IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 5489

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	Simon McGregor, Coroner
Deceased:	**Baby M**
Date of birth:	April 2015
Date of death:	30 October 2018
Cause of death:	Hypoxic ischaemic encephalopathy complicating drowning
Place of death:	The Royal Children's Hospital 50 Flemington Road, Parkville, Victoria

INTRODUCTION

1. Baby M was a three-year-old who lived in Cairnlea at the time of his death. Baby M fell into a swimming pool on 29 October 2018.

2. Although he was found shortly after, was resuscitated at the scene and was treated in hospital, he did not recover and passed away the following day.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Baby M's death was reported to the Coroner. It appeared to be unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury and so fell within the definition of a reportable death in the *Coroners Act 2008.*

4. 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.

5. 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.

6. The Coroner's Investigator, Detective Senior Constable Kane Treloar prepared a coronial brief of evidence in this matter. The brief includes statements from witnesses, including family, the forensic pathologist who examined Baby M and investigating officers. The brief also includes documents from the Brimbank City Council.

7. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

8. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

9. In considering the issues associated with this finding, I have been mindful of Baby M's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

BACKGROUND

10. Baby M lived at 1 Z Street, Cairnlea, with his family, including his mother Ms K and his uncle Mr Y.[2]

11. The Z Street house is a two storey building. There was a pool located behind the house. The area behind the house was accessible through a sliding door but the pool itself was surrounded by a fence with a gate.

12. According to one witness, this sliding door '*is a light door, and you don't need strength to open it*'.[3]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

13. On the afternoon of 29 October 2018 Ms K took Baby M to a maternal health appointment. They returned home to 1 Z Street at around 4.00pm. Ms K went to bed to sleep and put Baby M into the bed with her. Her bedroom was upstairs on the first floor of the house.[4]

14. That evening, Mr Y was planning to have dinner with his friends Mr Q, Ms R and Mr S. At around 6.15pm, they stopped by 1 Z Street so that Mr Y could change his clothes.[5]

15. Mr Y recalls asking his three friends to stay in the car before he went into the house and upstairs to his room.[6]

16. However, Mr Q recalls that Mr S asked Mr Y if they could look at the pool and that Mr Y responded '*yeah do whatever*', Mr S recalls asking Mr Y if anything had changed inside the house from the last time he visited, and Mr Y inviting them to come in and check out the

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1 This is 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.
2 Statement of Mr Y dated 25 April 2019, Coronial Brief.
3 Statement of Mr Q dated 29 October 2018, Coronial Brief.
4 Statement of Ms K dated 6 May 2019, Coronial Brief.
5 Statement of Mr Y dated 25 April 2019, Coronial Brief; Statement of Mr Q dated 29 October 2018, Coronial Brief.
6 Statement of Mr Y dated 25 April 2019, Coronial Brief.

house. Ms R similarly recalls Mr Y inviting them to look around the house while he changed.[7]

17. Mr Q, Mr S and Ms R followed Mr Y into the house, then walked into the area behind the house while Mr Y was upstairs.[8]

18. While looking around the house, Mr S went out to the pool. He opened the gate and splashed the water with his hand before leaving the pool area again. As he left, he pushed the gate behind him so that it swung towards its closed position. He did not look back to see if it latched.[9]

19. Mr S, Mr Q and Ms R went back into the house through the sliding door. Mr Q closed the sliding door behind him, but did not lock it.[10]

20. When Mr Y was coming down the stairs to leave, he saw Baby M and said goodbye. He and his friends left through the garage.[11]

21. Ms K woke and heard Mr Y speaking to Baby M. She was unaware that Mr Y was leaving and so went back to sleep, thinking that Mr Y would be watching Baby M.[12]

22. A few minutes later, shortly before 6.45pm, Ms K was awake and realised that she did not hear any noises from downstairs. She went down to check on Baby M. When she could not see him immediately, she went outside and saw that the pool gate was open. She ran through the gate and saw Baby M floating in the pool, face-down in the water.[13]

