File No: 9825209
Rel No: 199/98

The Northern Territory of Australia
Coroners Act

In the matter of an Inquest into the death of
Clinton Leslie Kingsley

FINDINGS

THE NATURE AND SCOPE OF THE INQUEST

On 21 November 1998, Clinton Leslie Kingsley ("the deceased") died at the Minyerri Community (also known as Hodgson Downs) in the Northern Territory. He was 2 years of age, having been born on 18 June 1996. By virtue of s. 12 (1) of the Corner's Act ("the Act"), the death is a reportable death pursuant to sub-paragraphs (i) (ii) and (iv). An inquest was held at Katherine Courthouse on 17 June 1999 and at Darwin Courthouse on 18 June 1999. An inspection of the community environs was held on 16 June 1999. Counsel Assisting was Mr Peter Elliott. Ms. Sievers was granted leave to appear and did appear for S & N. Plumbing, and Mr G. Dooley was granted leave and appeared for the family of the deceased.

Sections 34 and 35 of the Act set out the limits of the Coroner's jurisdiction as follows:

34. CORONERS' FINDINGS AND COMMENTS

(1) A coroner investigating –
(a) a death shall, if possible, find -
(i) the identity of the deceased person;
(ii) the time and place of death;
(iii) the cause of death;
(iv) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act*;, and
(v) any relevant circumstances concerning the death; or
(b) a disaster shall, if possible, find –
(i) the cause and origin of the disaster; and

(ii) the circumstances in which the disaster occurred.

(2) A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated.

(3) A coroner shall not, in an investigation, include in a findings or comment a statement that a person is or may be guilty of an offence.

(4) A coroner shall ensure that the particulars referred to in subsection (1) (a) (iv) are provided to the Registrar, within the meaning of the *Births, Deaths and Marriages Registration Act.*

35. CORONERS' REPORTS

(1) A Coroner may report to the Attorney-General on a death or disaster investigated by the coroner.

(2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

(3) A coroner shall report to the Commissioner of Police and the director of Public Prosecutions appointed under the Director of *Public Prosecutions Act* if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner.

Identity

1. The deceased was Clinton Leslie Kingsley, a male Aboriginal Australian born 18 June 1996 at Katherine in the Northern Territory of Australia. The deceased was registered at birth in the name of Clinton Leslie Joshua, Joshua being his mother's maiden name, but was known through his life by the surname of Kingsley, his father's surname.

Time and Place of Death

2. Death occurred around 1730 hrs on 21 November 1998 at Minyerri Community. The exact time of death is unclear on the evidence.

Cause of Death

3. The cause of death was drowning.

Particulars required to register the Death

4. The particulars required to register the death are:
   (i) the deceased was a male.
   (ii) The deceased was of Australian Aboriginal origin.
   (iii) The death was reported to the Coroner.
   (iv) The cause of death was confirmed by post-mortem examination.
   (v) The death was caused by drowning.
   (vi) The pathologist viewed the body after death.
   (vii) The pathologist was Dr Terence John Sinton of Royal Darwin Hospital.
   (viii) The father of the deceased is Harold Kingsley and the mother is Mildred Jacqueline Joshua.
   (ix) The usual address of the deceased was house 32 Minyerri Community.
   (x) The deceased was an infant.

Relevant Circumstances

During the afternoon of 21 November 1998, Harold Kingsley, Mildred Joshua and the deceased were at their home, house 32 Minyerri Community. Although the precise times that events occurred are unclear, it is clear that during that afternoon Harold Kingsley cooked a meal for the family, and that

this was consumed by (at least) him and Mildred. After eating, they watched a video. Either during the screening of this video, or after its completion, the deceased went outside, with his mother believing he would play with some puppies. On the evidence of Mildred he was out of her sight for a short time, only some minutes, when she started to make enquiries into his whereabouts. These enquiries led to the discovery of his body in a septic tank adjacent to the home.

For a period of at least 2 weeks prior to the 21 November 1998, several employees of a firm of plumbers (S & N Plumbing) had been performing work at the Community. Three people from this firm, Neil Rogers, Hayden McGill and Roger Sjolund gave evidence at the inquest. The work included, inter alia, installing septic tanks to various houses in the Community and repairing concrete guards that were security measures around existing septic tanks. The reasons for the installation of extra tanks was to have a separate tank for toilet waste as opposed to other household waste. It was also the case that the tanks at Minyerri Community were misused, including at House 32. Evidence was lead that unsuitable items were being used as toilet paper, with the result that the tanks were becoming blocked on a regular and routine basis. It was also the case that when taps were left on, as they sometimes were, that tanks filled at a rapid rate, and needed to be emptied. Further, if the taps were not completely turned off, as also sometimes happened, they would develop a slow leak. The result of these three practices was that the septic tanks were unable to operate as designed and access to their interior, via an attachable but removable lid, was required regularly. This created a problem in that the lid was attached to the tank proper by means of self-tapping screws, and regular screwing and unscrewing of these screws meant that they lost their thread, and ceased to work. The result of that was that if the concrete blocks that sat on top of the tank were damaged, or in any other way not effective in stopping unauthorised access to the tank's interior, then the lid was able to be removed, leaving a hole of approximately 2 feet in diameter at the top of the tank. It was through this hole that the deceased obtained access to the tank's interior.

