MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of Tallen John Pitt

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Tallen John Pitt (Tallen);

b) Tallen died in the circumstances set out below;

c) Tallen's cause of death was drowning; and

d) Tallen died on 7 November 2020 at Bridgewater, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Tallen's death which includes:

- The Police Report of Death for the Coroner;
- Affidavits as to identity and life extinct;
- Affidavit of the forensic pathologist Dr Andrew Reid;
- Affidavit of the Forensic Scientist Neil McLachlan-Troup of Forensic Science Service Tasmania;
- Medical records obtained from Tallen's general practitioner;
- Electronic patient care record obtained from Ambulance Tasmania (AT);
- Affidavits of Shayleen Dawn-Maree Pitt;
- Affidavits of Zachary Robert Brown;
- Affidavit of Shawn Ransley;
- Affidavit of Michele Smith;
- Affidavit of Stephen Stiglic;
- Affidavit of Amelia Blake;
- Affidavit of Jessie Leary-Hills;
- Affidavit of Janice Pitt;
- Affidavit of Constable Abu Chowdhury;
- Affidavit of Senior Constable Lauren McMahon;

- Affidavit of Constable Courtney Sykes;
- Affidavit of Senior Constable Alisha Barnes;
- Affidavit of Constable Lucinda Baines;
- Affidavit of Constable Adrian Woodhead;
- Affidavit of Sergeant Brad Conyers;
- Affidavit of Detective Sergeant Gregory Lowe; and
- Body worn camera footage, photographs, forensic evidence and miscellaneous paperwork.

The Role of the Coroner

In Tasmania, the coroner's functions are set out in s28(1) of the *Coroners Act* 1995 (the Act). By this section, the coroner is required to find the identity of the deceased, how death occurred, the cause of death and when and where death occurred. By s28(2), a coroner may make comment on any matter connected with the death; and by s28(3), a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.

Coroners complete their written findings pursuant to s28(1) into a reportable death after receiving documentary evidence in the investigation. In a small proportion of reportable deaths, the coroner will hold a public inquest, which almost always involves the calling of oral testimony to further assist the coroner in his or her investigatory function and subsequently, in the making of findings. Many of the public inquests held by coroners in Tasmania are made mandatory by the Act.[1] The remaining inquests are held because the coroner considers that a public inquest is desirable in the particular circumstances of the investigation.[2] I do not consider it desirable to hold an inquest in this case, even though as will be seen below there is a factual dispute between what Ms Pitt says occurred and what Mr Brown says occurred, because I am able to perform each of my duties in s28 without the need to resolve that factual dispute.

When investigating any death, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial; whereas in criminal or civil proceedings the proceedings are adversarial; that is one party against another.[3] In these proceedings I am required to thoroughly investigate the death and answer the questions (if possible) that s28

[1] S24(1) of the Act.
[2] S24(2).
[3] *Attorney-General v Copper Mines of Tasmania Pty Ltd* [2009] TASFC 4 at [21].

of the Act asks. Those questions in s28(1) include who the deceased was, how he died (that is the circumstances surrounding his death), what was the cause of the death and where and when it occurred. This process requires the making of various findings, but without apportioning legal or moral blame for the death.[4] A coroner is required to make findings of fact from which others may draw conclusions.

A coroner does not have the power to charge anyone with a crime or an offence nor does she or he have the power to award compensation. A coroner also does not have power to determine issues associated with an inheritance or other matters arising from the administration of deceased estates.

As noted, one matter that the Act requires is that a finding be made about how death occurred. It is well settled that this phrase involves the application of the ordinary concepts of legal causation. Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by s28(1)(b) upon the Coroner.[5]

A coroner may comment on any matter connected with the death into which she or he is enquiring. The power to make comment *"arises as a consequence of the [coroner's] obligation to make findings … It is not free ranging. It must be comment 'on any matter connected with the death' … It arises as a consequence of the exercise of the coroner's prime function, that is, to make 'findings'".*[6]

The standard of proof applicable to a coronial investigation is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an investigation reaches a stage where findings may reflect adversely upon an individual, the law is that the standard applicable is that set out in the well-known High Court case of *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation is proved must be approached with great caution.[7]

