IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 3658

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Findings of:	**GREGORY MCNAMARA, CORONER**
Deceased:	**ZE CHENG (TONY) GUAN**, born 23 February 1960
Delivered on:	7 July 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	5, 8, 9 and 31 May 2017
Counsel assisting the Coroner:	Mr Peter Matthews
Representation:	Mr Stephen Russell for the YMCA Ms Carmen Currie for the Moonee Valley City Council Mr Robert O'Neill for Kyra Fennell and Joseph Watson Ms Ruth Shann for Liam Bevanda

HIS HONOUR:

BACKGROUND

1. Ze Cheng (Tony) Guan was 54 years of age at the time of his death.

2. Mr Guan was diagnosed with Motor Neurone Disease (**MND**) (also known as Amyotrophic Lateral Sclerosis) in October 2012.[1] At an early stage his sister Ze Feng Guan had become his carer. That role was taken over by his brother Ze Biao (Bill) Guan approximately 10 days before Mr Guan's death.[2] Mr Guan's partner, Stan Turton, was also involved in his care but was not formally a carer.

3. Mr Guan had attended the Ascot Vale Leisure Centre (**AVLC**) for over ten years and used the pool at the Centre almost daily.[3] The leisure centre was owned by the City of Moonee Valley and at the time fully operated by YMCA.

4. On 16 July 2014 Mr Guan was seen floating face-down in the hydro (warm water) pool at the AVLC. He was unconscious when removed from the water. Emergency treatment was performed by lifeguards until emergency services arrived. He was then taken by ambulance to the Royal Melbourne Hospital. A test for brain function yielded a negative result and he was removed from life support on 19 July 2014.

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Mr Guan's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was unexpected and not from natural causes.[4]

6. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[5] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the

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[1] Statement of Dr Jim Howe (Exhibit 2).

[2] Transcript pp 181.27 and 209.21.

[3] Transcript p 181.25.

[4] *Coroners Act 2008* (Vic) s 4.

[5] *Coroners Act 2008* (Vic) s 89(4).

identity of the deceased person, the cause of death and the circumstances in which death occurred.

7. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[6] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

8. The expression '*cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

9. For coronial purposes, the phrase '*circumstances in which death occurred*' refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

10. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's '*prevention*' role.

11. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

12. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in

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[6] *Keown v Khan* (1999) 1 VR 69.

Briginshaw v Briginshaw.[7] 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 that they caused or contributed to the death.

MATTERS RELEVANT TO CIRCUMSTANCES OF DEATH

Mr Guan's health

13. Dr Jim Howe was Mr Guan's treating neurologist. He reported that he first met Mr Guan on 11 February 2013 and stated that Mr Guan had:

> *a lumbar onset ALS pattern of disease, that is muscle weakness progressing slowly from the legs upwards.*[8]

14. Dr Howe last saw Mr Guan in June 2014. At that time, Mr Guan could no longer stand unaided and required hoisting for transfers. He could do very little with his legs or right arm. His left arm was better than his right arm and he could use that to control his power chair. Weakness was just beginning to appear in the speaking and swallowing muscles and there was trunk muscle weakness and neck muscle weakness just beginning.[9] He was not in respiratory failure. Dr Howe said in evidence:

> *Given his muscle weakness, particularly that he couldn't use his arms to help movement in the water, I think he would have needed his feet on the bottom of the pool to keep his face out of the water. And I felt he needed someone in the water with him and I was told that he always did have someone in the water with him.*[10]

15. Dr Howe also recommended use of a flotation device.[11]

16. Mr Guan would not use a flotation device[12] and at times directed his carers to leave him when he was in the pool.[13] At times he preferred not to have a carer with him. "*My older brother*

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[7] *Briginshaw v Briginshaw* (1938) 60 CLR 336.

[8] Statement of Dr Jim Howe (Exhibit 2).

[9] Transcript pp 23-24.

[10] Transcript p 27(2-8).

[11] Transcript p 27.30.

was a rather stubborn person, and he would usually insist that his carer or the person with him go and swim themselves rather than stay very close to him".[14]

Mr Guan's Mental State

17. Dr Howe stated that Mr Guan had had one depressive episode which, with treatment, he seemed to get over quite quickly.[15] He had no reason to suspect depressed symptomology from his behaviour on the ward and he had not expressed suicidal thoughts or plans.[16] He further stated that Mr Guan was:

> *still speaking and swallowing and breathing satisfactorily in 2014. I would have expected at least another year of life without any life prolonging intervention.*[17]

18. Mr Turton stated that he and Mr Guan had plans to go out that night[18] and Ms Ze Feng Guan, when asked if Mr Guan was sad or depressed, stated:

> *I can confidently say to you that no, he wasn't.*[19]

19. Mr Bill Guan stated that Mr Guan:

> *was in a good mood that day.*[20]

20. There is no evidence that Mr Guan had any intention to harm himself on the day of his death.

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[12] Transcript p 28.7.

