IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2015 004688

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

*Section 67 of the **Coroners Act 2008***

I, AUDREY JAMIESON, Coroner having investigated the death of CHILD E

without holding an inquest:
find that the identity of the deceased was CHILD E
born 26 May 2013
and the death occurred on 14 September 2015
at 33 Morshead Street, Melton South Victoria 3338
from:

1 (a) DROWNING

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Child E was two years of age at the time of his death. He lived at 33 Morshead Street, Melton South with his mother, Lisa and the property's two tenants, Kristina Wilson and Edward Hewett. Lisa had moved to the Melton South premises with Child E in August 2015, and paid weekly rent in cash to the tenants. Lisa's six year old daughter, Child E's half-sister, lived with

her father. Child E's father, Craig was held at the Loddon Prison at the time of his son's death and was released on 15 September 2015.

2. On Sunday 13 September 2015, Lisa and Child E slept on a mattress on the floor. Child E coughed a lot and woke up a number of times; he had been unwell over the weekend with what appeared to be gastroenteritis. At 7.00am on 14 September 2015, Lisa was awoken by Child E. Lisa gave Child E a bottle, and they both went back to bed in her room at approximately 8.00am, where she closed the door. At this point, Child E was wearing his blue long sleeve top and his nappy with long pants. They both subsequently fell asleep; Lisa was tired from Child E being unwell during the night.

3. At about 1.00pm, Lisa awoke and saw that Child E was not in the bedroom. The bedroom door was closed, and his tricycle was near the door. Lisa began searching for Child E throughout the house. She became concerned and sent some text messages to her friend Deborah Thorn. Ms Wilson and Mr Hewett were in bed, and Lisa went to their room and informed them that Child E was missing. Lisa slid open the glass sliding door in the dining room and searched the patio area. The first gate was closed, which she opened to go into the backyard. She came back inside and subsequently realised she had not checked the pool. Lisa ran back outside and through the first gate. She saw that the second gate, which was part of the pool safety barrier and the entrance to the pool, was wide open. Child E was in the water, near the in-ground steps of the pool, immediately in front of the open second gate. He was wearing only his blue long sleeved top.

4. Lisa pulled Child E from the water; she screamed for help and ran inside the house. She placed Child E on his back on the dining room floor and Mr Hewett assisted by performing cardiopulmonary resuscitation (CPR). At this time, Ms Thorn and Lisa's other friends Jacob Falla and Sean McLoughlin arrived at the address. At 1.17pm, Mr Hewett's phone was used to contact emergency services, and the call-taker provided CPR instructions. At 1.27pm, ambulance paramedics arrived and continued resuscitation efforts. A Mobile Intensive Care Ambulance (MICA) attended at 1.34pm to assist and an air ambulance helicopter landed on an oval across the road. However, Child E was unresponsive and at 1.56pm, paramedics declared him to be deceased.

INVESTIGATIONS

5. The coronial investigation has encompassed a number of areas, including forensic pathology and police investigations, as well as further investigations by the Court, including: evidence provided by the Department of Health and Human Services and the Commission for Children and Young People; further statements from Barry Plant Real Estate Melton; research conducted by the Coroners Prevention Unit; and consideration of previous coronial recommendations and responses.

Forensic pathology investigation

6. Dr Victoria Francis, Forensic Pathology Fellow at the Victorian Institute of Forensic Medicine performed a full post mortem examination upon the body of Child E, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. At autopsy, Dr Francis observed hyperinflated, congested lungs with frothy clear liquid within the trachea and main bronchi and oral cavity, as well as mild bronchiolitis. Dr Francis observed no evidence of significant injury nor evidence of congenital malformation. Dr Timothy Cain at the Royal Children's Hospital provided a report based on a radiographic skeletal survey and whole-body CT examination of Child E. Dr Cain concluded that the cause of Child E's death was not demonstrated through these tests, but there was no evidence of unexpected skeletal trauma.

7. Toxicological analysis of post mortem blood detected no common drugs or poisons. Methylamphetamine and amphetamine[1] were detected in segments of Child E's hair. Dr Francis opined that this result was likely due to environmental exposure to methamphetamines, but possible ingestion of the drug at some point could not be excluded. Dr Francis noted that the circumstances and autopsy findings were consistent with drowning, and she ascribed the cause of Child E's death to drowning.

Police investigation

8. Senior Constable (SC) Donna Coutts, the nominated coroner's investigator,[2] conducted an investigation of the circumstances surrounding Child E's death, at my direction, including the

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[1] Amphetamines is a collective word to describe central nervous system (CNS) stimulants structurally related to dexamphetamine.

[2] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Child E's mother Lisa, General Practitioner Dr Kishore Parboo, tenants Kristina Wilson and Edward Hewett, Lisa's friends Sean McLoughlin and Deborah Thorn, property owner Gary Kitto, Senior Property Manager at Barry Plant Real Estate Melton Damian Parawa, and an attending Ambulance Victoria paramedic.

