STATE
CORONER
VICTORIA

11th February, 2004
Case No: 95/99

RECORD OF INVESTIGATION INTO DEATH

I, **LEWIS PHILLIP BYRNE**, Coroner,

having investigated the death of ABUBAKER AZIZ with Inquest held at Coronial Services Centre, Southbank on the 10th November, 1999, 15th July, 2002, 10th November, 2003 and 11th February, 2004
find that the identity of the deceased was ABUBAKER AZIZ and that the death occurred on the 10th January, 1999 at Royal Children's Hospital from

1(a). COMPLICATIONS OF NEAR DROWNING

in the following circumstances:

Abubaker Aziz died on the 10th of January 1999 at the Royal Children's Hospital without regaining consciousness following a near drowning on the 30th December 1998 which resulted in severe hypoxic brain damage and subsequent multi organ failure.

Abubaker Aziz was a 14 year old boy who immigrated to Australia from Pakistan with his family in June 1998. Abubaker was apparently a quiet, cautious boy who, although he had had two basic swimming lessons as part of a Moreland City Council school holiday activity program, for all intents and purposes was unable to swim.

On the 30th of December 1998 at approximately 4:00pm he attended at the Coburg outdoor municipal pool without the knowledge of his mother or father. It would appear he attended at the pool merely to observe the activities of other young attendees.

The Coburg Pool was managed by RANS Management Group Pty Ltd under contract from the City of Moreland. On the 30th December two employees of RANS Management, Adam Wild the Pool Manager and Julie Jones the Assistant Manager were rostered on. Both Mr. Wild and Ms. Jones were accredited lifeguards. At approximately 4:20 pm, certainly prior to 4:30 pm on the 30th December, Mr. Wild left the facility, leaving Ms. Jones alone to carry out all functions, including pool supervision. All pools including the diving pool were open and able to be utilized by patrons. Whilst I cannot be precise, by the time Adam Wild left there were probably less than 20 people at the pool.

A statement was obtained from Paul Amatore, an adult, who says he saw a boy, who I conclude was probably Abubaker, start to climb down a ladder facing the diving board (ie. with his back to the ladder); Mr. Amatore did not, however, see this boy actually enter the water. At one point Abubaker was seen sitting on the edge of the diving pool with his legs dangling in the water.

Some time later at approximately 5:00 pm, children observed what they concluded was a human figure on the bottom of the diving pool. One child alerted his father Mr. John Capuano, who rushed to the diving pool, dived in and brought Abubaker to the surface. Another related the observation to Jones, who rushed to the diving pool and assisted Mr. Capuano in lifting the unconscious Abubaker from the pool. Jones, a qualified lifeguard,

commenced CPR and 000 was contacted and advised of the emergency. Several ambulances attended including a MICA unit. Ambulance officers took over, continued attempts at resuscitation and subsequently conveyed Abubaker to the Royal Children's Hospital where he remained on life support.

During the afternoon of the incident there were a number of teenage boys "skylarking" at the pool including pushing each other into the pool. In spite of quite extensive enquiries by police, police have been unable to identify these individuals. I have no direct evidence Abubaker was pushed into the diving pool. Whilst that is certainly possible, a finding that occurred cannot, on the evidence, be made. It is also quite possible Abubaker fell into the pool, although I note he has been described as a cautious, careful boy. In the final analysis, how Abubaker came to be in the water of the diving pool, the evidence does not enable me to say.

On the 9th of January Abubaker's condition further deteriorated and despite continued efforts to sustain life he passed away at 4.45 am on the 10th of January 1999 without having regained consciousness.

There has been strident criticism of RANS in some quarters, some probably warranted, some not.

Quite early in the investigation, police indicated there was a prospect that serious criminal charges, including negligent manslaughter, conspiracy to pervert the course of justice and subornation of perjury, were likely to be laid against various RANS personnel.