[13] Transcript p 61 (Stan Turton), p 218 (Ze Feng Guan), p 191 (Ze Biao (Bill) Guan).

[14] Statement of Ze Biao (Bill) Guan (Exhibit 8).

[15] Statement of Dr Jim Howe (Exhibit 2).

[16] Transcript p 21.17.

[17] Transcript p 28.25.

[18] Transcript p 53.3.

[19] Transcript p 216.9.

[20] Transcript p 184.16.

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

Circumstances of death

21. On 16 July 2017 Bill and Tony Guan arrived at the pool at about 2.00pm[21] and followed their usual routine. In the disabled changing rooms, Bill used a hoist to assist Mr Guan to change into his swimming gear and then pushed Mr Guan in an aquatic wheel chair to the hydro pool and down the ramp into the water. When Mr Guan had reached a point of sufficient depth, he was able to move himself in the water and the wheel chair was removed.[22]

22. In the water Mr Guan was able to move about the pool holding a submerged rail. He could do some exercises.[23]

23. Stan Turton arrived at the pool and, at a time Bill Guan estimated to be about 3.15pm, Bill Guan moved to the spa area leaving Mr Guan and Mr Turton in the hydro pool.[24] In his statement dated 26 October 2014, Bill Guan said that Mr Turton arrived about twenty minutes after Mr Guan entered the water which would mean that Mr Turton's arrival and Bill's moving to the spa pool occurred much earlier than 3.15pm.[25] This timing is more probably correct.

24. Mr Turton's recollection was that he left the pool at about 3.15pm and came back to the pool to say good-bye to Mr Guan at about 3.30pm.[26] CCTV footage suggests that Mr Turton left at some time before 3.26pm.[27] Mr Turton did not tell Bill Guan that he was leaving and Bill Guan did not know that Mr Turton had left. From that point there was no-one acting as a carer for Mr Guan in the hydro pool. The lifeguards were unaware of the need for, or the absence of a carer.

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[21] Transcript p 183.13.

[22] Transcript p 183.14.

[23] Transcript p 181.4.

[24] Transcript p 184.22.

[25] Statement of Ze Biao (Bill) Guan (Exhibit 8).

[26] Statement of Stan Turton (Exhibit 3).

[27] CCTV Footage of AVLC on 16 July 2014 (Exhibit 14).

The lifeguards

25. The lifeguards on duty immediately before 4.00pm were Joseph Watson and Kyra Fennell. Liam Bevanda was the duty manager. All were qualified and experienced lifeguards and Liam Bevanda's role included taking supervision when the lifeguards were diverted to other tasks or on a break.[28]

26. Joseph Watson's shift was from 12.00pm to 4.00pm and Kyra Fennell's shift commenced at 3.45pm.

27. Rynelle Rogers, acting Aquatic Operations Manager at that time,[29] said that Kyra Fennell's shift started at 3.45pm to allow her time to prepare the program pool for swimming lessons.[30] Her lifesaving supervision duties were intended to start at 4.00pm. It is not disputed that Ms Fennell did do lifesaving surveillance before 4.00pm that day.

28. Although not of good quality, the CCTV recording does provide assistance with the timing and sequence of events.

29. At 3.47.11pm Joseph Watson left the pool deck at point A[31] of the pool plan. Although his shift was due to finish at 4.00pm he took a ten minute break beginning at 3.47pm. Joseph Watson said that before leaving the pool deck he asked Liam Bevanda to take the lifesaving supervision role.[32] Liam Bevanda is unable to recall that conversation or taking a supervisory role but, having seen the CCTV footage, accepts that he could have taken that role after the discussion with Mr Watson.[33]

30. At 3.47.57 Kyra Fennell came into view of the CCTV camera at point B, having come from the staff office at point A. She said that she was late coming to the pool deck as in the staff

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[28] Transcript p 168.29.

[29] Transcript p 232.9.

[30] Transcript p 241.25.

[31] Plan of pool deck with alphabetical markings (Exhibit 15).

[32] Transcript p 82.21.

[33] Transcript p 176.1.

room she had been unable to find the bum bag containing safety equipment that the lifeguards were required to wear. She said she spent quite a few minutes looking for the bum bag.[34]

31. At 3.48.05 Ms Fennell is shown walking past Liam Bevanda. I accept her evidence that at that time she reported to him that there was no bum bag or radio in the staff room for her use.[35] She then, on instruction from Mr Bevanda, moved to the lifeguard station (point D) and commenced supervising.[36] She was concerned at the time that she didn't have the bum bag and radio.[37]

32. At 3.49.20, Mr Bevanda arrived at the lifeguard station (point D) and Ms Fennell said that at 3.49.10 she proceeded to go to the lane ropes area behind the hydro pool to start setting up the lane ropes for swimming lessons.[38] She said that she assumed that Mr Bevanda was watching the pools. CCTV shows her unspooling the lane ropes at 3.49.10. At 3.51.06 Ms Fennell returns to point D and resumes lifeguard duties.

