STATE
CORONER
VICTORIA

19th August, 2003
Case No: 3758/00

RECORD OF INVESTIGATION INTO DEATH

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

having investigated the death of CINDY NGUYEN with Inquest held at Coronial Services Centre, Southbank on the 29th July and 18th August, 2003 **find that** the identity of the deceased was CINDY NGUYEN and that the death occurred on the 15th November, 2000 at Royal Children's Hospital from

1(a) IRREVERSIBLE CEREBRAL ANOXIA AND TERMINAL INHALATION BRONCHOPNEUMONIA RESULTING FROM A NEAR DROWNING

in the following circumstances:

On 10th November 2000 Ms. Van Luu attended the Footscray Swimming Centre with two of her children, Cindy Nguyen born 18/12/97 and Tien Nguyen born 29/12/96. It was their first visit to the facility, the layout of which is depicted in a plan in evidence as Exhibit "F". The complex has amongst other facilities three (3) pools described as the 25 metre competition pool, the teaching pool and the toddlers pool. The pool particularly pertinent to this enquiry is the teaching pool which ranges in depth from 40-60 centimetres.

The evidence establishes to my satisfaction that somewhere in the order of 50 people involved in various vigorous activities were in the teaching pool; this represented the majority of the attendees at the facility. This pool incorporates an activities facility described as a slide which one could reasonably anticipate is probably the principle attraction, especially for children.

After a period of time during which Ms. Van Luu anticipated with and supervised the children she needed to go to the toilet. I accept Ms. Van Luu told Tien to watch her little sister and

advised Cindy not to go near the water. It is to be recalled Tien was almost four years old and Cindy almost three years of age. In the event Ms. Van Luu went to the toilet leaving the children unattended. In her acknowledged statement provided to Senior Constable Merlino, Ms. Van Luu estimated she was absent for approximately five minutes anticipating other attendees would keep an eye on the children. This regrettably was an unrealistic expectation. I include in this finding the following excerpt from her statement:

> "*I didn't ask any adults to watch my children but I hoped that someone would keep an eye on them. I saw a couple who were looking after children as well and thought if something might happen they would call out and I would come straight away. I didn't know them but I hoped they would keep an eye on Cindy.*"

At approximately 5.30pm Miss Jessica Swan, who at the time was 14 years of age, observed a child face down in the teaching pool. Jessica turned the child over, immediately appreciated it was an emergency, carried the unconscious child toward the side of the pool and raised the alarm. The child was Cindy Nguyen.

Lifeguards took over, "000" was called and attempted resuscitation commenced. Subsequently MFB personnel arrived and took over resuscitation attempts until MICA paramedics took over from them. Paramedics re-established a pulse and blood pressure and the child was conveyed to the Royal Children's Hospital alive but in perilous condition in view of the "down time" before a pulse was re-established. Cindy remained on life support for some days until it became absolutely clear her position was irretrievable. Life support was withdrawn and Cindy passed away in the very early hours of 15th November 2000.

A comprehensive brief of evidence was prepared by Senior Constable Merlino. Having perused all the material available, including a report commissioned by Maribyrnong City Council, the operators of the Footscray Swim Centre, and prepared by Macquarie Lawyers & Strategists, I concluded there were three primary foci I proposed to pursue at formal inquest:

- The issue of parental supervision of the children.
- The efficacy of the resuscitation attempts mounted by the lifeguards.
- The issue of the adequacy, or otherwise, of the level of what I will call lifeguard supervision at the time of the near drowning.

Before turning to each of those issues I propose to say something about the modern coronial function and the applicable law on the subject.

The Coroners Act 1985, Section 19(1)(a)-(c) provides the core findings a Coroner must (if possible) make. They include findings of "how the death occurred" (Section 19(1)(b)) and "the cause of death" (Section 19(1)(c)). Sub-section (2) of Section (19) provides a Coroner they also "comment on any matter connected with the death".