Not surprisingly this had a bearing on how RANS dealt with investigating police. In fairness I think the matter needs to be put in context. Rigby Cooke solicitors were engaged to in effect manage RANS responses. RANS approach is explained by their solicitor Mr I. K. Fullagar of Rigby Cooke solicitors in a letter to Detective Murphy dated 18 February 1999. He stated:

> *"As previously advised our client is keen to assist the Police in this matter and not be seen as uncooperative. Regrettably because of the aggressive nature of the Police action taken earlier this year, (evidenced by the execution of a search warrant at RANS Head Office and the aggressive questioning of our client's staff at a number of our client's facilities), our client has had to take a defensive approach, because our client did not have enough knowledge of the circumstances of the incident to make or prepare definite statement to the Police."*

Although the suggestion that the execution of a "search warrant" was an act of aggression is an extraordinary claim, I do not view RANS approach as other than prudent. Although there was a delay in the provision by senior management of statements I do not conclude that necessarily represents an endeavour to jeopardise/compromise the investigation.

Prior to me having carriage of the matter, the coroner to whom the case was originally allocated directed the matter to the Office of the Director of Public Prosecutions with a view to determining whether prosecutions were in fact proposed.

Subsequently in a letter to the Registrar of this office dated 23rd of January 2002, the following advice from the DPP was received:

" I do not believe that there is anything in the conduct of Ms. Jones or Mr. Wild which could be said to amount to gross negligence for the purpose of a prosecution for Manslaughter, or in the conduct of Mr. Wild which can amount to subornation or attempting to pervert the course of justice. The conduct of RANS in the investigation is not desirable but it is highly unlikely to be criminal. The inquest ought to proceed and the matter can be revisited. It would be desirable for the coroner to be assisted by somebody briefed by the OPP."

_____

Before turning to the critical findings of causation and/or contribution I think it is important to make some observations concerning what I see as the Coroner's role and function and outline my understanding of several principles of law that are critical to the exercise of that function, namely the vexed issue of causation and the somewhat controversial question of the applicable standard of proof.

CORONERS ROLE AND FUNCTION

The Coroner's responsibility is to investigate the circumstances of the death; find the facts (as best one can) set out the facts in a formal finding; the facts then speak for themselves leaving others to apportion blame, allege culpability, draw legal conclusions and make judgements.

Broderick Committee (UK) (para 16.40) observed:

> "*In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceedings which affords to others the opportunity to judge and issue and one which appears to judge the issue itself."*

The Coroner's Act *1985*, Section 19(1)(a)-(c) provides the core findings a Coroner must make. They include findings of "how the death occurred" (section 19(1)(b)) and "the cause of death" (section (19)(c)). Sub-section (2) of Section (19) provides a Coroner may also "comment on any matter connected with the death."
In a landmark judgement which I believe has had the effect of focusing Coroners on the true nature of their task Mr. Justice Callaway in Keown v Khan (1999) VR 69 @ 76 stated:

> *"In determining whether an act or omission is a cause or merely one of the background circumstances, that is to say a non-causal condition, it will sometimes be necessary to consider whether the act departed from a norm or standard or the omission was in breach of a recognised duty, but that it is the only sense in which para. (e) mandates an inquiry into culpability. Adopting the principle recommendation of the Norris Report, Parliament expressly prohibited any statement that a person is or may be guilty of an offence. The reason for that prohibition apply, with even greater force, to a finding of moral responsibility or some other form of blame: the proceeding is inquisitorial; the conclusion would be more undetermined than a conclusion about legal responsibility; and there would be no prospect of a trial at which the person blamed might ultimately be vindicated by an acquittal."*

Callaway, J.A, drew a clear distinction between cause, or one of several causes of death, and a "background circumstance."

CAUSATION

The authorities established that causation has to be considered within the legal framework in which it is used. In considering the fundamental and difficult concept of causation it was suggested by Hedigan J., in Chief Commissioner of Police v Hallenstein (1996) 2 VR1, that the statements of principle relating to causation in the context of the law of negligence are applicable in this jurisdiction. The authorities further suggest that as the concept of causation is not susceptible of reduction to a satisfactory principle or formula, the application of common sense to the particular circumstances assists in determining the issue (see March v Stramare P/L (1991) 171 CLR 506; Fitzgerald v Penn (1954) 91 CLR 268; Chief Commissioner of Police Hallenstein (1996) 2 VR 1).

Another aspect of causation bears comment; often it is not one sole event that can be said to have caused an outcome, it can be a series of events, often some more significant than others, cumulatively, that can be said contributed or caused the death.