33. At 3.56.28 Joseph Watson is shown entering the pool deck from the members' change room. He passed point B and checked the lifeguard station at 3.57.22. Ms Fennell spoke to Mr Watson on his return. She told him that she didn't have a bum bag or radio and because he was going to finish soon, he handed her his bum bag and radio. Her evidence from this moment was:

> *As I then was adjusting the bum bag to put around my waist, I did hear Liam ask Joseph to collect water from the pool, so I do remember Joseph starting to head toward the hydrotherapy pool, I'm still trying to clip the bum bag, and then I hear Joseph yell out my name. I look up, see he'd already started to pull Mr Guan up out of the water a little bit. I ran over, hadn't had the bum bag connected yet so I dropped it by my – our sides, we proceeded to pull him out, it was pretty clear that he was unresponsive, so I started compressions.*[39]

34. For his part, Mr Watson said that he walked toward the hydrotherapy pool. When approximately half way from the lifeguard area (point D) to the warm water/hydro pool he

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[34] Transcript p 120.22.

[35] Transcript p 120.17.

[36] Transcript p 120.27.

[37] Transcript p 121.4.

[38] Transcript p 122.11.

[39] Transcript pp 124(20-31) and 125(1-5).

observed a patron in the pool trying to get his attention and then observed Mr Guan face-down in the water.[40] He estimated that he was approximately four metres from Mr Guan when he saw him.[41] He ran to the side of the pool, grabbed Mr Guan as best he could and shouted out to Ms Fennell to come and assist.[42] At 3.58.04 CCTV shows Mr Watson run to the side of the hydro pool.

35. Bill Guan heard the shouting and ran from the spa to the hydro pool. Although the lifeguards have no recollection of it, I accept Mr Guan's evidence that he did try to assist in moving his brother from the pool.

36. Ms Fennell accepts that she had surveillance duty from the time she returned to point D after moving the lane ropes.[43] She said that prior to being alerted by Mr Watson she had not noticed anyone in distress or anyone signalling to her[44] and that the situation with the bum bag did not restrict her vision in any way.[45]

37. The problem of the bum bag was not a difficulty of Miss Fennell's making. She had arrived at work early so that the bum bag could be found and fitted before her shift started. There wasn't one available. She advised the duty manager and still a bum bag and radio were not available until she was on duty. She was uncomfortable not having a bum bag and raised this in her debrief.[46]

38. Ms Fennell was trying to adjust and clip on the bum bag when she heard Joseph Watson yell out her name causing her to look up.[47] She was distracted by the problem of the bum bag and failed to see the patron in the pool trying to gain the attention of a lifeguard, Mr Guan face-down in the water and Mr Watson run the short distance to Mr Guan. In her first observation after hearing her name, Mr Watson was attempting to remove Mr Guan from the pool.

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[40] Transcript p 108.14.

[41] Transcript p 105(18-27).

[42] Transcript p 84(11-18).

[43] Transcript p 146(1-4).

[44] Transcript p 146(6-10).

[45] Transcript p 147.2.

[46] Transcript p 144(20-22).

[47] Transcript p 124(26-31).

39. I accept that the above events could all have occurred in a short period of time. It may be that there were no overt signs of distress other than Mr Guan being face-down, and that he may have become unconscious very quickly.

Evidence of Forensic Pathologist Dr Paul Bedford on the process of drowning

40. Dr Bedford, who had conducted the autopsy, provided further evidence on the last day of hearing. In particular, he was asked if he could say how long it would take from the time of immersion to loss of consciousness. He described the drowning process. He said that when a person is immersed in water and in difficulty they will hold their breath until the carbon dioxide level is so high they have to breathe. They will then gasp for air and at that time water may enter the lungs. Water in the lungs will impair the lung function and eventually the person will become unconscious and, with a certain period of time in that state, they will have irreversible brain damage and die.[48]

41. Dr Bedford said that Mr Guan's neurological disease would impact on that process.[49] He would have a decreased ability to right himself if his face was down in the water.[50] He also postulated a different neurological process in Mr Guan's upper airways affecting his larynx and response to the fluid entry to the lungs. Water could enter the lungs more quickly and in greater volume and this could lead to a shorter than normal period leading to unconsciousness.[51]

42. Dr Bedford was asked if he could give a minimum time for the period of Mr Guan's loss of consciousness.[52] He had said in his supplementary report that the timing of reaching unconsciousness (when drowning) is highly variable but often in the order of around one minute. When asked further, he said:

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[48] Transcript p 284(10-28).

[49] Transcript p 287.17.

[50] Transcript p 287.24.

[51] Transcript p 291.

[52] Transcript p 293.29.

it's a difficult area. And clearly the further you go towards zero, the less likely it is, and the closer you are to one minute, the more likely it is. So I think I'd like to leave my answer at that comment.[53]

I understood from Dr Bedford's evidence that the period could be thirty seconds or less. He was not prepared to estimate a minimum time.