9. General Practitioner Dr Kishore Parboo reported that Child E attended the Primary Medical and Dental Centre in Melton from birth. Child E was seen by numerous doctors for varied reasons, most of which involved insignificant day to day illnesses. Dr Parboo noted that none of his records showed any history of family related violence. Child E was last seen at the clinic on 12 August 2015.

10. Lisa reported that her relationship with Child E's father, Craig was a bit up and down. The couple had lived with Child E in Sunshine for the first year of his life; sometimes Craig had lived with his family in Geelong. In September 2014, Craig was arrested and later imprisoned for one year, including time served, on charges including contravention of a family violence intervention order.[3]

11. For a time, Lisa took Child E to live with her mother in Brookfield, and they also lived with a number of her friends in the Melton area. In August 2015, they moved into 33 Morshead Street in Melton South, with Lisa's friends Ms Wilson and Mr Hewett. The agreement involved Lisa paying Ms Wilson and Mr Hewett $120 cash per week in rent. Lisa reported that she moved into the Melton South address because she needed to quickly vacate a Kurunjang house to avoid a resident that she did not like, and she 'had nowhere else to go'. Lisa stated that she was not happy about staying there, as Ms Wilson and Mr Hewett were frequently arguing and yelling at each other. According to Lisa, a friend of hers had also lived at the property but moved out two weeks prior to Child E's death, due to the constant fighting.

<u>The layout and condition of the premises</u>

12. In the course of the investigation, police learned that the layout of the Morshead Street premises included a dining room with a sliding glass door that led to a decking area covered by a pergola. The decking area appeared to be the main zone where Mr Hewett and Ms Wilson's dogs were housed. From the decking area, next to the laundry, there was a first gate, which led to the backyard. There was a separate fence closer to the perimeter of the pool, which included a

[3] In correspondence dated 2 March 2017, SC Coutts advised that the most recent intervention order relating to Craig expired on 18 March 2015. There was no intervention order in place at the time of Child E's death.

second gate. Inside the pool area, there was a sauna/toilet/shower area which appeared to not be in use.

13. Upon attending the premises, SC Coutts observed that both the inside and outside of the property were generally un-kept. Inside the property, dog faeces were observed on the floor of the living room. The cot in Lisa's room was used to store clothing, rather than for sleeping. The mattress in the room had cigarette butts and ash on it.

14. Lisa reported that Child E would mainly sleep on the mattress with her. The door to the bedroom was able to close, but could not be locked. Lisa stated that Child E could not reach the doorhandle, nor open the door by himself. In hindsight, she believed that Child E may have been able to get onto his tricycle and reach the door handle, but she could not explain how the door was closed when she awoke on 14 September 2015.

15. SC Coutts described the bedroom used by Mr Hewett and Ms Wilson as messy, with dog faeces and rotting food on the floor. There was also evidence of drug use with a small amount of cannabis and a bong pipe located on top of the bedside drawer in this room. The bedroom window was wound out, with the flywire screen pushed out, and a gap large enough for a small child to fit through and access the backyard, without having to go through the first gate. Small fingerprints that appeared to belong to a child were located on this windowsill, but a subsequent fingerprint examination of the marks was determined to be of no value.

16. While at the property, SC Coutts observed that the dogs appeared to be able to open the glass sliding door that led from the dining room to the pergola area by themselves. SC Coutts noted that the latch on this door appeared to not function very well.

17. SC Coutts reported that a brick was located on the ground near the first pool gate, which may have been used to keep the gate open at times. Upon testing, the gate opened inwards and automatically closed, but did not appear to always automatically lock. Another brick was located by the second pool gate. There was also a bicycle lock attached to the pool's safety barrier, but it did not appear to have any function. Upon testing, the second gate opened inwards and did not automatically close at all, and did not automatically lock. Dog faeces were observed in the second pool area, indicating that dogs had access to this vicinity. The second pool gate had become detached from its attachment point and created a gap of about 10cm, which became greater when applied with limited physical force. SC Coutts observed that the brackets attaching the pool fence to the ground were mostly not working, with brackets coming loose and the fence

swaying quite a bit when gentle force was applied. She observed that the pool was filled with green and mouldy water. The pool cover was not in use; it was completely retracted.

18. Lisa stated that Mr Hewett was constantly coming and going from the property. When Lisa first moved in, the condition of the house was fine and neat. However, she observed that Ms Wilson and Mr Hewett were quite messy and said she would often clean the house as she did not want Child E walking around in the mess or ingesting any of the dog faeces that were inside the house. She added that at one stage there were four dogs, but at the time of Child E's death, two dogs were living at the property.

19. Lisa said that she and Child E never went into the backyard as she does not like dogs. Ms Wilson and Mr Hewett would often let the dogs inside the house and she would tell them to keep the glass sliding door in the dining room shut. She said that Child E would try and open the sliding door so that he could play with the dogs, but she would keep locking the doors and telling her housemates to do the same. Child E could open the sliding door if it was unlocked, but Lisa did not believe the dogs could do so.