The Coroners responsibility is to investigate the circumstances of the death; find the facts set out the facts in a formal finding; the facts then speak for themselves leaving others to

apportion blame or responsibility, draw legal conclusions and make judgements. The Broderick Committee (UK) (para 16.40) observed:

> "*In many cases, perhaps 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 an issue and one which appears to judge the issue itself*".

In the leading judgement of the court of appeal in Keown v Khan (1999) VR69, Mr Justice Callaway made a variety of observations about the jurisdiction. He referred to the Broderick Committee Report (U.K.) and the Norris Report (the report handed down by Sir John Norris, QC, upon which the Coroners Act 1985 is substantially founded).

I believe the judgement of Callaway, J.A in Keown v Khan refocused coroners upon the fundamental nature of their function, particularly when he stated:

> "*In determining whether a 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 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 reasons 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 indeterminate 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." (My emphasis)*

Causation is a concept which has bedevilled the law for centuries. In the coronial context Calloway, J.A., draws a distinction between a cause, or one of several causes of a death and a "background circumstance". 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 causations in the context of the law of negligence are applicable and helpful 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 v Hallenstien (1996) 2 VR 1). 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. Another aspect of causation bears comment; often it is not one sole event that can be said to have caused an outcome, it can often be a series of events, some more significant than others, that cumulatively can be said caused the death.

In cases where there is controversy over the core issue of whether an act departed from a norm or standard, or an act or omission was in breach of a recognised duty and therefore the actual cause, or one of several causes of a death, I feel it incumbent upon on me to comment on the standard of proof and satisfaction I apply to that critical finding.

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 Hallenstien (1996) 2 VR 1).

In Briginshaw v Briginshaw 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 finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect references.... 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.*"

The standard of proof applicable is therefore quite high, so that findings of causation cannot be made on inexact proofs, indefinite testimony or indirect inferences, but only on cogent and persuasive proofs; a comfortable degree of satisfaction must be reached to conclude an act or omission caused a death.

A full day inquest was conducted on 30th July 2003. Mr Adam McLean, of counsel, instructed by Victorian Legal Aid represented Ms. Van Luu who was also assisted by an interpreter (or more correctly a translator). Mr Michael Coldham, solicitor of Anderson Rice Lawyers sought and was granted leave to appear for the Metropolitan Fire Brigade and Mr. Terry Bramham, solicitor of Macquarie Lawyers & Strategists sought and was granted leave to represent the City of Maribyrnong, the operators of the pool, and lifeguards Logan, Putland, Sharples and Roberts.

On the scheduled first day of the hearing Ms. Van Luu attended alone and unrepresented. Her understanding of the English language, or more precisely her lack of understanding of the language was such I concluded the matter should not proceed. The following day when represented by counsel, I broached the difficult topic of whether I should in the circumstances

call Ms. Van Luu. Whilst I did not really desire that she go into the witness box much would depend on whether she resisted the contention that the short lapse in supervision of Cindy was a significant (perhaps the principle) link in the chain of causation culminating in her death. Quite frankly, objectively it appeared a position which would be difficult to resist. In the event, Mr. McLean, as I understood him, indicated Ms. Van Luu conceded her lapse and accepted a measure of responsibility. In those circumstances I determined not be put her "in the box". It is beyond contention that by leaving the children unattended while she went to the toilet, unjustifiably assuming someone else would supervise them, was tragically an omission that represents the principle link in the causal chain.