43. Dr Bedford accepted that the period between loss of consciousness and irreversible brain damage could, due to water in the airways blocking air transfer back to the bloodstream, include some of the time when resuscitation was attempted.[54]

Identity of the Deceased

44. On 19 July 2016 at the Royal Melbourne Hospital ICU a Statement of Identification was completed by Mr Guan's partner Mr Stan Turton.

45. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death

46. In his autopsy report dated 28 August 2014, Dr Paul Bedford, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, concluded that Mr Guan's medical cause of death was '*I(a) CONSISTENT WITH DROWNING I(b) ADVANCED MOTOR NEURONE DISEASE*'.

47. Dr Bedford considered background information, that being the relevance of a water environment,[55] the exclusion of other possible causes of death such as heart attack[56] and the presence of fluid in the lungs and stomach.

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[53] Transcript p 294(1-8).

[54] Transcript p 295(12-19).

[55] Transcript p 10.22.

[56] Transcript p 12.1.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

48. Having heard the evidence of Joseph Watson, Kyra Fennell and Liam Bevanda and having seen the CCTV recording, I am satisfied that there was a supervisory lifeguard on duty at all relevant times.

49. Uncertainty about this arose from the system which allowed on duty lifeguards to do tasks which took them from their life saving duties. This required a substitute to take on that role while they were otherwise occupied. There wasn't a clear system in place to ensure transfer of responsibility.

50. When Kyra Fennell went to change lane ropes she said she assumed that Mr Bevanda was watching the pools.[57]

51. Nor was there a clear method such as a particular clothing to identify to the public or to the lifeguards themselves which of the lifeguards was on lifesaving duty at any one time.

52. All of the witnesses at the Centre had been trained and were familiar with the Royal Life Saving guidelines. Those guidelines in fact require:

> 5.2 Minimum Supervision
>
> (a) A minimum of one qualified lifeguard should be supervising, facing and watching the people in the water at all times.
>
> (b) Sufficient lifeguards should be provided to ensure that all the body/s of water and people therein can be supervised effectively.
>
> (c) Lifeguards are responsible for the supervision of all persons within the aquatic areas of the facility including those children under parental supervision.
>
> 5.3 Line of Sight
>
> (a) Lifeguards should be positioned to maintain continual supervision of the water. It is recognised that lifeguards need to be mobile and a clear line of sight is a significant requirement. A clear line of sight must be established not only for the surface of the pool but also for the floor of the pool.[58]

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[57] Transcript p 122(10-11).

[58] Coronial Brief pp 961-962.

53. In July 2014, Rynelle May Rogers was the acting Aquatics Manager at the Ascot Vale Leisure Centre. Her evidence was that the '*number one*' job of the lifeguards was to supervise the pool and that for any other jobs outside that area the lifeguard was to get assistance from the duty manager.[59] She said that all cleaning duties, including the side of the pool, sweeping up rubbish and other cleaning duties would require the assistance of the duty manager.

54. She said that, other than checking the sauna and steam room, there was no job that should be undertaken at the same time as supervision without the assistance of the duty manager.

55. The evidence of Joseph Watson was that at times when people were in the pools the duty lifeguard would, without the assistance of a duty manager, do many of the tasks that Ms Rogers said should not be done. These include unspooling lane ropes, moving items around the pool deck, small cleaning tasks, sweeping up rubbish, cleaning the walls of the pool and sweeping water on the pool deck.[60] Mr Watson did say he could maintain his supervision while doing the tasks he described.[61]

56. Kyra Fennell said that she did cleaning tasks when on duty but that the duty manager would assist when she moved lane ropes.[62]

57. There was no change to this system while the YMCA was in control of this pool.[63]

The Bum Bag

58. Ms Fennell, although a short distance away and on life saving supervision duty did not observe the events surrounding Mr Guan's drowning until alerted by Mr Watson. Notwithstanding her belief that she was unhindered in performing her duties,[64] her evidence suggests she was distracted.[65]

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[59] Transcript p 234(1-3).

[60] Transcript p 101-102.

[61] Transcript p 107(14-18).

[62] Transcript p 118(8-17).

[63] Transcript p 143(23-26) (Kyra Fennell), p 226(25-28) (Nada Delich), p 205(10-13) (Emma Barry), p 238(18-21) (Rynelle Rogers).

[64] Transcript p 144(8-14).

[65] Transcript pp 124(22-31) and 125(1-5).

59. Miss Fennell had attempted to locate and fit the bum bag prior to her shift. She had raised this issue in her de-brief.[66] There appears to have been no structured plan for provision of this equipment and there was no suggestion that this changed after 16 July 2014.[67]

60. Liam Bevanda, the duty manager, said that "*nobody in particular*"[68] at that time was in charge of ensuring availability of a bum bag and radio for life savers.

Supervision of patrons with a disability

61. It is recognised that supervision of patrons with a disability and limited swimming competency is a challenging issue.

