifteen minutes, it was realised that "G" had not been heard of for some time. Her father went looking for her. He observed that two of the other young boys were inside the pool area. He asked them where his daughter was and they pointed to the pool. Her father then saw "G" in the pool. He jumped in retrieved her and then commenced CPR. Once again unfortunately to no avail. It seems that "G" and the other young boys had been able to enter the pool area and "G" then fell or otherwise entered the pool itself.
45. Following the death of "G" the pool fencing was inspected by the relevant local government authority and was found to not comply with the Swimming Pools Act 1992. The non-compliances were that the fence was less than 1200mm high, the gate did not have a child proof

lock or protected locking system, rocks and garden bedding against the fence reduced the height of the fence further, a horizontal member of the fence was missing at one part and a brick construction had been built inside the pool area.

46. The local government authority made a direction that the non-compliance be rectified and this subsequently occurred.
47. The circumstances of this death once again raised the issue of the obligation of owners and managers of rented accommodation to ensure that pool fencing complied with safety legislation. It also raised the further issue of a property being approved for the accommodation of foster children when the pool fencing was non-compliant with safety requirements.

Child "H."

48. "H" was one year and eight months old when she died. She, her parents and siblings resided on a semi-rural property that was over five acres in size. There was an in-ground swimming pool some 30-40 meters from the house. The top of the pool was at ground level. Between the house and the pool there was a children's play area. There was a general downward slope leading to the pool with concrete around the pool. There was also an unfenced dam some 200m further down the slope. The pool was unfenced and as the property was in excess of 5 acres there was no requirement for fencing.
49. On the day "H" died she was at home with her mother and siblings. Her father was away from the home at the time. "H" appears to have wandered off and when her mother went looking for her she was found in the pool. She was immediately removed, CPR commenced and the emergency services contacted. "H" was airlifted to hospital however it was not possible to save her life.

Issues.

50. This review of the deaths of a number of children aged four years and under in home swimming pools during the period June 2006 to January 2009 is not a scientific study of the subject. It is not, and does not seek to be, a review of the home swimming pool regulatory regime. It is simply an endeavour to identify whether or not any trends or issues might arise from the circumstances of the various deaths reviewed. It is hoped that by looking at the circumstances of a number of deaths at the same time possible trends or issues might be identified that would not have been as obvious if the circumstances of each death were looked at on and individual basis only.
51. The review of the eight deaths did identify a number of common factors that contributed to the deaths of some, or all, of the children whose deaths were the subject of investigation. Those factors were:
    - The supervision of young children near home swimming pools,
    - The maintenance of barrier fences and gates around home swimming pools,
    - The failure to ensure that barrier gates around home swimming pools were effective,
    - The absence of the requirement for barrier fencing and gates for home pools on properties greater in size than five acres,
    - The regulation and certification of the compliance of home swimming pools by local government authorities,
    - The responsibilities of owners, and managers, of rental properties to ensure that home swimming pools and barrier fencing and gates continue to meet minimum prescribed safety standards.
    - The obligation of sellers of aboveground swimming pools concerning safety warnings and the obtaining of local government authority approval.

Supervision.

52. The review of the circumstances of the eight deaths that were the subject of the inquest makes it clear that in each case the breakdown of supervision was a significant contributing factor to the deaths. The extent of the breakdown in each case was different however more effective supervision of the child would have prevented each death.
53. Supervision of young children has always been recognised as being important and this is especially the case when they are in the vicinity of dangerous environments such as bodies of water.
54. The Royal Life Saving Society suggests that because of the level of development and vulnerability of children four years of age and under effective supervision involves the supervising adult being within arms reach of the child at all times and committing all their attention to the task at hand. In some cases amongst those examined such a level of supervision would not have been possible, or even appropriate, however in every case examined had more effective supervision of the deceased occurred their death would almost certainly would have been prevented. The level of supervision of the respective children was thus a contributing factor to their death.
55. Given that supervision is such an important issue in the protection of young children I propose to recommend that a media campaign be conducted at regular intervals to remind the public of the dangers that home swimming pools pose for children under the age of 4 years and that parents and carers need to be very vigilant when young children are in the vicinity of a home pool.

Maintenance.