STANDARD OF PROOF

The Supreme Court of Victoria has repeatedly emphasised that the test expounded in Briginshaw v Briginshaw (1938) 60 CLR 336 should apply to findings of causation and contribution where the questions relate to individuals or other entities acting in their professional capacity (see Anderson v Blashki (1993) 2 VR 89; Health and Community Services v Gurvich (1995) 2 VR 69 and Chief Commissioner of Police v Hallenstein (1996) 60 CLR 336 Dixon, J. (as he then was) at p.362.3 explained the standard:

> *"Except upon criminal issues to be proved by the prosecution, it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. The reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular are considerations which must affect the answer to the question whether the issue has been proved to be reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences...When, in a civil proceeding, a question arises whether a crime has been committed, the standard of persuasion is, according to the better opinion, the same as upon other civil issues...But, consistently with this opinion, weight is given to the presumption of innocence and exactness of proof is expected".*

At the inquest Mr. Frank Gucciardo represented Moreland City Council the owners of the Coburg pool. RANS, as private operators were given the responsibility under contract of managing the pool. In those circumstances the Council has an obligation to ensure the private operators contracted manage the pool efficicatiously, in an professional manner with acceptable and appropriate practices and procedures in place. Among other things this would necessarily involve policies and procedures in place providing for safe pool management. I dispose of this issue shortly in two paragraphs.

Moreland City Council (the Council), prudently in my view, in fact engaged the Royal Life Saving Society of Australia, Victorian Branch (RLSSA) to advise on tender specifications and assisted in the evaluation of tenders. The RLSSA Guidelines for Safe Pool Operations (the Guidelines) are considered the benchmark, or as it had been described "industry best practice". It would appear the Council were satisfied RANS Operations Manual met the standards set by the RLSSA Guidelines. In fact upon examination they virtually mirror the Guidelines with additional commentary on each broad issue. I make one point

particularly. Presumably upon the advice of RLSSA a condition was written into the contract that there would be two RANS employees on duty at all times.

I am satisfied Moreland City Council in contracting RANS to manage the pool did so in circumstances which clearly satisfied their obligations.

_____

As the suggestion was the matter would or may be "revisited" by the Director of Public Prosecutions at the completion of the inquest it was not surprising that at the hearing all relevant personnel from RANS, in the case of those represented, through their counsel, and Ms. Jones personally, sought to be excused from giving evidence claiming the privilege against self incrimination. I ruled that all be excused.

In making findings I often describe the body of evidence as being akin to a mosaic made up of numerous pieces which provide a "picture". In excusing all the "major players" from giving evidence I am left with a mosaic with many pieces missing. Consequently, the "picture" is somewhat blurred.

To fill out that picture, am I entitled to draw inferences from the fact the major players sought to be excused from giving evidence? The headnote in the reported decision Anderson v Blashki (1993) 2 VR 89 states:

> *"There must be strict limits on the use that can be made of the failure of a person against whom allegation are directed to give evidence at a coroner's inquest. Given the nature of the allegations, it would be proper to apply by analogy the rules in a criminal proceedings."*

In the judgement proper Gobbo, J. in obiter, observed:

> *"But I am not to be taken as expressing any view that failure to answer questions in routine investigations of fatal accidents from example should not be able to be used within strict limits as part of the evidentiary material on a coroner's investigation.*

While the issue is not entirely clear what those "strict limits" may be, I adopt what might be viewed as a traditional, perhaps conservative approach and formally indicate I draw no adverse inference for the failure of those excused to give evidence.

_____

The relevant RANS Management structure at the time was (from bottom to top of the hierarchy):

- Julie Jones; Assistant Pool Manager
- Adam Wild; Pool Manager
- Gary McAllister; Area Manager
- Stephen Dix; Leisure Division Manager
- David Easdon; Acting CEO
- Simon Arnold; CEO

The specifications upon which the pool management contract was founded were as stated earlier, drawn up by Moreland City Council with specific input from RLSSA as to pool supervision and safety aspects. In broad terms supervision was to comply with RLSSA Guidelines together with compliance with specific contractual obligations. A critical contractual obligation under this management contract required the operator to have at least two lifeguards on duty at all times. The contract required one lifeguard always directly supervising the pool, whilst another to be readily available on site. RANS

Operation Manual are based upon RLSSA Guidelines for Safe Pool Operation with their own commentary on each chapter and paragraph.