62. The lifeguards, accepting the need for a high level of supervision in all pool areas, did not have a particular approach to supervision of the hydro pool. Kyra Fennell said she had no specific approach to supervision of people with physical difficulties who used the warm water (hydro) pool.[69] She nevertheless later said she would group swimmers with known mobility issues in a particular way.[70]

63. Liam Bevanda said his approach to supervision did not change when observing people with disabilities in the warm water pool.[71] He also said that after 16 July 2014 there was nothing done in respect of training for staff supervising people with disabilities in the warm water pool in the time YMCA operated that pool.[72]

64. Joseph Watson said that there was no specific or different approach to supervision of the warm water pool and other pools in the Centre.[73]

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[66] Transcript p 144(20-22).

[67] Transcript p 143(23-26).

[68] Transcript p 177(19-20).

[69] Transcript p 117(13-19).

[70] Transcript p 147(8-27).

[71] Transcript p 155(8-23).

[72] Transcript p 167(17-20).

[73] Transcript p 96(16-18).

65. The Royal Life Saving Guidelines section dealing with supervising people with disabilities[74] refers to the general supervision guideline SV.1.[75] There is no particular recommendation for supervision of people with disabilities or people using the warm water/hydro pool.

66. Life Saving Victoria (**LSV**) has advised that, following the delivery on 18 August 2016 of Coroner Audrey Jamieson's findings and recommendations in her Inquest into the Death of Paul Daniel Rayudu,[76] LSV has produced the "Drowning Deaths at Public Swimming Pools in Victoria: Working Document"[77] and that a Code of Practice will be developed.

67. The Ascot Vale Pool Operations Manual (**POM**) did say that special needs user groups were to be assessed individually to ensure their safety[78] and that a factor when considering positions for observations was observation of patrons with special needs.[79]

68. In evidence, Ms Rogers said that patrons would be grouped as part of a scanning strategy and that those in the warm water pool would be grouped as high risk and the life saver located to have adequate supervision of that pool.[80]

69. It does appear that the life savers were not all employing, or fully aware of a need for, a scanning strategy to identify pool users with disabilities and all said they had not read or could not remember having read the POM.[81]

The YMCA's refusal to provide Ms Barry's notes

70. The day after Mr Guan's drowning, Ms Emma Barry, who at that time was employed by the YMCA as a Health, Safety and Environment manager, interviewed Mr Watson, Ms Fennell and possibly Mr Bevanda. They gave detailed accounts of the incident. The YMCA, as it was entitled to do, continued to claim legal privilege over those notes of interview which were not made available to this inquest. There were no other witnesses to the events surrounding Mr Guan's drowning and by choosing this course the YMCA deprived the

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[74] Coronial Brief p 986.

[75] Coronial Brief p 961.

[76] Court Reference COR 2014 0761, available on the Coroners Court of Victoria Website under Case No 076114.

[77] Matthews, B for Life Saving Victoria. *Drowning Deaths at Public Swimming Pools in Victoria: Working Document* (2016). http://lsv.com.au/wp-content/uploads/Public-Swimming-Pools-Victoria-Working-Document.pdf.

[78] Coronial Brief p 552.

[79] Coronial Brief p 548.

[80] Transcript p 237(1-9).

[81] Transcript p 76.6 (Joseph Watson), p 115(12-18) (Kyra Fennell), 154(22-24) (Liam Bevanda).

inquest of contemporaneous accounts by key witnesses. The inquest was deprived of potentially significant information.

Expression of Sympathy

71. At the commencement of this Inquest, Mr Peter Burns, Chief Executive of the YMCA, was granted leave to make a statement. He said "*I wish to extend my sympathies to Tony's partner, family and friends, those who miss him every day. We're so sorry for any hurt, and all the hurt that's occurred.*"[82]

Submissions of the Moonee Valley City Council

72. There has been no independent expert evidence in this case as to best practice for lifeguard surveillance. However, I have been assisted by submissions from the Moonee Valley City Council (**MVCC**).

73. The MVCC is and was the owner of the Ascot Vale Leisure Centre (**AVLC**) at the time of Mr Guan's death. It was not, and is not, the operator. The operation of the AVLC was contracted out to the YMCA at the time of Mr Guan's death. That contract expired on 30 June 2015 and a new operator, Belgravia Leisure Pty Ltd (**Belgravia**), has operated the Centre since that time. There has been a review of systems in response to the findings and recommendations of Coroner Jamieson in her Inquest into the Death of Paul Daniel Rayudu, delivered 18 August 2016.[83] Changes have been made at AVLC.

74. Those changes are extensive and cover areas such as signage for non-swimmers in multiple languages, strategies to identify weak swimmers, warn them of risks and identify safe areas.

75. There is a strategy to identify the particular lifeguard(s) on duty at any one time. They wear a particular orange top and change to a black top when doing non-surveillance duties. This is a simple strategy to identify to the public and to the lifeguards themselves who is responsible for the surveillance at any particular time.

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[82] Transcript p 7.

[83] Court Reference COR 2014 0761, available on the Coroners Court of Victoria Website under Case No 076114.

76. Other strategies, including a Disability Action Plan by MVCC, have also been identified in the submissions. I commend the MVCC and Belgravia for their approach to ensuring a safe environment at AVLC.