23. Ms K pulled Baby M out of the pool and carried him into the living room. She called emergency services and began CPR.[14]

24. While she was beginning CPR, her sister Ms Y arrived at the house. As Ms K was in extreme distress, Ms Y took over CPR until paramedics arrived.[15]

25. After a period of CPR, paramedics moved Baby M to Sunshine Hospital. Emergency Department staff were able to resuscitate Baby M and connect him to life support, and he

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[7] Statement of Mr Q dated 29 October 2018, Coronial Brief; Statement of Mr S dated 29 October 2018, Coronial Brief; Statement of Ms R dated 29 October 2018, Coronial Brief.
[8] Statement of Mr Y dated 25 April 2019, Coronial Brief; Statement of Mr Q dated 29 October 2018, Coronial Brief.
[9] Statement of Mr S dated 29 October 2018, Coronial Brief.
[10] Statement of Mr Q dated 29 October 2018, Coronial Brief.
[11] Statement of Mr Y dated 25 April 2019, Coronial Brief.
[12] Statement of Ms K dated 16 May 2019, Coronial Brief.
[13] Statement of Ms K dated 16 May 2019, Coronial Brief.
[14] Statement of Ms K dated 16 May 2019, Coronial Brief.
[15] Statement of Ms K dated 16 May 2019, Coronial Brief.

was transferred to the Royal Children's Hospital. A CT scan showed that he had already suffered brain damage from the time during which his brain was deprived of oxygen.[16]

26. On the next day, due to the severity of Baby M's brain damage, it was decided to cease life support. Baby M passed away in hospital at 6.25pm on 30 October 2018.[17]

IDENTITY AND CAUSE OF DEATH

27. On 30 October 2018, a family member visually identified Baby M's body. Identity is not in dispute and requires no further investigation.

28. On 1 November 2018, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination of Baby M's body and reviewed a post mortem computed tomography (CT) scan, medical records and a deposition from the Royal Children's Hospital and the Police Report of Death for the Coroner.

29. The CT scan showed cerebral oedema and increased lung markings, and the deposition from the Royal Children's Hospital described evidence of severe hypoxic brain injury noted when Baby M was brought to hospital.

30. Dr Lynch provided a written report, dated 1 November 2018, in which he formulated the cause of death as '*I(a) Hypoxic ischaemic encephalopathy complicating drowning'*.

31. I accept Dr Lynch's opinion as to cause of death.

THE SWIMMING POOL GATE AT 1 Z STREET

32. The building permit to install the swimming pool at 1 Z Street was issued on 7 December 2006. The pool was built by Lazaway Pools & Spas. On 21 May 2007, Private Building Surveyor Leonard Dowell of Fisher Dowell Pty Ltd issued a Certificate of Final Inspection.[18]

33. This Certificate noted that three inspections had occurred: a 'pool steel inspection' on 11 January 2007, a 'pool fencing inspection' on 16 February 2007 and an 'inspection for final certificate' on 18 May 2007.[19]

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[16] E-Medical Deposition of Dr Tal Gadish dated 30 October 2018.
[17] E-Medical Deposition of Dr Tal Gadish dated 30 October 2018.
[18] Brimbank City Council Building Permit File #0000/06, Coronial Brief Exhibit Five.
[19] Brimbank City Council Building Permit File #0000/06, Coronial Brief Exhibit Five.

34. The pool was never inspected by the Brimbank City Council, and this was not required by law at that time.[20]

Post-incident inspection

35. On 29 October 2018, after Baby M had been taken to hospital, the Coroner's Investigator DSC Treloar conducted an examination of the pool area at 1 Z Street.

36. During this process, DSC Treloar opened and closed the pool gate a number of times and also examined the integrity of the latch and hinges of the gate.