56. In the case of children “A,” “D,” “E,” “F,” and “G” the barrier fence attached to the home swimming pool was either not maintained or non compliant for other reasons.
57. A barrier fence surrounding a home swimming pool is not a first line of protection for young children. Supervision is always the first line of

protection however no matter how vigilant a carer may be supervision of a young child can break down. It is in these situations that the barrier fence gives added protection by preventing the child from gaining access to the danger that the pool poses for them.

58. In the five cases mentioned the barrier fence was ineffective because it had not been built in a manner that would give the protection that was sought, had not been maintained once built, or had not been completed when the pool was filled with water.

59. It is trite to say that there is no point in having a barrier fence around a home swimming pool if it is not compliant or effectively maintained. Indeed its presence may give carers of children a sense of security that is unwarranted.

60. The failure to ensure that barrier fencing was properly constructed and maintained was thus a significant contributing factor to the deaths of several of the children whose circumstances were examined during the course of the inquest.

61. Ensuring that barrier fencing and gates are properly maintained and compliant is obviously very important for the protection of young children I propose to make a recommendation relating to this issue and will do so in the context of other matters that I will discuss later in these findings.

The Failure to ensure that barrier gates surrounding home swimming pools were effective.

62. In the cases of children “B,” “C,” and “D” I have already found that the gates that were installed were propped open and that this allowed the children to gain entry to the pool area. Once again it is trite to say that there is no point of having a barrier fence and gate surrounding a home pool if the gate is propped open. In the individual cases there were various reasons for the gate being propped open however, whatever the reason, the fact that it was propped open and allowed the children

to gain access to the pool was a significant contributing factor to the death of the children concerned.

63. Propping open a pool gate defeats the purpose of the legislation that is designed to protect young children from the danger that is constituted by the home swimming pool. I propose to make a recommendation concerning this and will do so later in these Findings in the context of other matters.

Exemptions.

64. In the case of child "H" there was no barrier fence and gate surrounding the home pool. Under the current legislative scheme there was, and still is, no obligation for such a pool to be fenced.

65. In the case in question the there was an incline from the house to the pool with a children's play area in between. This design in itself appears, on the face of it, to have been problematic. It might have been the play area that initially attracted child "H" in the direction of the pool. We do not know.

66. On rural properties there are always likely to be areas that are a danger to children. This fact imposes a greater obligation on the owners of such properties to provide supervision that is appropriate having regard to the dangers that exist. In this case there was also, but at some distance from the house, a dam. Such a facility is also, of course, a danger to children under four years of age who are allowed to wander into the vicinity.

67. The decision to exempt home pools built on properties that are greater than five acres from the requirement for barrier fencing is, of course, a matter for the Parliament. There are no doubt reasons for such an exemption. They may relate to the fact that there are resources such as dams and other dangerous areas on such properties. To suggest that such pools should be enclosed could result in cries that dams and other waterways would also need to be fenced. That would, of course, be an extreme and illogical response.

68. The building of a home swimming pool clearly adds an amenity to such properties. Such an amenity will, no doubt, be attached to or located close to the home so that the occupants might get the greatest usage from the amenity. Being close to the home will add a dimension of danger that dams and waterways might not pose. This will apply particularly for young people who are living in the home and might be able to escape supervision for the short time that it takes to get to the swimming pool. As in the case of child "H" once the supervision had failed there was nothing to prevent her accessing the danger and this resulted in her death.

69. As I have said elsewhere it is the role of the coroner to speak for the dead. From the perspective of child "H" the exemption is flawed and in her particular case was fatal. I propose to recommend that the Minister that the reasons for the existence of the exemption be examined with a view to it being removed.

The Regulation and Certification of Home Swimming Pools by Local Government Authorities.

70. As previously mentioned this issue was the subject of recommendations by the then Deputy State Coroner, Magistrate Stevenson, in 1999 and subsequently by the then State Coroner, Magistrate Abernethy, in 2002.

71. Three local government authorities were granted leave to appear as parties at the inquest. They were, of course, able to represent the interests of, and express the views of, their own councils but not local government authorities in general. The state government departments responsible for local government and the regulation of home swimming pools were also not parties in the proceedings.

72. In addition this inquest is not, and cannot be, a review of the regulatory scheme that is associated with home swimming pools. The conclusions that might be drawn from the evidence that was available during the inquest must thus be examined with caution. Notwithstanding this caution the evidence does show that the current regulatory scheme

has a number of limitations that contributed to the deaths of some or all of the children examined in the inquest.