The evidence as to the condition of the fibreglass lids was conflicting. According to Tiny Roy, the person from the community charged with pumping out the tanks, the screws on the tank in which the deceased died were working properly, and he is certain that he screwed them on properly just prior to the deceased's death. Hayden McGill, the apprentice plumber who inspected the lid on the morning of 21 November, felt that the lid was on and properly attached because it looked so, and he could smell nothing coming from the tank. On the other hand, the Workhealth Inspector Mr Martin of the Work Health Authority and Mr Rogers and Mr Sjolund of S & N Plumbers were adamant that the lid was not adhered, that the screws no longer had any adhesion, and, with the concrete removed, there was nothing to stop the deceased gaining access to the interior of the tank. I accept the evidence of Martin, Rogers and Sjolind on this point. If the screws were properly attached, a screwdriver was needed to unscrew them. It is plain that after the event, the screws were no longer serviceable. It is impossible that a 2 year old could have broken a previously serviceable lid, and there is no evidence of any one else being involved.

On the day of the death the plumbers in particular Hayden McGill the apprentice and Sellwood (who I accept was a qualified plumber but employed on this job in a labouring capacity), were instructed to remove the concrete slab covering the septic tank adjacent to House 32. They did not tell Mildred and Harold that they had commenced work, adjacent to their home and on the evidence appear to have believed House 32 was unoccupied. Sjolund directed McGill and Sellwood to remove the concrete covers from the septic tank leaving the tank covered by an ineffective (for reasons previously stated) fibre glass lid. The tanks were left in this exposed and unsafe condition throughout the day. The lid as it was could easily be picked up and removed, even by a two year old (as it probably was).

I should indicate that I accept that the plumbers did not know that the tank at House 32 was left in an unsafe condition. The evidence suggests that they thought the fibreglass lid was in working order and prevented access to the tank.

Notwithstanding the plumber's belief, I find it was unsafe to remove the concrete covers before new covers were ready to be placed over the tanks. The old covers in this instant were not that badly damaged that they could not have remained in place until the new covers were ready. I accept that the new covers had to be made on site, that they were heavy and needed to dry, however, that could have occurred before the broken covers were removed from the tanks at House 32. There was no evidence to suggest that the covers needed to be removed during the morning.

It is clear that the deceased went out to play on his own. How long he was unattended as he played in his community is not able to be accurately determined on the available evidence.

The deceased was playing in his community, he would have been known to everyone and his parents cannot be criticised for letting him play outside. The plumbers had been in the Community for some time and I am sure that the deceased's parents knew they were working on the septic tanks, in particular the tanks adjacent to their home. Mildred and Harold did not know (like the plumbers) that the exposed fibreglass cover was ineffective on the day their son died. I make no criticism whatsoever of the boy's parents and their supervision of him. The death of this boy was, with the benefit of hindsight, avoidable. However, having regard to the knowledge of persons involved on the day, his death was a tragic accident.

Recommendations

Evidence was taken at the Inquest as to why the septic tanks at the Community required regular maintenance.

It became apparent that the tanks were blocking for a number of reasons, including misuse and leaking taps. I am of the view that as the Community's population increases, (as on the evidence it clearly is) there will come a time when a sewerage system will be required. To ensure that it, (and in the interim the septic system) operates as it should, I recommend that the Community consider the implementation of an education program about how to use and understand septic and sanitary systems.

The Inquest also heard evidence about how the concrete covers were damaged by cars driving over them, and because they were used to hold up vehicles as they were worked on. I recommend that prior to the installation, or substantial repair of septic tanks in communities, that the systems and their component parts be designed in such a fashion to prevent them from being driven over or otherwise misused.

I also adopt the suggestion of Counsel for the family that in future greater community involvement be attained before, (and during) capital works programmes are undertaken in remote communities. Such involvement would enable all community members to be informed of the nature of the work and its dangers if any, (and the contractors would be able to communicate with members of the community during the work having had the opportunity of meeting them).

I agree with Counsel assisting that a register of accidents involving tradespeople on Communities be commenced and maintained by the Work Health Authority.