Controversy surrounds the attempts at resuscitation undertaken by lifeguards at the poolside. Lifeguard Timothy Logan, holder of a Level Two First Aid Certificate and a Lifeguards Certificate, together with pool supervisor, Steven Putland, the holder of a Senior First Aid Certificate, an Oxygen Certificate and a Lifeguards Certificate after undertaking the DRABC checklist commenced Cardio Pulmonary Resuscitation (CPR) and Expired Air Resuscitation (EAR). Timothy Logan explained how shortly after resuscitation attempts commenced oxygen was utilised by placing the hose under the pocket face mask that was being used. Timothy Logan maintained the methods attempted were undertaken correctly, he claimed he observed Cindy's chest going up and down with his breaths. It would appear the older style mask, without the oxygen nipple was utilised. During these attempts, Cindy regurgitated on a number of occasions requiring interruption to resuscitation attempts whilst her airways were cleared. Timothy Logan stated that sometime into the attempts a pulse was obtained, but it was intermittent. Other witnesses, including Mrs. Dianne Swan, Jessica's mother, confirmed that lifeguards "worked on" the child until MFB personnel arrived as the First Emergency Medical Responders.

As a Station Officer with the MFB, stationed at Spotswood at the time, Mark McMenaman was the officer in charge and the designated first responder. Initially, people queried why MFB personnel attended apparently unaware of the then relatively recent initiatives implemented in relation to Emergency Medical Response. In the event, Mark McMenaman and his colleagues, fire fighters David Organ and Mark Splatt, took over attempted resuscitation until the arrival some little time later of MICA paramedics, who after intensive treatment obtained a pulse and blood pressure. Spontaneous respiration was not obtained and Cindy was ventilated and conveyed to the Royal Children's Hospital.

In their statements, MFB members McMenaman and Organ were critical of the resuscitation attempts of pool lifeguards. Their statements speak for themselves, but I include several excerpts to provide a flavour of the concerns they expressed:

- "*As I walked in I made a comment to Mark that they were not doing CPR.*"
- "*My assistant, Mark SPLATT, set up the oxygen resuscitation equipment. I saw Mark hand the resuscitation mask to one of the lifeguards. As I watched I could see that the lifeguard did not seem to know what to do. He held the mask on the girl's face but did not squeeze the bladder on the mask when the time came to provide a breath. After a very short time I ask the lifeguard, "Do you know what you're doing?*"

- "*We had a debrief about what had happened. The main topic was that we were all surprised that no CPR was being done when we first arrived.*"

Fire fighter Organ observed:

> "*We were presented with the child on the ground, lying on her back with a male I presumed was a life guard holding an oxygen near her face. The mask wasn't on her face but about an inch off it. He wasn't doing anything else. No C.P.R., no nothing. He was just lying next to her holding the mask.*"

On the face, the versions of the lifeguard and the firemen seemed dramatically opposed; I faced an evidentiary conundrum difficult to reconcile.

However, the benefits of formal inquest where witnesses can be examined and cross examined were once again demonstrated. The apparent divergent views can in fact be reconciled. Both MFB members conceded the "window of observation" was very short, a matter of seconds; observations were made in the highly charged atmosphere of a real emergency. Each conceded, as I understood them, that their observation and assessment, whilst maintained at inquest, may not have been a valid assessment of the overall resuscitation attempts undertaken by pool lifeguards.

On the evidence, bringing to bear the appropriate quite high standard of proof (Briginshaw), I am <u>not</u> prepared to say that aspect of the pool lifeguards performance was inadequate. I do however, re-iterate my previous recommendation in Jin Yong Choi (Case No. 679/00) that the Royal Life Saving Society of Australia re-consider reviewing guideline SU 4.5 of the <u>Guidelines for Safe Pool Operations</u> with a view to suggesting all lifeguards carry a resuscitation pocket mask which incorporates an oxygen nipple; quite frankly the older style mask where an oxygen hose is stuck up under the mask to facilitate oxygen delivery, is dated technology.

As earlier mentioned, not surprisingly the issue of the adequacy of pool patron supervision by lifeguards at the Footscray Swim Centre was a major focus of the inquest.