73. The current legislative regulation of home swimming pools is to be found, in so far as is relevant to these proceedings, in the Swimming Pools Act 1992 (the Pools Act) and the Swimming Pools Regulation 2008. The Pools Act defines swimming pools as being all structures capable of being filled with water to a depth of 300 millimetres or more and are solely or principally used, or that is designed, manufactured or adapted to be solely or principally used, for the purpose of swimming, wading or any other human aquatic activity (Section 3).

74. The Pools Act requires that all swimming pools, other than those exempted, be at all times surrounded by a child resistant barrier. That barrier is required to be designed, constructed, installed and maintained in accordance with the standards set out in Australian Standard AS 1926.1-2007. (Section 8 and Regulation 6)

75. Section 5 imposes an obligation on local government authorities to:
    a) Take such steps as are appropriate to ensure that it is notified of the existence of all swimming pools to which the Act applies that are within its area, and
    b) To promote awareness within its area or the requirements of the Pools Act in relation to swimming pools, and
    c) To investigate complaints about breaches.

76. Section15 provides that child-resistant barriers must be kept in good repair. Section 16 provides that access to swimming pools must be kept securely closed. Failure to comply with the requirements of Section 15 or 16 is an offence that carries a maximum penalty of 50 penalty units. Local Court statistics contained in the Judicial Information Resource System show that in the five years from July 2005 to June 2009 there were two such prosecutions.

77. Section 28 provides for officers, authorised by local government authorities, to enter and examine pools for compliance with the provisions of the Act while Section 29 authorises such an officer to obtain a search warrant if there are reasonable grounds to believe that there has been a contravention of the Act.

78. Section 29A sets out the procedure for investigation of a complaint of a contravention whilst Section 30 provides the Land and Environment Court with the power to make orders requiring compliance.
79. This analysis of the current legislative structure is not meant to be comprehensive but simply to provide a picture of the structure in which the deaths of the eight children died.
80. In respect of seven of the eight children whose deaths were examined the Act was applicable to the pool in question. Of the six pools involved five were found to be non-complying with the requirements of the Pools Act. The two pools had not obtained the approval of the relevant of local government authority and one of those had been constructed some eleven years previously.
81. Although a small number of incidents were examined it is hard not to draw the conclusion that there is likely to be significant non-compliance with the requirements of the Pools Act within the community at large and that non-compliance with the safety requirements of the Pools Act is a significant contributing factor to the deaths of children under four years of age who drown in home swimming pools. A greater level of compliance with the safety requirements of the Pools Act would thus be likely to contribute to the protection of vulnerable young children.
82. The evidence given at inquest was insufficient to form any definitive view however the evidence available strongly suggests that:
    - Local government authorities do not have an accurate record of the home swimming pools within the boundaries of their jurisdiction,
    - There is no systematic assessment of home swimming pools for compliance with the requirements of the Pools Act,
    - There is a lack of consistency of approach to the regulation of home swimming pools between different local government authorities,
    - The lack of knowledge of the existence of home swimming pools by local government authorities and the lack of a systemic and consistent approach to the regulation of the safety aspects of home swimming pools allows non-complying pools to continue for long periods without detection.

- The minimal number of prosecutions undertaken for breaches of the safety provisions of the Pools Act suggests that such compliance activity as occurs could be best described as a “claytons” effort.
- In the circumstances it is reasonable to conclude that greater effort by local government authorities at ensuring that the safety requirements of swimming pools meet, and continue to meet, the requirements of the Pools Act would assist in the prevention deaths of young children.

83. I propose to recommend that consideration be given to the establishment of a register of private swimming pools within NSW. It is trite to say that if the existence of a home swimming pool is not known it cannot be regulated. I also propose to recommend that there be developed a method for the regular and systematic review of such pools so as to ensure compliance with the safety provisions of the Pools Act is maintained.

Rental Properties.

84. Two of the deaths examined during the course of the inquest occurred in pools that were a part of a rental property. The police investigation into the deaths established that neither pool was compliant with the safety provisions of the Pools Act.

85. Evidence provided to the Inquest by Hannah’s Foundation suggests that in the area in which they are collecting statistics more than fifty percent of child deaths in home swimming pools occur in rental properties.