37. DSC Treloar made the following observations:

> '*The plastic on the gate appeared to have not been replaced in some time, the plastic exterior was visibly weathered.*
>
> *Discolouration was also present on the metal heads of the bolts securing the hinge to the gate posts.*
>
> *Rust was present on some of the horizontal rails that immediately adjoined the gate, as were spiders cobwebs.*
>
> *The gate would not self-latch if the gate was rested at the post, it required manual force to engage the latch.*
>
> *If the gate were to be pushed closed, the latch would sometimes not engage and the gate would bounce backwards upon impacting the latch, remaining open.*
>
> *If the latch did not engage and the gate was left without intervention, the gate would rest at a point where it was approximately thirty five centimetres open.*
>
> *The upright mechanism to release the latch was operating correctly.*'[21]

38. At the time of this examination, DSC Treloar took a number of photographs and recorded a video demonstrating the action of the gate.

39. DSC Treloar considered that the above observations could be caused by the interior of the latch requiring lubrication or the gate dropping from the hinges, resulting in it not being level and the latch not being able to engage from inertia.[22]

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[20] Statement of Deanne Andrew dated 8 May 2019, Coronial Brief.
[21] Statement of DSC Kane Treloar dated 28 May 2019, Coronial Brief.

40. DSC Treloar also inspected the exterior of the hinges, and noted that they used a spring to self-close rather than newer-style ramped hinges. He formed the belief that the springs on the inside of the gate hinges had also become worn and required replacement.[23]

41. However, DSC Treloar was unable to conduct an internal examination of the mechanism.

Statement of Andrew Dennis

42. DSC Treloar provided these photographs and the video recording to Andrew Dennis, General Manager Public Training and Pool Safety at Life Saving Victoria. Mr Dennis provided a statement addressing the safety of the pool at 1 Z Street.

43. In his statement, Mr Dennis referred to two key sections from the Australian Standards on Swimming Pool Safety.

44. Section 2.11.2 requires that all gates through swimming pool fences should:

> '*be fitted with a device that will return the gate to the closed position and operate the latching device from any position with a stationary start without the application of a manual force.*
>
> *The self-closing device shall be capable of complying with these requirements with the gate at any position from resting on the latching mechanism to fully open.*'[24]

45. Section 3.4(b)(i) requires that a gate comply with the following requirement:

> '*The gate shall close and latch from a position from resting on the latching mechanism to fully open … under the natural [w]eight of the gate.*'[25]

46. Mr Dennis reviewed the footage provided by DSC Treloar. He summarised it as follows:

> '*The footage showed Victoria Police personnel attempt to close the gate five times in succession. Under force the safety barrier entry gate closed and latched on three occasions. Under a reduced amount of force, the safety barrier entry gate did not*

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[22] Statement of DSC Kane Treloar dated 28 May 2019, Coronial Brief.
[23] Statement of DSC Kane Treloar dated 28 May 2019, Coronial Brief.
[24] Australian Standards 1926.1-1993. Swimming Pool Safety. Part 1 – Fencing for Swimming Pools. S 2.11.2.
[25] Australian Standards 1926.2-1995. Swimming Pool Safety. Part 2 – Location of Fencing for Swimming Pools. S 3.4(b)(i).

close/latch. Under no force the safety barrier entry gate did not self-close/self-latch.'[26]

47. Mr Dennis concluded that the safety barrier entry gate to the pool at 1 Z Street did not meet the provisions set out in the above sections of the Australian Standards.[27]

Conclusions

48. I accept Mr Dennis' position on the noncompliance of the pool gate with safety standards.

49. DSC Treloar's lack of opportunity to examine the interior of the gate's mechanisms makes it impossible to determine the specific failure causing the gate to not comply with the above standards.

50. Nonetheless, DSC Treloar's general observations showed a state of disrepair and did not show evidence of any failure of design or original construction.