Evidence of Mr John Summers

77. Mr John Summers is the YMCA Executive Officer Disability and Aged Services. In his statement,[84] Mr Summers describes the extensive engagement of YMCA in review and improvement of practice concerning aquatic safety before and after July 2014 and YMCA engagement with industry associations including Royal Life Saving Society Australia (**RLSSA**) and Life Saving Victoria (**LSV**).

Life Saving Victoria Information Submission

78. Following the hearing of this inquest Life Saving Victoria (LSV), which was not represented, has provided a document headed "Life Saving Victoria – Information Submission". A copy of that document has been provided to the represented parties for comment and is appended to this Finding. The document outlines proposals of LSV to the National Aquatic Industry Safety Committee (NAISC).

The NAISC is, as advised in the document, conducting a review of the Royal Life Saving Society of Australia (RLSSA) Guidelines for Safe Pool Operation (GSPO).

There has been no independent expert evidence as to life saving practice in this Inquest. Nevertheless, I note the comment in the LSV document and support the proposals described.

CONCLUSIONS

79. I accept the findings of Dr Paul Bedford in his autopsy report dated 28 August 2014 that the cause of death was consistent with drowning and advanced motor neurone disease.

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[84] Statement of Mr John Summers (Exhibit 13).

Considering his report and the circumstances described above, I find a suitable cause of death to be '*ACCIDENTAL DROWNING*'.

80. I am unable to find exactly how it was that Mr Guan became face-down in the pool. The likely cause is muscle weakness in his legs and arms which would also have prevented him from recovering his position. No witness has been found as to what happened immediately before Mr Guan was seen unconscious in the water. Other patrons in the pool at the time have not been identified and the life savers on duty at that time only became aware of Mr Guan's situation when alerted by a patron.

81. The lifeguard supervising at the time Mr Guan was seen was distracted by her attempts to secure a bum bag. The period of time Mr.Guan was face down in the water cannot be determined and I do not find that that distraction contributed to Mr Guan's death.

82. Nevertheless, the lifeguard should not have been distracted and should have been watching the water at the time Mr Guan was found. The evidence of the lifeguards was that when doing lifesaving surveillance they also undertook tasks which were not consistent with their lifesaving duties as described in the Royal Life Saving Guidelines or as described by Rynelle Rogers in her evidence.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

83. That, notwithstanding the evidence of Mr Summers, the YMCA review its training and procedures to ensure that the duties of life savers are clear when conducting supervisory and non-supervisory tasks.

84. That the YMCA review it Pool Operations Manual (if that manual in some form is still being used) to clarify the role and duties of lifeguards.

85. That the YMCA review its training and procedures and continue to engage with Life Saving Victoria current guidelines and recommendations to ensure both that staff are trained sufficiently in the need to identify and adequately supervise pool patrons in need of closer supervision, and that staff are in practice doing this.

86. That the YMCA review its procedures to ensure that safety equipment for lifeguards, and in particular bum bags, is ready and available to life savers before a shift is commenced.

FINDINGS

87. Having investigated the death of Ze Cheng (Tony) Guan and having held an Inquest in relation to his death, I make the following findings, pursuant to section 67(1) of the Act:

    (a) that the identity of the deceased was Ze Cheng (Tony) Guan, born 23 February 1960;

    (b) that Mr Guan died on 19 July 2014, at the Royal Melbourne Hospital, from accidental drowning; and

    (c) that the death occurred in the circumstances set out above.

88. I convey my sincerest sympathy to Mr Guan's family and friends.

89. I would like to acknowledge the excellent work of the interpreter Phoebe Lee as well as the assistance of my counsel assisting and all other counsel who appeared at the inquest.

90. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

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

    (a) Mr Stan Turton, senior next of kin.

    (b) Mr Ze Biao Guan

    (c) Ms Ze Feng Guan

    (d) Ms Marissa Dreher, Dreher Legal

    (e) Mr Colin Almond, HWL Ebsworth Lawyers

    (f) Mr Dale McQualter, Maddocks Lawyers

    (g) Mr Vincent Azzopardi, Tony Hargreaves & Partners Lawyers

    (h) Mr Gilbert Richardson, Director of City Services, Moonee Valley City Council

    (i) Mr John Summers, Executive Officer, YMCA

    (j) Life Saving Victoria

    (k) Senior Constable Ryan Goodrich, Coroner's Investigator, Victoria Police.

Signature:

GREGORY MCNAMARA

CORONER

Date: 7 July 2017

APPENDIX I
LIFE SAVING VICTORIA – INFORMATION SUBMISSION

Life Saving Victoria - Information Submission

COR 2014 003658 – Ze Cheng (Tony) Guan

Authors: Dr Bernadette Matthews PhD, Principal Research Associate, Aquatic Risk & Research
Andy Dennis, General Manager, Public Training and Pool Safety

Objectives:

- Provide an industry peak body insight into some of the matters raised during the inquest
- Provide an overview of current and planned projects associated with public pool safety
- Provide recommendations intended to improve public pool safety in Victoria

Life Saving Victoria (LSV):

LSV has the mission to prevent aquatic related death and injury. The vision is that all communities will learn water safety, swimming and resuscitation, and be provided with safe beaches, water environments and aquatic venues.