The commentary to chapter SU1, Bather Supervision, is of special interest it states, inter alia:

"Some contracts have specific supervision requirements that must be adopted."

The commentary to chapter SU12 Supervision of Diving Towers and Springboards is also of special interest:

"All diving facilities are to be closed unless specific supervision is provided."(my emphasis).

By the completion of submissions two fundamentally contradictory positions that go to the core issue of supervision had crystallized. Reduced to the bare bones, management, including area manager and upwards, were contending company policy and procedures concerning staffing levels were sufficient to ensure appropriate levels of patron supervision. On the other hand Counsel representing Mr. Wild, and Ms. Jones were alleging a regime or climate of "running lean" on staff "pervaded the whole operations" and was imposed upon them from above so that if deficiencies in supervision occurred they were beyond their control.

Mr. Wild, in his statement and through Counsel claimed there were a number of other present and former employees of RANS who would support his claim that "lean" staffing levels were imposed from above and inadequate supervision was in effect countenanced. The question then was, should I adjourn the matter off and seek statements from those people, or should I, as most Counsel (including Counsel Assisting) submitted reach a view on the evidence (such as it was) as it then stood.

I concluded, bearing in mind I had not had the opportunity to hear (and see) any of the witnesses who could give evidence on this issue, that proceeding as matters stood I would be for all intents and purposes guessing what the truth was. That is an invidious position to be in and I did not feel at all comfortable about that prospect.

Adjournment would assuredly delay finalization of the matter (I could not have guessed by how long), but I thought in fairness to all, especially the family of Abubaker I should go in search of the truth; this was after all an inquisition, not an adversarial proceeding where the parties dictate upon what material the adjudicator will adjudicate.

In the event, after an inordinate delay I was provided with a further ten statements addressing specifically the allegations made by or on behalf of Mr. Wild in particular, supported to an extent by Ms. Jones. Having perused the statements I think it fair to say they did not significantly advance Mr. Wild's position, if anything the contrary.

The additional material was distributed to all "interested parties" who had been directly involved in the original hearing and they were invited to indicate who they wanted to appear for cross-examination. My understanding was that if statement providers were not required to attend for cross-examination their statements would be accepted into evidence and would speak for themselves.

Mr. Dann, Counsel for Gary McAllister advised he wanted to put matters to three of the additional potential witness, Micheal Graham, Emma McDonald and Jodie Hewitt. No other requests were received. The matter resumed on the 10th of November 2003. There had been an additional compounding but unavoidable delay due to the unavailability of Mr. Gyorffy, Counsel Assisting.

Subsequently, this office was advised of a further additional potential witness who it was suggested was in a position to give a statement supporting in broad terms Mr. Wild's

contentions. A statement was taken from Dean Andrew Walker which when perused did not advance Mr. Wild's position. He was not sought to be cross-examined so his statement was accepted and also speaks for itself.

Let me say something about the evidence of one of the three additional witnesses who gave evidence in November 2003. Mr. Micheal Graham was the Area Manager for RANS who was succeeded by Mr. McAllister. He stated in evidence the suggestion there was pressure from management to operate with only one person responsible for all roles "did not accord with his experience" when employed by RANS.

_____

The reality was that after Adam Wild departed the pool on the 30th of December 1998, Julie Jones was the sole employee/lifeguard on duty carrying out all the functions from attending the turnstiles and the kiosk to "supervising" (in a very loose sense) all four pools open, including the diving pool which was something like 100 metres from the kiosk. To ensure adequate supervision of this pool at this time at least two lifeguards would have needed to be on duty with one of them paying special attention to the diving pool.

Ultimately the duty of care owed by the manager of a pool to patrons is to ensure that if anything untoward occurs that puts a patron's welfare in jeopardy, it will be observed and responded to. Whether a certain number of supervisors are in attendance, or whether a guideline is complied with, or whether a contractual obligation is met, may be of some relevance, but whether the fundamental objective is achieved should be determining factor.

The level of supervision provided from approximately 4:20 pm onwards was patently inadequate. The supervision regime was in contravention of RLSSA guidelines, in contravention of the RANS operational Manual and in contravention of contractual obligations.