20. Mr Hewett reported that he awoke at 6.00am on 14 September 2015 and went out to purchase food from McDonald's for Ms Wilson and himself. He did not see either Child E or Lisa. Mr Hewett stated that he and Ms Wilson went back to sleep as Ms Wilson was unwell and they had not slept well during the night. Mr Hewett said the dogs had urinated inside the night before, and he had put them outside in the decking area and closed the door behind him. He had not heard from them all night.

Management of the property by the landlord and Barry Plant Real Estate Melton

21. Gary Kitto stated that when he purchased the Morshead Street premises as an investment property in 2010, the house was in immaculate condition. The property already had a pool, and there was a side gate near the laundry door, but no actual fence surrounding the pool. The property was managed by Barry Plant Real Estate Melton (Barry Plant) from 23 September 2010.

22. On 16 December 2011, the Melton City Council Municipal Building Surveyor inspected the property, following notification from Barry Plant that the pool had no safety barrier. Mr Kitto was subsequently issued with a Building Notice[4] on 19 December 2011, in relation to an existing in-ground swimming pool without a safety barrier around its perimeter. Mr Kitto said

[4] The Building Notice was issued pursuant to Section 106 of the *Building Act 1993*.

he met with the surveyor at the property and complied with the notice requirements, erecting a new pool safety barrier. The Council then agreed that compliance was achieved, issuing a 'Cancellation of Building Notice' dated 11 January 2012. Mr Kitto noted that he left the original pool gate near the laundry, so the pool then essentially had two gates. Melton City Council did not have any further interaction with Mr Kitto prior to 14 September 2015 in relation to the pool fence.

23. Ms Wilson and Mr Hewett rented the Morshead Street property from November 2014. Mr Kitto received a copy of the condition report at this time, and said the house was in good condition. Mr Kitto reported that he visited the premises on 23 January 2015, following a report that the pool pump needed replacing. He did not go inside but observed that the house appeared to be in reasonable condition. However, in his statement, Mr Hewett noted that the owner was aware when he came to change the pool pump, that the actual gate to the pool (which was read to imply the gate immediately adjacent to the pool) did not lock, and that when the fence moved, the gate could open.

24. Mr Kitto stated that he was not notified of any other repairs while Mr Hewett and Ms Wilson were residing at the property, and did not attend the address again prior to Child E's death. Mr Kitto was unaware of Lisa and Child E living at the property, and stated that the tenants had not notified the real estate agents that they were sub-letting. He was also unaware that there were animals living at the property.

25. Damian Parawa, Senior Property Manager at Barry Plant reported that an ingoing condition report was completed on 3 December 2014, which noted the 'pool fence and gate' was undamaged and working. The tenants signed the condition report and made no comments.

26. Mr Parawa stated that a general inspection took place on 30 March 2015. The routine inspection report was included in the coronial brief. The only reference within the structure of the report to the pool area appeared to be 'gardens', and 'fences' which were ticked as 'fair' as opposed to 'good' or 'poor'. There was also an 'other' category which did not have any tick. The report noted that no maintenance was required, and that the tenants were maintaining the property in a reasonably neat and tidy standard. Mr Kitto reported that after the March inspection, he was advised that everything was fine, and that he was never informed that there were any issues with the pool fence.

27. Mr Parawa added that the tenants did not raise any issues or concerns with Barry Plant in relation to the pool fence or gate prior to the incident. Mr Kitto noted that the tenants had been

regularly getting behind in their rent and had been sent notices indicating payment was overdue. Mr Kitto said that he could not understand how the property could have deteriorated so much and so badly over the few months prior to Child E's death, and that as far as he knew, it was in good condition. He said that Barry Plant had informed him that people had been squatting at the house.

28. Mr Parawa stated that he and the Director of Barry Plant Edward Pivk, met with Mr Hewett and Ms Wilson on 23 September 2015. He reported that the tenants told Mr Pivk that the pool gate did not lock properly and was broken; they were unable to say when the pool gate was damaged, but inferred it was a recent event. According to Mr Parawa, they also confirmed that they had not notified Barry Plant about the damaged pool gate. An Emergency Order was issued by the Melton City Council on 14 September 2015, following an inspection that found the current pool safety barrier did not comply with Building regulations.[5]

29. Mr Parawa noted that Mr Kitto had carried out the rectification works on the pool safety barrier himself when the Building Notice had been issued in December 2011. He added that Mr Kitto's preference was to complete maintenance on the property himself, unless a licenced plumber or electrician was required.

30. By way of email dated 1 August 2016, SC Coutts confirmed that no other actions or fines were taken by Melton City Council, other than the Emergency Order which was satisfied as the pool safety barrier was repaired and returned to a compliant status.

Further investigations

Evidence provided by the Department of Health and Human Services (DHHS)

31. Emma Orchard, Area Manager of Child Protection in Brimbank Melton, West Division, provided a statement to the court dated 19 August 2016. In her statement, Ms Orchard noted that Lisa advised Child Protection she suffered from anxiety. As a result, a referral to Child FIRST and Women's Health West was discussed and Lisa was advised on 3 April 2014 by Child Protection that Child FIRST would shortly be in contact. Ms Orchard said there was no record in the department's file that Child FIRST made contact with Lisa.