LSV (est. 2002) is an initiative of the Royal Life Saving Society Victoria Branch (est. 1904) and Surf Life Saving Victoria (est. 1947). LSV is a registered training organisation, a registered charity and a member of Emergency Management Victoria.

Background:

The information contained in this report has been developed jointly by LSV representatives in the 'Public Training and Pools Safety' and 'Aquatic Risk and Research' areas. It is focused on what are perceived to be some of the key matters pertaining to the inquiry into the death of Mr Tony Guan at the Ascot Vale Leisure Centre in 2014 (COR 2014 003658).

LSV has taken the decision to submit this information based on i) having expert knowledge in the area of aquatic safety and injury prevention, ii) knowledge specific to the facility operation and safety standards at the Ascot Vale Leisure Centre and iii) attendance in court through the inquiry in May 2017. More specifically, this submission is based on, but not limited to the documents listed below. These documents were provided to the facility management and / or the facility owners at the time of their completion.

Pre-Incident LSV Engagement	Post-Incident LSV Engagement
AFSA -02.12.2009	Critical Incident Systems Review - 05.08.2014
AFSA - 01.02.2012	Design Assessment - 19.03.15 (unrelated)
AFSA - 31.01.2014	AFSA - 17.01.17 (unrelated)

AFSA: Aquatic Facility Safety Assessment

LSV have previously been engaged by the Coroners Prevention Unit (CPU) to provide information into similar incidents. This most recently occurred following the drowning death of Mr. Paul Daniel Rayudu at Watermarc in February 2014, where LSV co-authored the 'Drowning at Public Swimming Pools Review'[1] with the CPU. This document was included as a component of the findings of Coroner Jamieson, which were released on 18 August 2016 (COR 2014 0761).[2]

[1] Coroners Prevention Unit and Life Saving Victoria. (2016). *Drowning at Public Swimming Pools Review.* Coroners Court of Victoria: Melbourne. http://www.coronerscourt.vic.gov.au/resources/9fc29ea2-b5bd-499e-8b6b-9b0af1b1c6ad/pauldanielrayudu_076114.pdf

[2] Coroners Court of Victoria. *Finding Into Death With Inquest: Paul Daniel Rayudu.* 18 August 2016. COR 2014 0761, Coroners Court of Victoria: Melbourne.

Following the release of the findings by Coroner Jamieson, LSV were requested to provide recommendations to Emergency Management Victoria on how to initiate improvements in public pool safety. LSV subsequently produced the 'Drowning Deaths at Public Swimming Pools in Victoria: Working Document'[3]. The State Government has since committed funding in the recent budget towards the development of a Victorian based 'Code of Practice' with LSV acting as the lead agency.

Guidelines for Safe Pool Operation

The Royal Life Saving Society Australia (RLSSA) Guidelines for Safe Pool Operation (GSPO)[4] is recognised and used throughout the Australian Aquatic Industry as the key reference to water safety and Industry standards. The GSPO was first developed in 1992 and the last review took place in 2013.

As noted in the joint CPU / LSV report from 2014 "In May 2014, RLSSA produced the 'Guidelines for Safe Pool Operations Review Report.' The report set out the need for (and intention to) complete a full review of the scope and content of the current Guidelines. Following this a 'Terms of Reference – National Reference Group' document was also developed and circulated."

LSV is represented on the National Aquatic Industry Safety Committee (NAISC) by Dr Bernadette Matthews. The NAISC is responsible for the current review of the GSPO. The status of the review as of June 2017, sees three sections released for Industry feedback, a further three sections under development and additional sections in the planning / scoping phase.

Primary Matters

Some of the matters raised through the inquiry into the death of Mr Guan were similar matters to those raised in the case of Mr Rayudu. Some of these have progressed based on the formal recommendations from the Findings into the death of Mr Rayudu, whilst others are being progressed within the aquatic Industry by LSV. These key matters are summarised below and make up the body of this submission.

1. Non-Supervisory Tasks Performed by Lifeguards
2. Structured Pool Supervision
3. Supervision of Patrons with a Disability

Non-Supervisory Tasks Performed by Lifeguards

The completion of tasks other than active pool supervision at the time of the incidents was raised during the inquiries in the deaths of both Mr Guan and Mr Rayudu. These included tasks such as, i) moving lane ropes, ii) plant room checks and iii) water testing (Mr Guan inquiry) as well as iv) moving the pool boom and v) plant room checks (Mr Rayudu inquiry). As a result LSV has proposed to the NAISC and Victorian Aquatic industry that the following provisions are incorporated into the new guidelines to ensure that non-supervisory tasks by lifeguards are:

- Limited to only tasks which directly contribute to safe pool use.
- Considered through a supervision risk assessment.
- Cancelled where there is an unacceptable risk to one or more patrons.
- Clearly structured, documented and communicated through staff training.