Background

Tallen was four years of age (date of birth 2 October 2016), and he resided with his mother Shayleen Pitt and her partner Zachary Brown at the date of his death. Tallen's biological father is Timothy Smith but he had no interaction with Tallen after his birth. Tallen had two

[4] *R v Tennent; ex parte Jaeger* [2000] TASSC 64, per Cox CJ at [7].
[5] See *Atkinson v Morrow & Anor* [2005] QCA 353.
[6] See *Harmsworth v The State Coroner* [1989] VR 989 at 996.
[7] (1938) 60 CLR 336 per Latham CJ at 347 and Dixon J at 362 and 368-9.

older half-brothers who resided with him when it was his mother's turn to have custody of the boys. They were not staying with their mother at the date of Tallen's death.

Ms Pitt's pregnancy with Tallen was incident free and he was born at the Royal Hobart Hospital without any complications. Following his discharge from hospital Tallen had no significant health issues. He had regular visits to his general practitioner for checkups and immunisations. He was, according to his mother, an active and healthy child who did not have any allergies or other general health concerns. He did however, according to his mother, suffer from delayed intellectual development. His speech was not to the standard of a child of his age and he usually communicated with a simple but limited vocabulary. On 4 September 2020 Tallen was referred to the paediatric clinic at the Royal Hobart Hospital for an assessment with respect to these concerns.

Tallen had 7 appointments with his GP at which he received five immunisations and had a general checkup at six of those appointments at which no issues were identified. His last appointment, which led to the referral to the paediatric clinic, on 4 September 2020 was when his mother advised the general practitioner about her concerns with respect to speech delay, tantrums and Tallen wanting to play by himself.

Circumstances Leading to Death

Ms Pitt says she suffers from fibromyalgia. This is a disorder which is often characterised by widespread musculoskeletal pain accompanied by fatigue and difficulties with sleep and memory. In order to enable her to exercise and keep her weight in check Ms Pitt purchased, on 6 October 2020, a pool online. It arrived within approximately 2 to 3 weeks of the purchase date. On its arrival it was set up by Mr Brown in the front yard of the couple's home. It was not heated and did not have a cover.

A ladder was used to access the pool which was positioned inside the pool when not in use. Ms Pitt says Tallen had used the pool twice in her company prior to his death. She says he had not had any swimming lessons and could not swim.

On 7 November 2020 Tallen spent the day with his mother. His brothers were absent that day and Mr Brown left their home early that morning. Ms Pitt says she left the front door of the home closed but unlocked as Mr Brown was expected to return that afternoon. The weather was clear, it was daylight and partially cloudy.

In the afternoon Ms Pitt says she prepared a meal for Tallen and she played with him that afternoon. She says he was wearing a jumper which she removed after he spilled his afternoon meal of chicken, pasta and vegetables on his jumper. This left him wearing a T-

shirt and a nappy. She says the day had been unremarkable and incident free up until the time of the drowning.

At approximately 4:25pm Ms Pitt went to use the bathroom leaving Tallen in the lounge room. She left the toilet door open and called his name periodically to ensure he was still in the living room. At some point she says Tallen came to the toilet door and pushed the door shut while she was still inside. She says she continued to call his name without receiving a response. Ms Pitt spent approximately five minutes in the toilet before she exited the bathroom and saw Mr Brown returning home.

Mr Brown asked about Tallen's whereabouts after which both he and Ms Pitt began to look for Tallen. Mr Brown left the residence and walked along Bromley Street and headed towards the corner of Albion Road. This is because Tallen is said to have frequently run out onto the street towards a particular address. Ms Pitt began searching inside the residence but after a short period she exited the residence and checked the pool and located Tallen face down, floating in the pool near the top railing in the area closest to the residence. He was observed to be unresponsive, cold to touch and purple in colour. Ms Pitt removed Tallen from the pool at approximately 4:35pm and commenced cardiopulmonary resuscitation (CPR) for approximately one minute while Mr Brown contacted 000.

Mr Ransley who was visiting his nephew at a nearby home came to Tallen's assistance. He commenced CPR which he continued for approximately 12 minutes under the direction of the operator on the 000 call. Paramedics from AT then arrived and commenced treatment. Police officers arrived on the scene at approximately 4:59pm while paramedics were performing CPR. Tallen could not be revived and he was pronounced deceased at 5:10pm.