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[5] Specifically, the Emergency Order was issued under section 102 of the *Building Act 1993*, and the child safety barrier was found to not comply with Part 7 of the Building Regulations 2006, Building Code of Australia Part 3.9.3. In addition, Performance Requirement Part 2.5.2 and Part 2.5.3 (Barriers and Swimming pool access) were deemed to have not been satisfied using the Deemed to Satisfy provisions of the Building Code of Australia.

32. Ms Orchard also stated that Lisa advised Child Protection on 16 May 2014 that she was not engaged with any services and believed she was required to attend counselling. According to Ms Orchard, Child Protection spoke with Lisa about obtaining a mental health care plan from her General Practitioner. The DHHS had no record that Lisa subsequently obtained such a plan.

33. Ms Orchard stated that over the three month interim protection order that was made by the Children's Court on 22 May 2014, Child Protection considered that Lisa demonstrated an ability to seek appropriate professional assistance for Child E and ensure his safety and stability. It was noted that she had remained separated from Craig and there was no family violence related police attendance at her mother's home, where she was living. Child Protection assessed no further involvement was required, and that there were no further protective concerns. Ms Orchard stated that it was due to an administrative oversight that Child Protection's file was not closed until 21 January 2015.

Evidence provided by the Commission for Children and Young People (CCYP)

34. By way of letter dated 3 October 2016, the Court was provided with the Commission for Children and Young People's Child Death Inquiry Report relating to Child E. The report is confidential and highly sensitive; I refer to it only broadly, and to the extent that it avoids unnecessary duplication of inquiries and investigations.[6] Of relevance, the CCYP's report identified the same concerns as those identified throughout the course of the investigation, regarding the lack of engagement of Lisa with support services prior to closure of the Child Protection file. The DHHS has responded to the CCYP's recommendations, directly to the CCYP's Principal Commissioner. I am satisfied that the response is comprehensive and focused upon improving engagement between families and support services, and ensuring this occurs prior to case closures. I am also satisfied that some of the issues identified in the CCYP investigation, relate to matters which are not causally connected with Child E's death, and are thus outside the scope of my investigation.

Further statements from Barry Plant Real Estate Melton

35. By way of email dated 3 February 2017, Ganga Narayanan, Partner at Norton Rose Fulbright Australia, provided two additional statements to the Court on behalf of Barry Plant Real Estate Melton, made by Laura Ritchie and Damian Parawa.

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[6] See: Section 7, *Coroners Act 2008* (Vic).

36. Laura Ritchie stated that she was a property manager at Barry Plant Real Estate Melton from 20 February 2015 until 9 June 2015. Ms Ritchie advised that she has no recollection of the inspection she conducted at the Morshead Street property on 30 March 2015. She was unable to say from her own recollection whether she inspected the pool fencing that day, and if so, what condition it was in. However, Ms Ritchie said that if a property has a pool, it is her usual practice to inspect the pool and its fencing, to ensure it is secure and intact. Her usual practice is, and was, to open the gate to the pool fence to check that it closes and locks properly.

37. Upon reviewing the Routine Inspection Report she completed on 30 March 2015, Ms Ritchie said her notation of the 'Fences' as 'Fair' most likely related to the condition of the boundary fencing. She stated that the heading 'Fences' in the pro forma inspection report is generally meant to refer to boundary fencing. If she was referring to the pool fence, she believed she would have made a note in the comments section of the report that it was the 'pool fence'. Ms Ritchie stated that her usual practice is to photograph any damage to a pool fence or gate and note it in the inspection report. She would then return to the office and take action to repair the damage. Given no problems were noted on the inspection report, Ms Ritchie believed she did not observe any issues with the pool fence and / or gate at the time of her inspection.

38. In a supplementary statement, Damian Parawa noted that Barry Plant's property managers are given 'on the job' training to conduct property inspections in accordance with industry standards and best practice. He stated that part of that training involves instruction in relation to inspection of pool fences and gates to ensure they are not damaged or require repair. Mr Parawa stated that as of 30 March 2015, Barry Plant's property managers were instructed that if there were any issues with pool fences, they were to photograph the damage; report it on the inspection report under the section 'fences'; and note the precise problem with the pool fence in the comments section. As Ms Ritchie did not note any maintenance issues with the pool fence in her report, Mr Parawa stated that this indicates the pool fence and gate were not damaged on 30 March 2015.

39. Mr Parawa stated that at the relevant time, Barry Plant used a routine inspection report template with no specific reference to 'pool' or 'pool fences'. He added that this was not uncommon in the industry at that time. Mr Parawa said that if Barry Plant were to take on the management of a property with a pool in the future, they have created a general inspection report which differentiates the property fencing from the pool fencing and gates. The amended template was attached to Mr Parawa's statement and included boxes to tick as 'clean', 'undamaged' and 'working' for each of 'pool/spa gate', 'pool/spa latch', and 'pool/spa barrier'.