[3] Matthews, B. (2016). *Drowning Deaths at Public Swimming Pools in Victoria: Working Document.* Life Saving Victoria: Melbourne. http://lsv.com.au/wp-content/uploads/Public-Swimming-Pools-Victoria-Working-Document.pdf

[4] Royal Life Saving Society Australia. (2013). *Guidelines for Safe Pool Operation.* Royal Life Saving Society - Australia: Sydney.

- Not allowed for pool water testing, boom / starting block movements or change room checks.
- Enforced to ensure staff adherence and understanding.

Structured Pool Supervision

The matter of who was actively supervising the pool spaces at the time of the Ascot Vale incident was raised throughout the inquiry with three staff present but not noticing the event. This matter was similarly raised during the inquiry into the death of Mr Rayudu. LSV has proposed to the NAISC and the Victorian Aquatic industry that the following provisions are incorporated into the updated guidelines in the GSPO.

- The existing supervision risk assessment considerations are expanded to include instruction on the completion of non-supervisory tasks.
- A mechanism is put in place to identify which lifeguard is responsible for which area/s of an aquatic facility during a given period of operation. This may be by way of, but is not limited to: a structured supervisory matrix; a recognised / formal hand over process; differentiated uniform / equipment; use of advanced technology tracking.

A research project into supervision standards has recently been initiated by LSV in partnership with RLSSA and RLSS Western Australia to further investigate the variables, considerations and challenges which impact supervision. This project will be undertaken in the 2017/18 financial year and the results will be provided to the NAISC for consideration / inclusion in the GSPO.

A new RLSSA 'Lifeguarding, 5th Edition'[5] was released in 2016 and provides further clarification of lifeguard supervision expectations by introducing additional content on 'effective supervision' and 'situational awareness'. These manuals should be provided by all Registered Training Organisations who deliver accredited Pool Lifeguard courses to new lifeguards in Victoria. This role out will assist in the level and quality of information provided to lifeguards as a part of their initial training.

Supervision of Patrons with a Disability

The identification of patrons with existing medical conditions / physical impairments was raised in the Mr Guan inquiry, in a similar context to how the identification of weak swimmers was identified during the Mr Rayudu inquiry. It was acknowledged by all parties that these were challenging issue, particularly for those that may not wish to be identified as having a disability or limited swimming competency.

LSV have drafted an initial framework to address these matters. This is based on the approach used to support the provision of appropriate supervision to young children by parents / guardians. These provisions have been presented to both the NAISC and the Victorian Aquatic industry and include ensuring that there is a structure to:

- Encourage patrons to advise staff of any medical conditions or lack of swimming competency/ experience upon entry to a facility. This may be by way of, but is not limited to: membership conditions, website information, entry based signage and changing room signage.
- Enable the specific instructions regarding safe use and facility conditions to be provided through the use of appropriate signage consistent with the Australian standard.
- Ensure information is provided advising on pool spaces which are recommended for use by patrons with disabilities (including areas of shallow water) and areas not recommended for use.
- Ensure the supervision provided to other pool users isn't diminished as a result of facility attendance by non/ weak / disabled swimmers.

[5] Royal Life Saving Society Australia. (2016). Lifeguarding 5th Edition. Royal Life Saving Society -Australia: Sydney.

As an outcome of the COR 2014 0761, Belgravia Leisure and Banyule City Council initiated an education campaign to non/ weak swimmers. The initial evaluation of this demonstrated a low level of patron understanding, recall and recollection. Further research is necessary in this area and appropriate funding is required to ensure this work can be undertaken.

Secondary Matters

Lifeguard Bum bags / equipment - Lifeguards should have appropriate uniform (on) and equipment (in place) prior to entering the pool area of the facility to start their official supervision duties. Radio equipment may be the exception to this as it is an item handed over at the change of shift.

Lifeguard Numbers - The vast majority of Council owned swimming pools have lifeguard supervision in place at all times. This key safety measure is welcomed by LSV but is also acknowledged to come at a significant expense (approximately $100,000 per Lifeguard position per year).

On the other hand Lifeguards are rarely engaged at non-Council facilities such as, i) swim schools, ii) body corporate facilities and ii) hotels / motels. As a result the Council pools are at a financial and competitive disadvantage and it is important to note that:

- The supervision levels provided at Council owned facilities exceeds the standards currently in place at non-Council facilities.
- Recommendations made with the intention of improving water safety should give consideration to both Council and non-Council owned pools in Victoria.

Conclusion

The information above is intended to provide an overview of some of the key matters raised during the inquiry into the death of Mr Tony Guan at the Ascot Vale Leisure Centre in 2014 (COR 2014 003658). It is also intended to provide some recommendations for consideration and an insight into some of the progress which has been made since the similar drowning incident involving Mr. Paul Daniel Rayudu at Watermarc (COR 2014 0761).