Investigation

Attending police spoke to a number of people who were present and they visited neighbouring properties and found no eyewitnesses to the incident nor any CCTV footage. Affidavits were taken from relevant witnesses and enquiries were made of the Brighton Council. The scene was inspected and photographs were taken.

Looking at Tallen's home from the street there are wooden paling fences on both sides which are approximately 1.5 m in height. Across the driveway is a two-piece cyclone wire gate of approximately the same height which runs between the two boundary fences and which is secured by a latch. The left side, or first piece of the gate, is a gate through which a person can walk and to which an arm is attached. The right hand side, or second piece, of the gate forms the largest side of the gate and that has a mechanism to which the arm from the left-hand side of the gate attaches. An unlocked padlock was attached to the right-hand

side of the gate. At the time of the incident the gate was open which permitted unimpeded access to the pool from the street. The home itself was a single story grey brick residence located in a cul-de-sac. The residence was L-shaped with the front door facing towards the front fence and gate.

The pool was a 15 foot Bestway Steel Pro Max model sold by Myer. It was ordered by Ms Pitt on 6 October 2020. It held approximately 16,000 L of water and was 1.25 m high. It had been set up by Mr Brown on or about 5 November 2020. It was positioned in the front yard of the property approximately two metres to the left of the driveway on the grass. A ladder was used to access the pool which was observed by police to be inside the pool at the time of their attendance. Printed on the side of the pool was a warning not to dive in shallow water because it could result in permanent injury and that in order to prevent drowning children were to be watched at all times. There was a large pink inflatable and four pool noodles floating in the pool. The pool was connected to an electric filter which was operating. The pool was in good condition. On the ground between the pool and the side fence were some semi-inflated pool toys. On the exterior pool wall closest to the driveway were three areas of dirty marks. Towards the base of the exterior pool wall was a reinforcement strip which ran over the vertical poles of the pool and in two areas this strip was creased through the middle. On the driveway side of the pool (Side A), the pool was measured at 1240 mm in height, on the side of the pool which faced the front fence (Side B) it measured 1200 mm, on the side of the pool which was adjacent to the side fence (Side C) it measured 1210 mm and on the side of the pool which faced the house (Side D) the height was 1205 mm. The water level was measured on each side of the pool at 1000 mm (Side A), 980 mm (Side B), 905 mm (Side C) and 965 mm (Side D) respectively. The diameter of the pool from side A to C was 4420 mm and from side B to D it was 4600 mm. From the ground to the top of the inflatable toys beside the pool measured 270 mm, the inflatable toys in the pool were 500 mm from Side A and from the ground to the top of a reinforcement strip that was placed around the bottom of the pool was a distance of 320 mm. It was 400 mm from the edge of the pool to the ladder which was inside the pool. Tallen himself was 1000 mm tall however when his arms were extended above his head he measured approximately 1200 mm. No fingerprints were detected on the pool.

AT received the call to attend Tallen's home at 4:36pm. Paramedics were on the scene eight minutes later. Despite the treatment detailed in AT's report Tallen could not be revived.

The forensic pathologist Dr Andrew Reid conducted a post-mortem examination on 10 November 2020. As a result of that examination and after consideration of a post-mortem CT scan and the results of histology, microbiology and toxicology Dr Reid says the cause of death is drowning. He noted drowning is a diagnosis of exclusion and some of the

characteristic features of drowning were not seen in this case because there was bystander CPR and further resuscitation by AT. Witness accounts describe water and fluid being expelled from Tallen's aerodigestive tract at the time of resuscitation. These actions would have dispelled or dissipated any frothy fluid/plume which might have formed in association with drowning. The autopsy itself revealed slightly over expanded, overinflated lungs meeting in the midline and features consistent with drowning on histology examination. There were also features of aspiration of gastric contents, both on macroscopic examination and on histology. Dr Reid notes there was no other evidence of any natural cause or condition which either contributed to death or which may have caused Tallen to have tripped, slipped, fallen or otherwise become immersed in the water. Dr Reid noted fluid levels within facial bone sinuses can occur in drowning and after passive post-mortem immersion in water. However, in the absence of evidence of a natural cause of death or any other explanation for the cause of death, a diagnosis of drowning can be made by exclusion in this case. As would be expected, alcohol and illicit drugs were not detected on toxicology.