Previous Coroners Prevention Unit Research

40. The Coroners Prevention Unit (CPU)[7] recently conducted research in relation to incidents of children drowning in domestic swimming pools. It was identified that between 1 January 2000 and 31 January 2015, 26 children drowned in domestic pools in Victoria. The ages of the children ranged from eight months to 12 years. Of the 26 deaths, the safety barrier gate was left open in eight instances. In three instances, the gate was found to be faulty and in three others, the safety barrier fence was faulty. In four instances, there was no safety barrier fence. In all of the 26 cases, it was noted that adult supervision was inadequate at the time of the drowning.

41. In 2012, a research study entitled "An analysis of stratagems to reduce drowning deaths of young children in private swimming pools and spas in Victoria, Australia," by Lyndal Bugeja and Richard C. Franklin, identified four stratagems as critical in effecting a reduction in the incidence of young children drowning in domestic swimming pools. These stratagems were: a legislatively compliant safety barrier; adequate caregiver supervision; water familiarisation; and early administration of cardiopulmonary resuscitation. The study showed that when the four stratagems were used in combination, young children rarely drowned.

Previous Coronial Recommendations and Responses

Findings into the Deaths of Chanel Peckham and Jacob (Yakkov) Ovadia Ben Zur

42. Chanel Peckham[8] and Jacob (Yakkov) Ovadia Ben Zur[9] were both children whose deaths I investigated, after they drowned in backyard swimming pools or spas of rental properties in 2010.

43. On 6 September 2012, I delivered the Finding into the death of Chanel Peckham and recommended *inter alia* that Consumer Affairs Victoria (CAV) amend its tenancy forms and publications created for tenants and landlords, to include regulatory information about pool barrier fencing.[10] I also recommended that the Real Estate Institute of Victoria (REIV)

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[7] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

[8] COR 2010 001291.

[9] COR 2010 000377.

[10] I also made this recommendation in the Finding into the death of Jacob (Yakkov) Ovadia Ben Zur, delivered on 23 August 2012.

communicate to their members the importance of property inspections, and the duty to ensure the health and wellbeing of tenants.

44. By way of letter dated 26 November 2012, Phil D'Adamo, Acting Executive Director of CAV wrote that my recommendation would be implemented, and that in August 2012, line items 'pool fence and gate' and 'spa fence and gate' were added to the electronic version of CAV's standard form condition report. By way of letter dated 11 December 2012, Enzo Raimondo, Chief Executive Officer of the REIV wrote that there were issues needing resolution regarding the inspection of properties with pools and spas, including the division of legal responsibilities between landlords and tenants.

Inquest into the Death of Lauren Kayley Harris

45. On 14 October 2014, Victorian Deputy State Coroner Iain West delivered the Finding following the Inquest into the death of Lauren Kayley Harris.[11] Lauren was three years of age when she died on 26 September 2008, after being found unresponsive in the backyard swimming pool of her family's Essendon rental property. It emerged during the coronial investigation that the pool safety barrier failed to comply with relevant standards and regulations. Following the Inquest, His Honour made a number of recommendations, including:

- *7. That the legislation be amended to enable authorised officers to enter private properties upon reasonable written notice for the specific purpose of investigating or monitoring compliance with the legislation and any Building Permit relating to a swimming pool.*
- *8. That swimming pool owners be required to obtain a mandatory inspection of their swimming pool safety barriers every three years by licensed pool safety inspectors, with the results to be recorded on the Statewide swimming pool register. A new offence should be established for failing to have a mandatory inspection of the swimming pool conducted with a suggested penalty of at least 20 penalty units to reinforce the gravity of the obligation given the importance of public safety.*
- *9. That the relevant legislation be amended to make it a mandatory pre-condition to the sale or rental or house sitting of any property that has a swimming pool, that pool safety barriers be inspected and where necessary brought into compliance and a certificate of*

[11] COR 2008 004363.

compliance be received from a registered pool inspector, before occupation by the purchaser, tenant or house sitter can occur.

- *11. That pool owners be required to self-register free of charge on a Statewide, online register and provide certification that their pool barrier complies with the legislation. Pool owners should have twelve months to register and provide the necessary certifications. A new offence should be established for failing to register a swimming pool with a suggested penalty of at least 20 penalty units to reinforce the gravity of the obligation given the importance of public safety.*
- *12. That the Victorian Parliament consider providing a single piece of legislation containing a uniformed set of rules and requirements relating to the construction and fencing of pools, irrespective of their date of construction....*
- *13. That the Real Estate Institute of Victoria educates its members about the importance of swimming pool surrounds forming part of property inspection from a duty of care perspective to ensure the health and wellbeing of tenants.*

46. In a response to the recommendations dated 24 October 2014, Glenn Corey JP, Chief of Staff for then Minister for Police and Emergency Services the Honourable Kim Wells MP, indicated that the recommendations relate to amendments to legislation covering the construction of home swimming pools, which come under the *Building Act 1993* and the *Building Regulations 2006*. The letter was forwarded to the Minister for Planning, who was responsible for administering building legislation.