The fact that it is likely Abubaker was on the bottom of the diving pool, undetected, for approximately 20 minutes, prior to that fact being brought to the attention of lifeguard Jones by a young patron, is stark proof of the inadequacy of supervision.

No matter how Abubaker came to be in the water, the incontrovertible fact that the pool generally, and the diving pool in particular, was not adequately supervised remains the principle reason Abubaker sustained the hypoxic brain injury that ultimately resulted in death.

The crucial question for me is, how far up the management hierarchy, the "chain of command", can I reasonably on the evidence attribute contribution in a causal sense to the death of Abubaker Aziz.

A finding that RANS management, senior, middle and lower caused or contributed to Abubaker's death can not be made on "inexact proofs, indefinite testimony or indirect inferences". A comfortable degree of satisfaction that an act departed from a norm or standard, or an omission was in breach of a recognised duty must be reached in respect to each individual in the "chain of command" before that individual can be said to have caused or contributed to the death.

In my view, for an act or omission to be the cause, or one of several causes of a death the connection between the act and/or omission and death must be logical, proximate, and readily understandable; not illogical, strained or artificial.

Whilst in a corporate sense the "buck stops" at the top, that concept does not provide the answer to where in a coronial sense the chain of causation extends. Senior management are entitled to rely on subordinate staff if there is in place an appropriate reporting

regime, subordinate staff are adequately trained and if there is appropriate operational documentation.

Mr. McKenna, Counsel for Adam Wild submitted his client could not properly be said to have in any sense caused the death of Abubaker, maintaining his absence for the period late in the afternoon, no matter what the reasons for that absence, was "simply a background circumstance."

I do not accept that contention; it was a clear breach of his duty of care to patrons to leave Ms. Jones alone as after his departure it is beyond contention that adequate supervision, in any practical sense, ceased. By "abandoning" Ms. Jones in those circumstances I find Adam Wild contributed to the cause of Abubaker's death.

When Mr. Wild proposed to leave he should have either:

- closed the facility, or
- rostered on alternative casual staff.

What were Ms. Jones's options?

- As Assistant Manager (it would appear there were all "chiefs" and no "indians") she could, have unilaterally closed the facility,
- she could and should at least have closed the diving pool, or
- she could have closed the kiosk and turnstiles and solely performed lifeguard duties.

The fact is she took none of those steps. Ms. Jones was "in charge" of the pool in the absence of Adam Wild and the level of supervision was inadequate. She was therefore in breach of her duty of care to patrons. In that sense it must be said she contributed to the cause of Abubaker's death.

I make that finding with a level of unease because Ms. Jones was put into an impossible, or at best invidious position by Mr. Wild's early departure, leaving her alone. Furthermore, although I have made certain adverse findings against Adam Wild and Julie Jones one gets the impression they have, in some respects, been "hung out to dry".

The staffing issue is complicated by the concept "low patronage pools" and the interpretation of that Guideline which was never meant to refer to large metropolitan pools.

The fact is Gary McAllister was responsible in his role for ensuring adequate supervision at facilities under his management <u>at all times.</u> He "signed off" on the roster for the Coburg facility. The roster provided for a minimum of two staff to be on duty at all times. Ms. Jones maintained she advised management of this situation. She further contends Gary McAllister, the Area Manager, countenanced the position. If that is so it would mean Mr. McAllister was aware that from time to time supervision was, of necessity, entirely inadequate. Whilst I am not convinced it was a regular occurrence, I accept that on occasions the facility operated "one up". I accept Ms. Jones claim McAllister was aware and in any event if he wasn't, he should have been.

In regard to the conflict between "the competing versions", what I will call the Wild/Jones position and that put in behalf of RANS management, Mr. McKenna for Adam Wild made an interesting submission. He suggested, leaving other matters aside, there was a "stark contrast" between the way his client provided a statement to police and that adopted by RANS management, who he maintained "filtered" their statements through solicitors.