Interestingly, a report concerning the circumstances of Cindy's death was prepared by Macquarie Lawyers & Strategists for Maribyrnong City Council, the operators of the Swim Centre. This seems to be a developing trend where a review or audit undertaken internally or commissioned by a party is undertaken after an incident and a report generated. In the event, Mr. Bramham's firm made a copy of their report available and it was introduced into evidence as Exhibit "H". Chapter 2 of the report contains the conclusions reached; I reproduce it in this finding for reasons which will soon become obvious:

> "*2. CONCLUSIONS*
>
> *Having regard to -*
> - *various statements by witnesses;*
> - *subsequent interviews with those witnesses;*

- *an inspection of the Centre;*
- *a re-enactment of the incident;*
- *an assessment of the Centre's procedures and practices by reference to the established guidelines of the Royal Life Safety Society of Australia; and*
- *an evaluation of the Centre's compliance with recommendations contained in a previous Coroner's report relating to 2 separate municipal pool drowning in 1991;*

it is our opinion that the actions of the Centre staff in performing the rescue of CINDY NGUYEN were satisfactory and conformed with the Society's guidelines."

Some of the internal audits/reviews and subsequent reports I have examined have been extremely comprehensive and objective; real "warts and all" exercises. Others have been cursory, selective, highly subjective and wholly self serving and of little or no value to the inquisitorial process. Other reviews fall somewhere in between. I have been around long enough to realise it is not a perfect world (although it certainly is becoming a litigious one), the reality is people have different agendas. The coronial function is to endeavour to establish the truth concerning the circumstances surrounding a death.

Public swimming pool operations are not regulated in this and other States save Western Australia, which, as I understand, has a hybrid form of regulatory regime. The guidelines published by the Royal Life Saving Society of Australia the July 1996 (Second Edition) entitled Guidelines for Safe Pool Operations are considered best practice in management of aquatic centres. In my experience pool operators found their Operations Manuals on these guidelines; a thoroughly reasonable and commendable approach. Whilst compliance with the Guidelines does not render a pool absolutely drownproof, it does undeniably reduce the risk of adverse events.

Statements by lifeguards were initially provided to the investigating police officer, Senior Constable Merlino, by Macquarie Lawyers & Strategists. Not entirely satisfied with those statements, Senior Constable Merlino ultimately took further statements from lifeguard supervisor, Steve Putland and lifeguard, Timothy Logan in the presence of Mr. Bramham and the pool manager, Lyn Celotti. It must be said these statements are virtually silent, or at best, light on detail concerning the critical issue of pool supervision. On the basis of the information contained in those statements a realistic assessment of the efficacy of patron supervision could not possibly be made.

However, the matter proceeded to formal inquest and lifeguards Logan and Sharples were called and gave viva voce evidence. I accept both these young people were telling me the truth; Renee Sharples was alarmingly frank. The matter dramatically changed complexion. It soon became apparent Logan's primary role at the time of the incident was supervising the water slide in the teaching pool. He estimated 85% of his time was spent on it and only 15 % scanning the pool. Furthermore, Sharples stated she had just taken over at the start of her shift and whilst she was "generally looking about" she was involved in several other activities resulting in her attending at the spa-room and/or sauna. She was not fully engaged in her primary function of patron supervision. Ms. Sharples commented she had not in a real/full sense commenced that role when the incident occurred.

Senior Constable Jeff Stewart of the State Coroner's Assistants Unit sought from Royal Life Saving an expert opinion as to, inter alia, the performance of the lifeguards.

A report was prepared by Alister Thom, Aquatic Risk Manager of the Royal Life Saving Society. In summary, on the basis of the material and information available to him, Mr. Thom in that report opined Footscray Swim Centre personnel had complied with guidelines SUI 4.1.a), SUI 4.1.b), SUI 4.1.c), SUI 4.2.a), SUI 4.2.b), SUI 4.3, SUI 4.4.a), SUI 4.4.b), but indicated on the information available he was not in a position to make a judgement as to whether SUI 4.4.c) was complied with. Those guidelines are reproduced in his report. SUI 4.4.c) is a broad, general guideline indicating that a whole "range of factors" determine an appropriate number of lifeguards in given circumstances. Mr. Thom was in court throughout the evidence and when called, having heard the evidence of lifeguards, Tobin and Sharples, sought, not surprisingly, to revise his opinion. In viva voce evidence he maintained guidelines SUI 4.2.a) & b), 4.3, 4.4.a) & b) were <u>not</u> complied with. In cross examination Mr. Bramham challenged Mr. Thom, but the latter remained steadfast stating he stood by his "amended statement". Fundamentally, he maintained supervision was, in important aspects, inadequate and not in compliance with relevant guidelines.