47. In a response dated 24 December 2014, Christine Wyatt, Deputy Secretary, Planning, of the then Department of Transport, Planning and Local Infrastructure (DTPLI),[12] wrote that the *Building Regulations 2006*, which contain the relevant detail in respect of swimming pools, were due to 'sunset' on 6 June 2016 and were being reviewed by officers in the department's Planning Group, in accordance with the requirements of the *Subordinate Legislation Act 1994*. Ms Wyatt wrote that the Coroner's recommendations could be considered within the context of this review, and she would ask the relevant departmental officers to ensure that this occurred.

48. In a response received by the Court on 5 January 2015, Dr Claire Noone, Director at CAV advised that 'Recommendation 9' proposed mandatory inspection and certification of pool

[12] The planning component of the Department of Transport, Planning and Local Infrastructure is now part of the Department of Environment, Land, Water and Planning.

safety barriers prior to sale and leasing of a property, which suggested legislative amendments to the *Sale of Land Act 1962* and the *Residential Tenancies Act 1997*, which falls within the administrative responsibility of the Minister for Consumer Affairs. Dr Noone noted that as the *Building Regulations 2006* were under review by the DTPLI, Recommendation 9 would be considered in the context of the DTPLI's review to ensure an integrated and holistic approach is taken to addressing issues around pool safety barriers.

49. Dr Noone also noted that CAV had included 'pool fence and gate' as an item in its pro forma condition report, to prompt landlords, estate agents and tenants to check pool safety barriers prior to renting a property.

50. In a response dated 23 December 2014, Enzo Raimondo stated that the REIV would be prepared to provide education to its members on the importance of residential swimming pool surrounds being compliant with regulations. Mr Raimondo stated that the REIV supported a three yearly, mandatory inspection, but believed inspections should be carried out by the local municipal council. He also noted that the REIV did not support the creation of a state-wide swimming pool register, nor the recommendation that it be a mandatory pre-condition to the sale or rental of any property that the swimming pool safety barriers be inspected, and a certificate of compliance be received from a registered pool inspector. Mr Raimondo suggested that if there were to be three yearly, mandatory inspections, adding a mandatory inspection as a pre-condition to sale or lease would be over-burdensome regulation.

51. The *Building Regulations 2006* are generally reviewed every 10 years,[13] but the *Subordinate Legislation (Building Regulations 2006) Extension Regulations 2016*, dated 16 February 2016, have since extended the 'sunset' date of the *Building Regulations 2006* to 5 June 2017. The Court has corresponded with the Department of Environment, Land, Water and Planning (DELWP) regarding the review of the *Building Regulations 2006* and the commencement date for the new regulations.

52. By way of email dated 8 February 2017, Helen O'Connell from Building Reform at DELWP advised that the department expected to commence consultation on the Regulatory Impact Statement and draft regulations in early 2017. Ms O'Connell noted that new Building Regulations would be made following consultation on the Regulatory Impact Statement and approval of settled regulations by the Minister for Planning. The department was currently

[13] See: http://www.vba.vic.gov.au/practitioners/legislation/sun-setting-of-the-building-regulations-2006, accessed online 5 February 2017.

finalising communications and release dates. In further communication with DELWP staff on 24 March 2017, the Court was advised that the release date for the Regulatory Impact Statement was still to be determined.

Inquest into the Death of James Gregory Box

53. On 30 October 2013, Western Australian Coroner Barry King delivered the Record of Investigation following an Inquest into the death of James Gregory Box.[14] The Inquest had been held at the Kalgoorlie Courthouse, from 16 to 18 September 2013. James was three years of age when he drowned in the backyard swimming pool of his mother's rental property in Kalgoorlie on 11 March 2012. In the Record of Investigation, His Honour referred to new legislation in Queensland, which was introduced in two stages to provide *'a much more stringent regulation of private swimming pools.'*

Queensland's Pools Safety Laws

54. In 2008 the Queensland government reviewed the state's pool safety laws, with a focus upon reducing the number of drownings in swimming pools involving children less than five years of age.[15] A two-stage swimming pool safety strategy was subsequently implemented. Stage once commenced on 1 December 2009 and stage two started on 1 December 2010. Measures included a training and licensing framework for pool safety inspectors; replacing 11 different pool safety standards with one pool safety standard for all regulated pools;[16] a sale and lease compliance system, requiring pool safety certificates to be obtained from a licensed pool safety inspector when a property with a pool is sold or lease agreement is entered into;[17] and requiring all regulated pools to be included in a state-based pool safety register.

Coroners Prevention Unit Review

55. Following the receipt of the coronial brief and Court's additional investigations, I asked the CPU to review the number of deaths in backyard swimming pools in Queensland over the past ten years, to determine if there had been a decline in fatalities since the introduction of the second stage of that state's new pool safety laws on 1 December 2010.

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[14] Reference No: 38/13.

[15] See: Queensland's Department of Housing and Public Works, 'Guidelines for pool owners and property agents', dated October 2016, http://www.hpw.qld.gov.au/SiteCollectionDocuments/GuidelinesForPoolOwnersAndPropertyAgents.pdf, accessed online on 6 February 2017.