He contented I could attach more weight to his client's statement for that reason alone. It is a proposition which, if adopted, would leave me with a distinct feeling of unease. To accept it would impinge upon several fundamental tenets/principles. The fact is parties

are not obliged to make formal statements, even if requested. If subpoenaed and sworn the circumstances (as here) may warrant an application to be excused from giving evidence relying on the privilege against self incrimination. One has the right to consult a legal practitioner before responding to a request to provide a statement. Save perhaps from the principles of law enunciated in Weissensteiner v R (1993) 178 CLR 217, R v Parker (Victorian Court of Appeal - unreported 10th August 1995,) and R v Rice (1996) 2 VR 406, it can not be that exercising those rights can provide the basis for an adverse inference to be drawn upon which an adverse finding is made.
Ultimately, whilst the overall operation ran under tight fiscal policy, which could probably be seen as sound business practice, I am not persuaded it could reasonably be seen as imposing impossible expectations on staff concerning adequate supervision of patrons.

Whilst there remains some contention, the weight of evidence does not support the contention RANS senior management tacidly promoted a management regime which was significantly systemically flawed.

My level of comfortable satisfaction, bringing the relevant principles of law to bear, does not extend up the "chain of command" beyond Gary McAllister. I don't believe I can, on the evidence, conclude there were systemic failures that can be sheeted home to Stephen Dix, Leisure Division Manager, David Easdon, Acting CEO and Simon Arnold, CEO.

There are however, aspects of Stephen Dix's involvement which leave me with a distinct feeling of unease. The Director of Public Prosecutions in his advice in response to referral stated:

> *"The conduct of RANS in the investigation is not desirable but it is highly unlikely to be criminal"*

I presume the Director was referring to the claims made by Adam Wild and Julie Jones that Stephen Dix, Leisure Division Manager, having arranged with police proposing to execute an authority (in effect a search warrant) to meet them at the pool at 3:00pm, attended at the pool prior to their arrival and removed various unidentified documents, which he allegedly placed in his car. Whether others in the heirachy where involved in this exercise, the evidence does not enable me to say.

Interestingly, in his comprehensive statement provided through Rigby Cooke solicitors, Mr Dix canvassed the arrangement to meet police at the pool, but made no reference whatsoever about attending early and surreptitiously removing documents. This is one of the questions in respect of which I would like to be able to confidently make definite findings, but find myself unable to do so. Various inferences are open to be drawn, but to draw a damning adverse inference would require speculation, which is not a proper basis for the making of firm findings.

I formally find Adam Wild, Gary McAllister and Julie Jones contributed in a causal sense to the death of Abubaker Aziz.

RESEARCH

Before the matter was allocated to me the State Coroner directed Ms. Lyndal Bugeja, Injury Prevention Research Officer to examine the coroner's findings of all drowning deaths in public swimming pools between July 1988 and June 2002. Quoting from the introduction to the report its purpose was stated as:

> *"...undertaken in order to provide the Coroner investigating the above-mentioned death with contextual information about the nature and extent of preventable drowning deaths at public swimming pools.*

The examination aimed to gain an understanding of the circumstances in which the deaths occurred and to identify any systemic factors that could be addressed by the aquatic industry to ensure that drowning deaths at public swimming pools do not continue to occur. Consideration was given to the issues of lifeguard supervision and low patronage requirements" (page 1).

The research report titled Drowning Deaths at Public Swimming Pools, Victoria July 1988 - June 2002 was compiled in conjunction with the RLSSA Victoria Branch. I annex the report to this finding so it forms part of the formal public record of these proceedings.

The recreational aquatic industry is strictly speaking unregulated. RLSSA Guidelines for Safe Pool Operations (the Guidelines) are just that, guidelines although, as stated earlier, they are recognised by the industry as best practice. Most public swimming pools are operated in accordance with them and the operations manuals developed by private service providers are largely founded upon these Guidelines.

What became apparent during this inquest was that the Guidelines for Safe Pool Operations developed by RLSSA require some refinement, particularly in respect of supervision and the concept of "low patronage pools". The Guidelines relating to those issues are, in my view, somewhat convoluted, involve considerable cross referencing and are too open to interpretation. This contention is amply demonstrated if one examines the transcript of the evidence give by Mr. Norman Farmer, Chief Executive Officer of RLSSA Vic Branch (now Life Saving Victoria). Mr. Farmer undertook the 1996 review of the Guidelines and is probably more familiar with them than anyone else. As I understood his evidence Mr. Farmer accepts that the Guidelines need some attention.