Ms Pitt advised police she was aware she needed to have secure fencing around the pool but they had a few young family members over to their home and she decided to set the pool up without the fence. She accepts that erecting a fence around the pool was her responsibility. Ms Pitt advised police she had always had pools and was aware of the requirement to fence. She and Mr Brown had planned to put a fence up and were going to do it themselves because of Mr Brown's prior experience in fencing. They intended to purchase the fence from Bunnings after their payday which was 9 November 2020.

Mr Brown advised police he had been in a relationship with Ms Pitt for about four years at the time of this incident. He was not Tallen's biological father but he confirmed that he looked after him as if he was. He confirmed Tallen was healthy and *"he always wanted to be up and about doing things"*. Mr Brown was unemployed but he helped Ms Pitt look after her children and he also helped out other people with chores so as a result he was not home all the time. At 10:30am on 7 November 2020 he received a phone call from a family friend to assist in removing some rubbish from his mother-in-law's yard. He did some grocery shopping before he went to his mother-in-law's home. The balance of Mr Brown's first affidavit is consistent with the circumstances set out on page 5.

In Mr Brown's supplementary affidavit he advised that since Tallen's death he and Ms Pitt had separated in part because he blamed her for Tallen's death. He said on 7 November 2020 she had smoked two to three cones of cannabis before he left the residence and when he returned she was on the couch in a sleepy state and she did not know where Tallen was. It was then they started searching for him. Mr Brown advised Ms Pitt used cannabis daily and slept during daylight hours after use for between one and six hours. Mr Brown became

convinced Ms Pitt had fallen asleep and lost track of Tallen and had not gone to the toilet as previously advised. He indicated she had made changes to her story over time and that she told him to *"not mention about her being on the couch and stick to the story that she was in the toilet"*. Mr Brown confirmed he had become upset about this three to four days after the incident and therefore he confided in Ms Leary-Hills.

Mr Ransley who was on the scene and who assisted with CPR confirms a female who I infer was Ms Pitt was frenetic and crying and stating she had been in the toilet for only a short period of time and that it was no longer than five minutes. Mr Ransley who had previously done first aid training and CPR training associated with his work commented that Tallen was blue and very cold to touch and therefore he deduced he had been in the pool for longer than five minutes.

Ms Leary-Hills picked up Mr Brown on the morning of 7 November 2020 so that he could assist her move rubbish from her mother's home. When she arrived she saw the pool, without any fence and a stepladder was placed on the edge of the pool. One side of the ladder was inside the pool and the other side was outside the pool. She became concerned about children jumping in the pool so she threw the stepladder into the middle of the pool in order to stop children getting in. She says Mr Brown returned home mid-afternoon and she attended his home after she became aware of this tragedy. She says she heard Ms Pitt say she had been feeding Tallen in his high chair and then she went to the toilet. When she came out she could not find him in the house. About three or four days later Ms Leary-Hills says Mr Brown told her that Ms Pitt had left the front door unlocked for him to get back in but then she had fallen asleep on the mattress in the lounge room for a couple of hours. She says Mr Brown also told her he promised Ms Pitt he would not tell anyone about her falling asleep.

Janice Pitt is Ms Pitt's mother. She was cleaning up her property with the help of Mr Brown, Ms Leary-Hills and others on 7 November 2020. She says her daughter also told her on 7 November 2020 she was using the toilet when she lost track of Tallen.

Michele Smith is the grandmother of one of Tallen's half brothers. Her grandson and her son would stay with her each weekend. She became concerned about her grandson's personal hygiene. She was reluctant, when she would pick up her grandson from Ms Pitt's home, to enter her home because she observed the house to smell of cigarettes and cat urine. She says Ms Pitt had a number of pets that she would not clean up after. She raised this and other concerns with respect to her grandson's care with Child Safety Services. Similar concerns were raised with Child Safety Services by Stephen Stiglic; the former partner of Ms Smith and the grandfather of one of Tallen's half-brothers. He observed dog and human

faeces in the corridor and the kitchen table was cluttered with dirty pots and dishes and dirty laundry, rubbish and empty food boxes and containers were scattered across the floor.