86. The need to ensure that barrier pool fencing and gates in rental properties were compliant was, as I have previously mentioned, the subject of recommendation by the then Senior Deputy State Coroner, Magistrate Milledge in 2007.

87. Had it been necessary, prior to the leasing of the properties in question, for the fencing and gates to be compliant it is likely that the death of the two children involved may well have been prevented.

88. During the course of the inquest evidence was received as to the management of domestic real estate by licensed real estate agents. Such properties are the subject of regular inspection by agents. Indeed one of the subject properties had been inspected not long before the death of the child involved.

89. The agent undertaking the inspection in that case apparently did not pay much attention to the pool and the surrounding fence and gate. The fact that the fence and gate were non compliant was not identified in the inspection. No criticism of the agent in question is made as he or she did not give evidence and in any event, on the basis of the evidence as to the training received by such agents, it would be unlikely that he or she would have been qualified to make such an assessment.

90. The situation of rental properties is one where there may be a conflict of interest that could prove fatal to the young child. On the one hand the owner of the property would be seeking to maximise the return on their investment and the assessment of compliance and the undertaking of maintenance of pool fencing and gates on a regular basis would be an additional cost that would have to be incurred by the owner.

91. On the other hand the tenant may not be in a position due to the inequality of their bargaining position, where they are aware of a lack of compliance, to insist that repairs or maintenance be undertaken in a timely manner. In addition managing agents may not be aware of non-compliances and, even if they are, can only incur expenses on behalf of the owner with the owners approval.

92. Such a situation is fraught with difficulty and would only seem to be able to be effectively addressed if the owner had an obligation at law to take all reasonable steps to ensure that the pool barrier fencing and gates are, and remain, compliant. In the circumstances I propose to make a recommendation that this be the case.

The Obligation of sellers of aboveground swimming pools

93. As previously mentioned this was, in part, the subject of recommendations made by Magistrate Railton in 2002.
94. Children “A” and “F” died in aboveground swimming pools. Neither pool was compliant with the safety provisions of the Pools Act. Neither pool had been the subject of an application for council approval.
95. During the course of the inquest evidence was given that dealt with the manner in which aboveground pools were purchased. For the most part this is now done online. Evidence was received from both purchasers and sellers of such equipment.
96. The evidence is that there is no requirement that sellers inform purchasers of their obligations to obtain the approval of their local government authority for the construction of the pool and otherwise comply with the requirements of the Pools Act. This appears to be the same issue that Magistrate Railton was dealing with when he made the recommendation he did in 2002.
97. It would appear that there might be a lack of understanding within the community as to the application of the Pools Act to aboveground swimming pools. I propose to make appropriate recommendations to deal with this issue.

Criminal law.

98. I indicated earlier that a coroner conducting an inquest has an obligation to examine the evidence available and where the coroner forms the view that the requirements set out in paragraph 17 are met the coroner is required to suspend the inquest and refer the matter to the Director of Public Prosecutions.
99. In the cases that were the subject of these inquests the relevant indictable offence is manslaughter by criminal negligence. There is

considerable law on what constitutes this offence which I do not need to go into here however the action, or inaction, that constitutes the offence has been described as follows:

> *"In the case of a negligent act or omission it is necessary that the accused was under a duty of care recognised by law, such that by his or her deliberate act or omission, constituting a breach of that duty of care, he or she fell so far short of the standard of care which a reasonable person would have exercised in the circumstances, and involved such a high risk of grievous bodily harm to another or others, that the act or omission of the accused merited criminal punishment"*

100. For action to amount to criminal negligence, that is to be sufficient to give rise to the offence of manslaughter, it must be established that the degree of disregard for the life and safety of others was such that it constituted a crime against the community generally and be conduct that was thus deserving of criminal punishment.

101. As already mentioned, having considered the evidence available in each case, I am satisfied that there is no basis to consider that any of the carers of the various children who died were negligent in the manner in which they cared for the subject child to an extent sufficient to ground a charge of manslaughter. As such I have no obligation to refer any of the subject matters to the Director of Public Prosecutions in accordance with Section 78 of the Act.

102. That said the loss of life of a vulnerable child is a tragedy. Where it results from the negligence or carelessness of a parent or carer, even if that negligence is not of such a gross nature as to justify a charge of manslaughter, there is none the less reason for a community response.