[16] Both new and existing pools must comply with the standard (Queensland Development Code Mandatory Part 3.4) by 30 November 2015, or earlier if sold or a lease agreement is entered into.

[17] Pool safety certificates are valid for one year for shared pools and two years for non-shared pools.

56. As part of the review, data was sourced from the Royal Life Saving Society – Australia, from the Royal Life Saving National Fatal Drowning Database, for the period from 1 July 2006 until 30 June 2016. The data indicated that 148 children below the age of five died in Australian backyard swimming pools over this time. Of these deaths, 130 occurred in four states: New South Wales (57), Queensland (39), Western Australia (19) and Victoria (15).

57. In Queensland, the number of deaths of children under five, halved in the five financial years following the introduction of the second stage of new pool safety laws on 1 December 2010. In the financial years from 2006-07 to 2009-10, there were 23 deaths; an average of 5.75 per year. In the five financial years from 2011-12 to 2015-16, there were 13 deaths, or an average of 2.6 deaths per year.

58. However, the review noted that there was also a decline in the same periods in New South Wales (from an average of 8 deaths per year, to 4.2 deaths per year) and Victoria (from an average of 2 deaths per year, to 1.4 deaths per year). Among the four states with the highest number of deaths over the ten year period, only Western Australia saw an increase (an average of 1.5 deaths per year, increased to 2.6 deaths).

59. While the review identified that the average annual frequency of drowning deaths in Queensland, among children aged 0 to 4 years, was approximately 50% lower after the introduction of new pool safety laws in December 2010, it also noted that there are issues in attributing this decline in deaths to the new laws. The review suggested that the new pool safety laws have probably contributed to the declining number of drowning deaths among young children in Queensland, but in the context of many other factors and initiatives (such as a background decreasing trend in other states, earlier fencing regulations and public education), it was not possible to state what the exact impact had been.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. Child E's tragic death has occurred amidst a confluence of issues which include the sub-optimal involvement of the DHHS; the lackadaisical approach about responsibilities to a child by a number of adults; and the seemingly perpetually inadequate regulation of swimming pools in Victoria. No single, specific factor is wholly responsible for Child E's death.

2. I have considered whether it was appropriate to suppress Child E's name, and his parents' names in this Finding. I reviewed social and news media, where I readily located news items

which clearly depict a photograph of Child E, and also identify his parents. There has been extensive media coverage involving Lisa and Craig, who I assume provided the photographs of Child E and consented to them being displayed in the media. I have therefore determined that it is not in the public interest to suppress Child E's identity. I also acknowledge that an article naming Lisa and Craig, published by the Herald Sun and dated 18 December 2015, referred to pool fencing safety issues, some of which I have attempted to address in this Finding. However, while there is no suppression order in place and I have received no requests for anonymity, out of respect for Child E's family, I have determined for publication purposes to redact certain names.

3. The investigation has identified that the conditions at the Morshead Street premises were squalid, and that both pool safety barriers were badly damaged and faulty. Lisa's desperate circumstances were implicit in her decision to reside at this highly unsuitable address with Child E, and I note that she has stated that she *'had nowhere else to go'*. In what was then a context of serious family violence, it is deeply concerning that the DHHS apparently failed to ensure Lisa was effectively engaged with support services, prior to closing the Child Protection file. I do note that the DHHS has responded positively to the recommendations made by the Commission for Children and Young People's Child Death Inquiry report, and it is reassuring that initiatives are underway to improve referrals and the engagement of clients with support services.

4. I note Mr Hewett's evidence that he was aware the pool safety barrier's gate was in a poor condition and did not lock. It was incumbent upon Ms Wilson and Mr Hewett to report the damaged pool safety barrier and gate to Barry Plant Real Estate Melton. Despite their intimate knowledge of the state of the pool safety barriers, they nevertheless unofficially sublet the premises to Lisa, a woman with a two year old son, without seeking to ensure the safety of the property. In the absence of hearing directly from Ms Wilson and Mr Hewett, I have determined however to focus on the systemic issues identified in my investigation, rather than the actions or inactions of individuals.

5. I remain unclear as to the condition of the pool safety barriers on 30 March 2015, the date of Laura Ritchie's inspection of the Morshead Street premises. Ms Ritchie advised that it was her usual practice to inspect pool fences, and the evidence of both Ms Ritchie and Mr Parawa seeks to suggest that the absence of any specific notation in the Routine Inspection Report regarding the pool fence and gate, indicates that they were not damaged on this date. Given the lack of any prompt in the documentation to inspect the pool safety barrier, I find this reasoning

unsatisfactory. Moreover, it is difficult to conceive that the condition of the pool safety barrier could have deteriorated so substantially in the space of six months, that is, between March 2015 and the date of Child E's death.

6. I note that Consumer Affairs Victoria have produced a pro forma Condition Report document, which includes the items 'pool fence and gate' and 'spa fence and gate', with the columns 'clean', 'undamaged' and 'working'. It seems clear that this approach should be replicated in Routine Inspection Report templates, and I note that Barry Plant Real Estate Melton has incorporated reference to 'pool/spa gate', 'pool/spa latch', and 'pool/spa barrier' in documentation for future routine inspections of properties with swimming pools or spas.