Attending police namely Constable Baines, Constable Sykes, Constable Woodhead and Sergeant Conyers all comment on the residence smelling strongly of cigarettes and that there was rubbish, human and animal waste and soiled clothing and bedding strewn throughout the house. Sergeant Conyers reported his concerns to Child Safety Services.

Detective Sergeant Gregory Lowe also attended the scene of this incident and examined it. He was shown by Sergeant Conyers several marks and scuffs around the outside of the lining of the pool which he believes is consistent with Tallen attempting to climb into the pool. No obvious injuries were detected to have been sustained by Tallen. He believes the scene was consistent with the account provided by Ms Pitt who was inside the residence at the time of her son's death. He goes on to say from his enquiries Tallen was known to be very energetic and a good climber but he could not swim. The water temperature was taken and it measured 18.3° Celsius. He and Sergeant Conyer's arrived at the conclusion Tallen's death was not suspicious but it was extremely unfortunate. He believes Tallen made a number of attempts to climb into the pool and was finally successful. He was then unable to climb back out or reach the ladder and he drowned. I agree with Detective Sergeant Lowe's opinion.

Amelia Blake is a permit authority[8] with the Brighton Council (the Council). Her functions in that capacity are set out in s25 of the *Building Act* 2016. That section provides as follows:

> *"(1) A permit authority has the following functions in respect of building work, plumbing work or demolition work:*
>
> *(a) to accept applications submitted to it under this Act and, if the application is incomplete, to seek further information before considering the application;*
>
> *(b) to consider any application submitted to it under this Act within the relevant specified period for the application;*
>
> *(c) to accept any other documents submitted to it under this Act and seek further information in respect of the document if required;*
>
> *(d) to ensure that any permit issued by the permit authority is in accordance with this Act;*

[8] See s24 of the *Building Act* 2016-
"S24 (1) A permit authority means –
(a) a person appointed under subsection (2) or subsection (5)(a) for a municipal area; and
(b) if the Minister has published a notice under subsection (6) , the Director of Building Control.
(2) The general manager of a council must appoint a person as a permit authority for the municipal area of that council.
(3)-(6)…"

(e) to comply with this Act when issuing, or refusing to issue, a permit under this Act;

(f) to ensure that work performed under a permit is to be performed by appropriately qualified persons;

(g) if appropriate, to issue a certificate as required under this Act.

(2) A permit authority has the following general functions:

(a) to make the public aware of the building and plumbing requirements in the State and the application of this Act;

(b) to ensure compliance with this Act as required under this Act;

(c) to keep any registers required to be kept by a permit authority under this Act".

Ms Blake says the council has a pamphlet which outlines the requirements when a pool is being installed in the Brighton municipality. There is no specific legislation like there is in New South Wales,[9] for example, with respect to swimming pools. Part 2 of Division 1 of the New South Wales *Swimming Pools Act* 1992 provides for access to swimming pools for dwelling houses and s7(1) says:

"(1) The owner of the premises on which a swimming pool is situated must ensure that the swimming pool is at all times surrounded by a child-resistant barrier--

a. that separates the swimming pool from any residential building situated on the premises and from any place (whether public or private) adjoining the premises, and

b. that is designed, constructed, installed and maintained in accordance with the ***standards prescribed by the regulations.***

: Maximum penalty--50 penalty units." (my emphasis)

The standards prescribed in the *Swimming Pools Regulations* (NSW) 2018 are those set out in the *Building Code of Australia.*[10]

In Tasmania s11(1) of the *Building Act* 2016 says a person performing building work, plumbing work or demolition work must ensure that work complies with the Act and the applicable provisions of the National Construction Code (NCC). The NCC is defined in s4 of the *Building Act* 2016 as the NCC series published by the Australian Building Codes Board. The NCC is published in three volumes. The Building Code of Australia is volumes one and two and the Plumbing Code of Australia is volume three. Swimming pool is defined in the NCC

[9] *Swimming Pools Act* (NSW) 1992.
[10] See Regulation 5.

as *"any excavation or structure containing water and principally used, or that is designed, manufactured or adapted to be principally used for swimming, wading, paddling, or the like, including a bathing or wading pool, or spa"*.[11] If a swimming pool or spa holds a depth of water of 300 mm or more then the NCC requires installation of a pool safety barrier. A barrier must be constructed around a swimming pool and must:

(a) extend continuously for the full extent of the pool; and
(b) be of a strength and rigidity to withstand the perceivable impact of people; and
(c) restrict the access of young children to the pool and the immediate pool surrounds; and
(d) have any gates and doors fitted with a latching device that is not readily operated by young children, and constructed to automatically close and latch.[12]

Safety barriers must be installed in accordance with Australian Standard (AS) 1926.1- *"Swimming pool safety – Safety barriers for swimming pools"* and AS 1926.2 *"Swimming pool safety – Location of safety barriers for swimming pools"*. In Tasmania installation of pool safety barriers must be performed by a licensed builder and overseen by a licensed building surveyor.

Ms Blake advises the council's requirement, when a pool is installed, is that the work is performed by a licensed builder and overseen by a licensed building surveyor. She says fencing or barriers should be installed before the pool can be used and if that does not occur the pool must be drained or emptied or if that is not possible precautions must be in place until the fencing is installed. She says the council refers pool owners to building surveyors to ensure fencing or barriers are appropriate and meet the relevant code. The Council itself does not have surveyors who liaise with pool owners. She says it is the owner's responsibility to liaise with the building surveyor.

Ms Blake goes on to say the council only does random checks of pools as they do not have the staff or resources to conduct regular, routine checks. Sometimes a member of her section of the Council comes across a pool while on his or her way to another job, or her section is notified by another section of Council. Occasionally the council receives phone calls or emails from the general public about non-compliant pools.

Ms Blake says if a pool is found to be non compliant, the owner is sent a letter informing them of the issue and how to rectify the situation. If the home is owned by Housing Tasmania, that entity is contacted with a request that the tenant is followed up. Advice is

[11] Page 192 Volume 2 NCC.
[12] Page 139 Volume 2 NCC.

provided that the pool needs to be emptied or removed immediately until such time fences or safety barriers have been installed in accordance with the NCC. A person is given 14 days to respond to such a request and she says no penalty has ever been imposed because people have always complied with the requirements set out in the letter sent to them by the Council.

Ms Blake says from November 2019 until November 2020 the Council responded to approximately 30 to 50 reports of non-compliant pools. She says they do not have a list of properties with pools in the municipality but once a complaint is received or a pool is assessed a record is entered into the Council's database. She had no knowledge of any pool at Tallen's home and nor had the Council received any complaints from the general public in relation to that pool.

The Royal Lifesaving Australia *"National Drowning Report"* 2023 says that during the period between 1 July 2022 and 30 June 2023, 281 people drowned in Australia. Of those there were 29 drowning deaths in swimming pools and of those deaths six were of people aged between zero and four years of age. Pleasingly it was reported the *"number of drowning fatalities in young children (0-4 years) was 33 per cent below the 10-year average, highlighting the ongoing success of legislative changes to pool fencing regulations and water safety messages directed at the carers of young children".*[13]

It was also reported 11% of all drowning deaths occur in private swimming pools however among children aged 0 to 4 years this figure rises to 50% which is the highest of any age group. Accordingly young children are the age-group at the highest risk of drowning in private swimming pools. It is said they are curious and naturally attracted to water and once they become more mobile children are at an increased risk of drowning. Data from the Australian Bureau of Statistics shows drowning is the number one cause of death in one, two and three-year-old children.

The Royal Lifesaving Australia report indicates previous research identified the risk factors for drowning among children which included lapses in adult supervision and a lack of appropriate barriers around water. The report says lapses in adult supervision are commonly caused by distractions such as indoor and outdoor household duties, talking or socialising, electronic distractions and childcare. *"In situations where a distraction leads to a lapse in supervision, a barrier between a child and water can prevent unaccompanied access and thus, prevent child drowning. Pool fencing functions as an environmental intervention, averting unintended access to water".*[14]

[13] See page 4 of the report.
[14] See page 70 of the report.

The report mentions the Australian Water Safety Strategy 2030 (AWSS 2030) which acknowledges the complexity of reducing drowning in Australia and which identifies children aged 0-4 years as a priority population. *"Existing interventions include public awareness campaigns, jurisdictional pool fencing legislation, swimming and water safety education for children and first aid training for parents and carers"*.[15] It is noted progress has been made, with fatal child drowning falling by 50% over the last ten years. However despite this improvement, one-year olds still record the highest fatal drowning rate of any age group at 3.47 deaths per 100,000 population. Programs such as Royal Life Saving's Keep Watch Program (the Program) aim to reduce child drowning by educating parents and carers of children aged 0-4 years.