The Research Report discusses some of the perceived deficiencies - the author observes: (pp. 18 - 19):

"Assessment of the adequacy of patron supervision by lifeguards has been an issue that has recently come under some scrutiny by the Coronial jurisdiction (See Appendix 2 - Case Number 3758/2000). During the inquest proceedings into the current matter, evidence was given by a number of pool managers, including an Area Manager. There was no consensus amongst the witnesses about what "specific supervision" in the context of a diving pool meant. One witness was of the opinion that specific supervision meant keeping the diving pool within the line of sight while supervising other pools. Others, quiet correctly, said that specific supervision involved primarily and directly watching the diving pool. This discrepancy has implications for how well understood the issue of supervision is across the aquatic industry, from the operational level lifeguard to the aquatic and area managers" (page 18-19).

In her report Ms. Bugeja makes a critical observation with which I entirely agree. She concluded that while drowning deaths at public swimming pools were rare events in the context of all drownings, such deaths were preventable and that "the key to prevention is supervision". She recognises:

- establishing what is an appropriate level of staff to adequately supervise patrons at any given aquatic facility is critical, and
- as a very high percentage of staff are casual and part time there needs to be greater emphasis on <u>training</u>.

On the first point, the Research Report discusses a RLSSA initiative introduced to provide public pool operators with an independent assessment on staffing requirements to ensure patron safety and other suggestions for improvement. I include another excerpt from the Report relating to assessments undertaken in 2000 - 2001, the potential benefits of these

assessments, and practical difficulties in extending the process and disseminating the data collected. Not surprisingly funding is the obstacle to its implementation.

> *"During 2000 and 2001 the RLSSA, with funding provided by Civic Mutual Plus (CMP), conducted the Swimming Pool Safety Assessments (SPSAs) on 271 of the 288 public swimming pools in Victoria. Each of these facilities received a safety improvement plan and a safety score.*
>
> *The RLSSA have proposed that the data collected from the SPSAs be collated into a database in order to inform Sport and Recreation Victoria (SRV), the Victorian Aquatic Industry Council (VAIC), aquatic sporting bodies and Local Government on the current state of the aquatic industry. Not only would this information provide an accurate list and assessment of public swimming pools in Victoria, it would also allow safety measures to be improved and refined in order to prevent further deaths and injuries at these facilities.*
>
> *In relation to patron supervision, data from these assessments would enable the RLSSA to recommend a minimum number of lifeguards for each facility.*
>
> *Once this information is collated, the RLSSA could provide stakeholders with a comprehensive report on the current state of compliance to national industry standards for safe pool operations. The cost of collating and distributing this information was estimated at $57,200. This would be a one off expense to set up this process. As the RLSSA is a not-for-profit organisation, they have sought funding for this project, however their proposal was unsuccessful. (See Appendix 1 for project cost breakdown).*
>
> *The RLSSA also recommend that the SPSAs be conducted every two years in order to achieve the objectives stated above. The cost of conducting these audits has been estimated at $1000 per facility. Although there are 281 public swimming pools in Victoria, the RLSSA believe they could undertake the SPSAs for all facilities for $250,000. At present no organisation has agreed to fund the SPSAs.*
>
> *RLSSA believes that the SPSAs process should be considered as part of the performance criteria or part of management contractual requirements. This would provide facility owners, for example Local Government, with an independent evaluation of the contract manager's compliance to industry best practice" (page 6-7).*

The proposal has much to commend it and would render it extremely difficult for an operator to rely on a strained interpretation of the Guidelines to cut corners and reduce overheads at the expense of public safety. The suggestion that a potential operator pay for the SPSA as part of the contractual requirements seems eminently sensible.

DISCUSSION AND RECOMMENDATIONS

A threshold issue requires earnest consideration. Is it time to move from an unregulated industry operating under the industry best practice arrangements as prescribed in the RLSSA Guidelines?

Alternatively, is it time consideration was given to the establishment of a formal Australian Standard? These issues were raised with Mr. Farmer in cross-examination. I invite a perusal of the transcript of his evidence.