Mr. Thom's opinions as to Ms. Van Luu's lack of supervision of her children were not challenged.

In this finding I do not propose to dwell on that aspect of the report dealing with what he called "Emergency Response", except to observe he also noted the contradictory versions and very properly left the issue for coronial determination.

It must be remembered the Royal Life Saving Society publication provides guidelines only. Whilst it may be viewed as aquatic industry best practice, on occasions initiative must be exercised by those individuals responsible for pool management. Thorough training is imperative, lifeguards need to have a <u>practical</u> understanding of the guidelines and, just as importantly, understand the rationale and objects behind them.

It is difficult to accept the contention patron supervision was adequate when unobserved a child remains face down in a pool for a period sufficient to in effect drown. I am sorry to borrow a hackneyed phrase but the "proof of the pudding is in the eating". Having carefully considered all the evidence, I conclude Ms. Van Luu's failure to constantly supervise her child in combination with inadequate pool supervision by lifeguards, Tobin and Sharples, clearly breaches of recognised duties, resulted in the tragic death of Cindy Nguyen.

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Royal Life Saving have been at the forefront in raising awareness of water safety issues having delivered a number of successful water safety programs, particularly the "*Keep Watch*" campaign. In conjunction, Sport and Recreation Victoria have also been involved in public awareness campaigns relating to supervision. Supervision can be a rubbery concept.

Royal Life Saving in it's "*Keep Watch*" campaign defined adequate supervision in the following terms:

> "*Supervision means your child is being continually watched by you or an appropriate adult. Supervision should be constant, not the occasional glance whilst you read a book or relax. Regardless of what you are doing, always keep watch when children are around the water. Take your child with you whenever you leave the swimming pool or bathtub. Never under any circumstances leave them alone.*"

Frankly that level of supervision of a child by a lifeguard at a public pool is wholly unrealistic. Hence the need for constant parental vigilance. It appears in some instances parents/carers virtually abdicate their primary responsibility for supervision to lifeguards. It seems to me that rightly or wrongly the perception is that the "*Keep Watch*" campaign is related specifically to private pools rather than the broad range of aquatic environments including public pools.

In a valuable report compiled by Lyndal Bugeja (nee Owens), Research Officer at the State Coroner's Office, the author observed:

> "*Another issue that may have hampered the uptake of RLSSA and SRV's parental supervision message, was the presentation of the messages. Much of the imagery and references that accompanied the parental supervision message, both on television and in printed publications, were associated with backyard swimming pools (See Appendix 1). While such a focus is reasonable given that backyard pools have accounted for the highest rate of toddler drowning, the campaigns aimed to target all parents of toddlers. The concentration on backyard pools may have impacted on the messages' perceived relevance to parents of toddlers who reside on rural properties with dams.*"

The same rationale may apply to the perceived reduced relevance of parental supervision in public pools. The one common denominator in child drowning, no matter where, is inadequate supervision.

Recommendations:

It would seem timely that at the commencement of the summer period a public awareness/educational campaign be delivered stressing the need for parental/carer supervision at public pools stating that the "first line defence" rests squarely with parents/carers. The nature of the campaign, that is the approach, should be a matter for those with expertise in "selling" these messages.

As the Guidelines stand, signage stressing the need for parental supervision is merely recommended. I believe this Guidline should be "beefed up". I recommend that appropriate, conspicuous signage be mandatory at strategic locations within the aquatic facility; for example, the entrance, the changerooms and perhaps in the immediate vicinity of the toddlers/teaching pool.

PHILLIP BYRNE
CORONER