103. An analogous situation arose in the case of the negligent use of a motor vehicle that resulted in the death of another person. The Parliament, in its wisdom, recognised that there were situations where the level of negligence in the use of the motor vehicle that resulted in a death was not such as to found a charge of manslaughter but did require the public condemnation that would flow from criminal proceedings. The consideration of these issues in the early 1990's led, on 9 April 1992 the then Attorney General to ask the Staysafe

Committee of the Parliament to review existing legislation. This resulted in the publication of the report known as Staysafe 25.

104. In 1994, following consideration of the recommendations contained in Staysafe 25, there was a comprehensive restructure of the relevant law by Parliament which included the creation of the offence of negligent driving occasioning death (Section 42(1)(a) Road Transport (Safety and Traffic Management) Act 1990). This was enacted by the Crimes (Dangerous Driving Offences) Amendment Act 1994 and the Traffic (Negligent Driving Offences) Amendment Act 1994.

105. The circumstances are, of course, different however the loss of life of the innocent victim is the same. It is a precious life that has been cut short. In the case of a child such a death causes untold grief and trauma to both the child's family, the police, ambulance and other workers who are required to deal with such trauma.

106. The ownership of a home swimming pool is a right of the homeowner. It is a social amenity that is of great benefit to those who have use and access to it. With the right however goes the obligation to maintain the pool in a safe manner. Where this is not done and there is a loss of life, particularly of a vulnerable child, and where that loss is due to the negligence of the person responsible for the maintenance of the safety aspects of a pool then the considerations that led to the enactment of the offence of negligent driving causing death appear to be relevant. In the circumstances I propose to recommend that consideration be given as to whether or not a criminal offence ought be created to apply in such circumstances.

107. In making the comments set out above, together with the recommendations that I propose to make, I want to make it clear that by doing so I am not suggesting that any of the parents or carers of the children that were the subject of the coronial investigation or the owners of the pools in which they drowned would, or should, be the subject of such a criminal charge were it to already exist.

108. The bringing of a criminal charge would always be the undertaken by prosecuting authorities applying the ordinary procedures that are followed in such cases. The existence of such a criminal

charge would however emphasise the importance to the community in general of taking matters, such as the maintenance of pool fencing and gates, seriously and the public condemnation of the failure to do so when a life is lost as a result.

Other Matters.

109. During the course of the Inquest the issue of the nature of barrier fencing was raised. There appears to be an issue as to the relative effectiveness of four-sided fencing as opposed to three-sided fencing of home swimming pools. There is also suggested to be an issue as to the possible contribution of pool fencing to the drowning of persons over the age of 56 years in home swimming pools.

110. As to each of these matters I do not consider that the evidence before me was such that I would be able to come to a concluded view. In any event neither of these issues appear to be matters that arose out of the deaths of any of the children that were the subject of inquest and as such there would not be jurisdiction for me to make recommendations in accordance with section 82. In the circumstances I do not propose to deal with this matter any further.

111. In the case of one of the children whose deaths were examined it was found that the house to which the pool formed part was occupied by a family who were carers for a number of children who were in foster care. A question that must be asked is how it was that foster children were allowed to reside in a property in which a non-compliant pool existed. This is not however a question that can be dealt with by this inquest. The child who died in the subject pool was not one of the foster children. Section 82 of the Act allows a coroner to make recommendations concerning matters that arise out of the death of the person whose death is the subject of the inquest. The issue of the approval of the property for occupation by foster children is not a matter that is within my jurisdiction to deal with in this inquest.

Conclusion.

112. The death of any loved one is always distressing. The death of a young child in circumstances that could have been prevented is a tragedy for the family, the community and most of all for the child. It is a life that has not been allowed to develop and contribute to the wellbeing of the community in general.

113. In each of the deaths that were examined could have been prevented. As a community are we not obliged to develop systems that will prevent the unnecessary loss of life, particularly of those who are most vulnerable? I have no doubt that the children involved in this inquest, if they were able to have their say, would ask that all efforts be taken to ensure that the numbers of children who follow them be reduced. The loss of even one innocent life is too many.

Magistrate P.A.MacMahon
NSW Deputy State Coroner
30 April 2010.