7. The tragic deaths of three children; Chanel Peckham, Jacob (Yakkov) Ovadia Ben Zur, and Lauren Harris in backyard swimming pools of rental properties, should be an impetus for regulatory change in Victoria. However, while we have waited for the Victorian Government's reform of the *Building Regulations 2006*, and the response to Deputy State Coroner Iain West's recommendations following the Inquest into the Death of Lauren Harris, Child E has died. The regulation of backyard swimming pools in Victoria is inadequate, and the evidence indicates that tenants are made especially vulnerable by the status quo. There is a theme wrought by the devastating deaths of these children, and an intransigent response or lack of reform will keep the Victorian public at an unacceptable level of risk.

8. The regulatory changes in Queensland evince a welcome progression of this country's approach to pool safety and death prevention. I acknowledge that the Court's research has not ascertained the discrete impact of Queensland's regulatory changes on the reduction of deaths involving children aged under five. However, the formation of a state-wide pool register and the instigation of a sale and lease compliance system, requiring pool safety certificates to be obtained when a property with a pool is sold or a lease agreement is entered into, are undoubtedly a far sight superior to the current framework – or lack thereof – in Victoria, and represents a proactive response to the obvious need to implement more comprehensive regulations with the aim of preventing harms and like deaths.

9. In Victoria, it is relatively simple for properties with pool safety barriers and gates that do not meet regulatory standards, to remain undetected. The consequences, as in Child E's case, are too often catastrophic. The Department of Environment, Land, Water and Planning's slated review

and amendments to the *Building Regulations 2006*, signifies an important opportunity for Victoria's pool regulatory framework to be greatly enhanced.

FINDINGS

The criticalness of safety precautions when children are near water and the tragic consequences of complacency, have been oft repeated messages in coronial findings. I find that the deadly combination of a lack of adult supervision – for an unspecified period – while Lisa slept, and a malfunctioning pool safety barrier and gate, served to enable Child E's untimely death. Whether Child E was able to exit the house on 14 September 2015 via an unlocked glass sliding door in the dining room, or via the open, broken window in Mr Hewett and Ms Wilson's bedroom, the property was ill-equipped to safely house a two year old child.

The investigation has illuminated shortcomings regarding the involvement of the Department of Health and Human Services in Child E's care. While a lack of engagement with support services, in the context of a family violence intervention order, may have influenced Lisa's reported desperation regarding accommodation, I find that there is no direct causal link between the actions of the Department and Child E's death.

I accept and adopt the medical cause of death as identified by Dr Victoria Francis, and find that Child E tragically drowned in a backyard swimming pool.

AND I further find that the death of Child E was preventable.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations:

1. With the aim of improving Victoria's pool safety regulation framework and preventing like deaths, **I recommend that** during the review of the *Building Regulations 2006*, the Minister for Planning consider adopting elements of the framework enacted in Queensland, including but not limited to, requiring that a pool safety certificate be obtained prior to a property with a pool being sold or leased.

2. With the aim of improving Victoria's pool safety regulation framework and rigorously monitoring compliance, **I recommend that**, as anticipated in the recommendation made by Deputy State Coroner Iain West in the Finding following the Inquest into the death of Lauren Kayley Harris dated 14 October 2014, the Minister for Planning consider the creation of a state-wide pool register.

3. With the aim of emphasising and enhancing the role of real estate agency staff in detecting malfunctioning pool safety barriers in rental properties, **I recommend that** the Minister for Consumer Affairs, Gaming and Liquor consider that Consumer Affairs Victoria also produce a pro forma Routine Inspection Report document, which incorporates reference to 'pool fence and gate' and 'spa fence and gate', as in its condition report.

Pursuant to section 73(1A) of the *Coroners Act 2008,* I order that this Finding be published on the internet. Out of respect for the family of Child E, for publication purposes, I have redacted certain names in this Finding.

I direct that a copy of this finding be provided to the following:

Child E's Mother

Child E's Father

Ms Liana Buchanan, Principal Commissioner, Commission for Children and Young People

Ms Kym Peake, Secretary of the Department of Health and Human Services

Ms Catrina Boemo, Senior Solicitor, Legal Services Branch, Department of Health and Human Services

The Honourable Marlene Kairouz MP, Minister for Consumer Affairs, Gaming and Liquor Regulation

The Honourable Richard Wynne MP, Minister for Planning

Ms Laene Matahaere, Acting Manager, Building Reform, Department of Environment, Land, Water and Planning

Mr Barrie Woollacott, Slater and Gordon Lawyers

Ms Ganga Narayanan, Norton Rose Fulbright Australia

Ms Pene Snashall, Royal Life Saving Society - Australia

Senior Constable Donna Coutts

Signature:

AUDREY JAMIESON
CORONER

Coroners Court of Victoria

Date: **1 May 2017**