IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 006780

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	KW
Date of birth:	15 September 2016
Date of death:	13 December 2020
Cause of death:	1(a) Drowning
Place of death:	Mildura Base Hospital, 216 Ontario Avenue, Mildura, Victoria, 3500

INTRODUCTION

1. On 13 December 2020, KW was 4 years old when he passed away at the Mildura Base Hospital. At the time of his death, KW lived at home with his family in New South Wales.

THE CORONIAL INVESTIGATION

2. KW's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of KW's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the KW's death including evidence contained in the coronial brief. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

7. The Mildura Riverside Holiday Park (**Holiday Park**) provides accommodation facilities and includes cabins and a caravan and camping park. It also includes an entertainment area for the use of guests but which can also be booked for events such as birthday parties.

8. The entertainment area includes a fenced enclosure which contains a toddler pool and a larger pool with a slide. The slide is situated to enable children to slide down it and exit into the deep end of the pool which is 1.7 metres in depth. There is a 'Splash Park' adjacent to the pool enclosure which contains two water slides. These slides are independent structures which do not exit into any pool. Also adjacent to the pool enclosure is a barbeque area and an indoor play area. The Holiday Park was equipped with CCTV cameras which provided live coverage of various locations including the pool enclosure but footage was not recorded.

9. Signs were attached to the gate leading into the pool enclosure which included statements that "*Kids under 15 and those with special needs must have an adult with them at all times"* and *"Guests are responsible for using the swimming pool safely, please be aware no lifeguard is on duty"*.

10. On 12 December 2020, KW's family checked into a cabin at the Holiday Park where they stayed overnight. They had made a booking to utilise the entertainment area the following afternoon to celebrate the sixth birthday of KW's older brother. They had invited a group of family and friends to celebrate with them.

11. The birthday party began in the indoor play area and later the children were allowed into the pool enclosure to swim. The gate between the pool enclosure and the 'Splash Park' was left open to enable children to access both areas. In his statement provided to police, KW's father recalled that as a *"rough estimate"* about 20 people attended the party with eight being adults and the remainder children.

12. KW's mother fitted him with a vest which provided an aid to buoyancy in the pool. However, at some stage, the vest was removed as KW wanted to use the water slides more freely in the 'Splash Park'.

13. When the children started swimming in the pools, KW's father cooked some food in the barbeque area which he then placed on a table between the two pools. Later, KW's mother

asked him to take over supervising their two year old daughter, who was playing in the toddler pool, while she returned to their cabin to collect ‘lolly bags’ to be given to the children before the party concluded.

14. Shortly afterwards at around 5.25pm, while KW’s father was watching his daughter in the toddler pool, he heard a child call out *“excuse me, there’s something in the pool”*. KW’s father turned around and walked over to the large pool and observed a child under the water whom he later recognised to be his son. He immediately jumped into the pool and lifted his son out and placed him on the ground to the side. He was unresponsive. One of the parents commenced cardiopulmonary resuscitation (**CPR**) while another parent contacted emergency services. CPR continued with the assistance of instruction over the telephone from the emergency operator. The manager of the Holiday Park arrived shortly afterwards and attached and used a defibrillator before continuing with CPR. At around 5.35pm, Ambulance Victoria paramedics arrived and assumed responsibility for treating KW. They noted that he was in cardiac arrest and continued CPR. Victoria Police and the Country Fire Authority also attended.

15. At around 5.50pm, KW was conveyed to the Mildura Base Hospital by Ambulance Victoria. CPR was continued for over an hour by staff at the hospital but return of spontaneous circulation could not be achieved and KW was declared deceased at 7.25pm.

16. A 12 year old child who was present in the pool enclosure but not attending the party later reported to Victoria Police that she had seen KW come down the slide into the large pool and not come to the surface.

Identity of the deceased

17. On 13 December 2020, KW, born 15 September 2016, was visually identified by his father.

18. Identity is not in dispute and requires no further investigation.

Medical cause of death

19. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 15 December 2020 and provided a written report of his findings dated 21 December 2020.

20. Dr Lynch reviewed a post-mortem computed tomography (**CT**) scan which revealed mottled lungs and no skeletal injuries.

21. Dr Bedford provided an opinion that the medical cause of death was 1 (a) Drowning.

22. I accept Dr Bedford's opinion.

CPU REVIEW

23. I asked the Coroners Prevention Unit (**CPU**)[2] to provide an analysis of recent statistics relating to drowning deaths of children up to 4 years of age. The CPU identified 17 deaths that occurred between 1 January 2017 and 30 November 2021. All but one of those deaths occurred in circumstances where it was found that inadequate adult supervision had been a contributing factor. Six of the deaths occurred in circumstances involving a backyard or public pool.

FINDINGS AND CONCLUSION

24. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was KW, born 15 September 2016;

    b) the death occurred on 13 December 2020 at Mildura Base Hospital, 216 Ontario Avenue, Mildura, Victoria, 3500, from drowning; and

    c) the death occurred in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

25. KW's death could have been prevented if there had have been adequate adult supervision of the children who were swimming in the large pool on 13 December 2020. The use of life vests or other buoyancy aids are not a substitute for close, focussed and active supervision. The Royal Children's Hospital considers supervision to be *"constant visual contact, not the occasional glance"* and advise that children under five must be within arm's reach.[3]

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[2] 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. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[3] Royal Children's Hospital, 'Safety: In and around water', accessed 10 December 2021.

26. Kidsafe Australia[4] recommends that:

> *"When there are lots of adults around (eg at a BBQ or pool party) it can be easy to assume that someone is watching the kids, when in fact, nobody is. That's why it's a good idea to have designated adult supervisors whose role it is to actively supervise the kids in and around water – this role can be shared throughout the day so that everyone gets a chance to relax and enjoy themselves".*[5]

27. In this case, the busy and hectic environment of a child's birthday party involving a swimming pool and other adjoining entertainment facilities has created the circumstances where the attention of the attending adults has been stretched, distracted or divided leading to a corresponding lack of active supervision of the children swimming in the large pool. There may have been an assumption that adequate supervision would be provided given the number of adults attending the event.

28. Kidsafe Australia also recommend that pool gates never be propped open. In this case, the gate between the pool enclosure and the "Splash Park" was left open to enable easy access to both areas but the existence of the extra barrier would have provided a further opportunity to trigger further adult awareness of exactly which children were using the large pool.

29. These findings and comments are not made by way of criticism of KW's parents who have suffered a devastating tragedy. They are deserving of sympathy and not judgment. The comments are provided as a salutary warning to all caregivers of children so that drowning deaths relating to inadequate supervision can be prevented in the future. The importance of ensuring the safety of children around water cannot be overstated and it should be discussed and planned by caregivers beforehand. It is timely to reiterate and emphasise this message now with another summer having just begun, and much of the Victorian community having recently emerged from lockdowns imposed to manage of the Covid-19 pandemic. As a result, many children will be enthusiastically embracing the opportunity to engage in water-based activities with friends and family, in circumstances where few of those children would have had the opportunity over the last couple of years to develop and improve their swimming skills with organised lessons.

I convey my sincere condolences to KW's family for their loss.

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[4] Child Accident Prevention Foundation of Australia.

[5] Kidsafe Australia, 'Water Safety', accessed 10 December 2021

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Senior Next of Kin

Constable Matthew Adams, Coroner's Investigator

Signature:

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Coroner David Ryan

Date : 17 December 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.