Finally in so far as drownings in this age group is concerned the Program advocates four strategies to keep children safe around water:

1. Supervise: Actively supervise children around water at all times,
2. Restrict: Restrict children's access to water by placing a barrier between the child and water,
3. Teach: Teach children basic swimming and water safety skills and
4. Respond: Learn how to respond in an emergency and make sure first aid skills are up to date.

I endorse those strategies.

Comments and Recommendations

Tallen's death tragically occurred for reasons identified in the *"National Drowning Report"* referred to above; namely a lack of parental supervision and a lack of appropriate fencing. Whether the lack of supervision was due to Ms Pitt being asleep or in the bathroom does not change the fact that Tallen was not appropriately supervised. The risk to Tallen was heightened by the fact the front door was unlocked which, given the absence of pool fencing, meant that once he was not supervised he had unimpeded access to the pool. I note Ms Pitt accepts responsibility in relation to fencing the pool and as Tallen's mother she is, by definition, responsible for supervising him.

Ms Pitt says that she and Mr Brown intended to erect fencing themselves. I **comment** that unless they were licensed builders they were not permitted to do so.

[15] See page 70 of the report.

In the investigation into the death of Kobie Blackaby [2016] TASCD 210 Coroner McTaggart said:

"With the introduction of cheaper and smaller portable and inflatable pools into the market, there appears to have been an increase in the number of pools in Tasmania which do not comply with Tasmanian pool fencing requirements. I am not, however, aware that any such increase has been officially monitored or that statistics are available". I find myself in the same position as Coroner McTaggart. I note in this case Kobie drowned in an unfenced inflatable pool.

In that case Coroner McTaggart made the following recommendations:

*"I **recommend** that the responsible State and local government bodies determine and monitor the extent of any increase in the number of portable and inflatable pools purchased in Tasmania, and, consequently, develop and implement appropriate water safety strategies relating to such pools.*

*I **recommend** that the responsible State and local government bodies incorporate into existing water safety awareness and education strategies, a public education and awareness campaign highlighting the requirement for approved pool fencing relating to the installation of portable and inflatable pools.*

The above recommendations are supported by the Royal Life Saving Society Australia".

I am not aware of those recommendations being implemented and clearly the first recommendation is not relevant to this case as the pool purchased by Ms Pitt was not inflatable or portable. Although the second recommendation is relevant, given the absence of fencing in this case, had it been implemented it would have made no difference as Ms Pitt was well aware of her responsibility to provide fencing although I suspect she was not aware of the technical requirements for the fencing or what qualifications were required before someone could erect it.

I make the following **recommendations**:

1. The State Government consider implementing legislation similar to the NSW legislation discussed above which creates an offence for the owner of premises on which a pool is situated which is not surrounded by a child proof barrier or fence;
2. The Brighton Council implement a program whereby pools within its municipality are checked to ensure compliance with the requirement to fence. Clearly pools are not limited to that municipality alone so in my view all Councils ought to be implementing such a program; and

3. The relevant State Government Department and each Council ought run an education program prior to summer each year which highlights the key messages of the Royal Life Saving's Keep Watch Program referred to above and also the legal requirements with respect to the fencing of pools.

A draft of this decision was forwarded to Mr James Dryburgh who is the General Manager of the Brighton Council. He responded very promptly indicating that both he and Ms Blake reviewed the draft *"and we do not have any issues with it."*

Attempts to contact Ms Pitt on five occasions so that a copy of the decision could be provided to her for comment were unsuccessful. On each occasion her number was called there was a message indicating her mobile was not accepting incoming calls at this time.

I **commend** the efforts of Shawn Ransley who immediately came to Tallen's assistance and attempted to revive him.

I extend my appreciation to investigating officer Constable Abu Chowdhury for his investigation and report.

I convey my sincere condolences to Tallen's family and loved ones.

Dated: 7 August 2024 at Hobart, in the State of Tasmania.

Magistrate Robert Webster
Coroner