Whilst the organisation did not seek leave to be joined as an "interested party" the Australian Services Union, MEU Victorian branch submitted a short submission the thrust of which is that there is a "lack of sufficient regulation" of the industry. I include in this finding an excerpt from that submission:

> *"Currently, the industry in Victoria has guidelines covering staffing requirements, qualifications, entitled "Guidelines for Safe Pool Operations". While this document provides useful and sensible advice on safe operations of aquatic facilities, it is toothless in so far as enforcement is concerned.*
>
> *The ASU is committed to the creation and implementation of regulations for the safe operation of municipal aquatic facilities that are legally binding and readily enforceable. This would ensure that all operators ensure staffing levels and qualifications are adequate, as a minimum. Lifeguarding is an extremely responsible and demanding career."*

The submission concluded with an offer by the Union to "participate in a review of the Guidelines and the creation of suitable regulations if, and when, the Coroner gives such a direction". I am not empowered to give such a direction.

The options are either, full blown statutory regulation with a bureaucracy to administer all aspects of the regulatory regime, or perhaps a hybrid form of regulation akin to that undertaken by Royal Society for the Prevention of Cruelty to Animals (RSPCA) in relation to animal welfare/protection. Under the second option, RLSSA could exercise a formal policing, investigative and prosecutional role. That option would require adequate funding and of course a preparedness on the part of RLSSA to accept that onerous responsibility.

A statutory regulatory regime or a hybrid arrangement without an adequate policing and enforcement capacity is very much a "toothless tiger". Research clearly shows the strongest motive to ensure compliance with a regulatory regime is the real prospect of sanctions for non-compliance.

It may be that revised/refined RLSSA Guidelines to Safe Pool Operations, in effect, the self regulating status quo, is sufficient. But whilst RLSSA is widely recognised as an extremely pro-active not for profit public health and safety organisation, it has its limitations. For instance, when asked about the organisation's research capacity Mr. Farmer conceded it was "very, very small" in fact he conceded "almost negligible".

The scope of this inquest has not enabled me to reach a concluded position as to whether more formal regulation of the aquatic industry is necessary. If the industry is to move from self regulation to full statutory regulation a significant injection of funding would be necessary.

I merely recommend a wide ranging review be undertaken to enable the responsible Minister to be adequately advised. Ultimately it is a matter for Government.

Irrespective of what direction the matter takes, the RLSSA Guidelines require immediate attention. Recommendations are included in the Drowning Deaths at Public Swimming Pools, Victoria July 1988- June 2002 (see pages 21-22). As an interim measure I commend and adopt those recommendations with the exception of the age limitation referred to in recommendation 4. Whilst I understand the rationale behind the age limitation, I consider it so restrictive it would assuredly be widely circumvented.

"1) Low Patronage

a. Low patronage should not be defined by region, instead it should be determined solely on usage and design of the facility and once determined is a continuing classification.

b. This assessment needs to be independent and based on the data collected by RLSSA in the SPSA.

c. Classifications could be reassessed bi-annually if funding were received to conduct SPSA on an ongoing basis.

2) Patron Supervision of Diving Pools

a. RLSSA Guidelines should be amended in relation to patron supervision of diving pools to refer to direct/primary supervision of such pools when open for operation. Both lifeguards should also occasionally scan the other pool as well as each other. (see figure 1).

b. This issue should be specifically addressed during the Pool Lifeguard course and annual reaccreditation administered by the RLSSA and other registered lifeguard training organisations. This may include a question on the written examination and be addressed in the testing scenarios.

3) Training

a. It is common for lifeguards to work at more than one facility during their lifeguarding career. Some of these facilities may be managed by the same company where policies and procedures are similar. Regardless of this, each facility is unique in terms of its design and patronage. Therefore a thorough induction process should be undertaken by the aquatic manager for each new employee prior to the commencement of the first shift and regardless of their experience.

4) Parental Supervision

a. RLSSA Guideline 4.1 of SU10 (Parental Supervision) should be amended from children under 10 years to children under 15 years should not be allowed entry unless under supervision of a person 16 years or older.

5) Swimming Pool Safety Assessments

a. Funding should again be sought to conduct SPSAs as a means of ensuring that public swimming pools are operated in accordance with the Guidelines for Safe Pool Operation (see appendix 1). Alternatively RLSSA consider formulating the Guidelines into legislation, regulations or Australian Standards and subsequently develop an enforcement process of such legislation/regulations/ standards similar to the SPSAs".

PHILLIP BYRNE
CORONER