51. Considering these observations as well as the fact that the pool fencing satisfied initial inspections in 2007, I am satisfied that the cause of the gate's noncompliance with standards was wear over time and a lack of maintenance.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

52. As part of his statement, Mr Dennis provided a history of recent efforts by Life Saving Victoria and other organisations to reduce the number of drowning deaths of young children in home swimming pools. This included reference to recommendations made by Deputy State Coroner Iain West in October 2014 and Coroner Audrey Jamieson in May 2017.

53. Mr Dennis noted that, at the time of his statement, the Victorian government had announced that it would establish a comprehensive register of all home swimming pools and spas, as well as a regime of regular inspections to ensure safety barriers are operational and effective. However, at that time these measures had not yet been put in place.

54. On 1 December 2019, amendments to the *Building Regulations 2018* came into force which addressed these issues.

55. These amendments made it mandatory for owners of land where a swimming pool or spa is located to register their pool or spa with the relevant council. Once a swimming pool is

[26] Statement of Andrew Dennis dated 22 May 2019, Coronial Brief.
[27] Statement of Andrew Dennis dated 22 May 2019, Coronial Brief.

registered, it is mandatory that the owner arrange an inspection of the safety barrier to determine if it is compliant with the applicable barrier standard. From that time onward, safety barriers will need to be inspected every four years.

56. It was initially planned that residents would need to have their pool or spa registered by 1 June 2020. Due to the pressures of the COVID-19 pandemic, this deadline has been pushed back five months to 1 November 2020.

57. If this regime had been in place prior to Baby M's death, and had it been effectively enforced and complied with, it is likely that the wear on the gate would have been detected and Baby M's death would have been prevented.

58. All Victorians who own pools or spas must register them as soon as possible. To ensure that these pools are well-maintained, local councils in Victoria must ensure that the requirements of the regulations are rigorously enforced.

59. It should be emphasised, however, that while this program can do much good, the existence of program itself is not sufficient to ensure that private swimming pools and spas are safe for children.

60. Ms K has written to the Court encouraging her local council to communicate the gravity of these risks with residents in conjunction with the commencement of the registration and safety inspection program.[28]

61. I agree with Ms K's point. Councils can do more than simply operate the regime and inform their residents of it. I urge all local councils in Victoria to engage in community outreach to ensure that all swimming pools are safe and to offer their residents education and assistance in maintenance and safety.

62. These children's deaths are preventable. Local councils can play a key role in their prevention.

Hinge design

63. Although a regime of regular inspections may have been able to ensure that the pool gate at 1 Z Street had been better maintained, I consider that pool gate design standards should nonetheless ensure that pool gates are as robust as possible and retain self-closing function despite wear over time.

[28] Emails from Ms K to the Court dated 26 May 2020 and 29 May 2020.

64. The current Australian Standards addressing self-closing pool gate hinges set stringent requirements for the 'durability' of a gate unit. Gate units must continue to meet required specifications after a total of 10,000 repeated operations of the self-closing mechanism.

65. However, it appears that the issue in the case of the pool gate at 1 Z Street was not one of wear from frequent use, but rather wear from disuse.

66. DSC Treloar raised concerns about the possible degradation of quality of the springs within the hinges on the pool gate. He noted that this degradation may have been avoidable had the gate been designed with 'ramped' cam-rise self-closing hinges as opposed to spring-based self-closing hinges.

67. It is also possible that spring-based hinges may vary in durability over time depending on the grade of material used in the spring.

68. The current Australian Standards specify that gate units may be constructed from any type of material, provided that the finished components comply with the Standards' requirement, although they note that components of gate units should be effectively protected against corrosion, UV degradation and other effects of exposure to weather, sunlight, pool chemicals and water.

69. Considering the importance of reliable self-closing hinges, as can be seen in this tragic death, it may be that the standards should make extra allowance for the possibility that this protection of gate units fails or otherwise breaks down.

70. For this reason, I will make a recommendation that the relevant committee at Standards Australia consider whether amendments should be made to the current standard to reflect how wear over time may affect different mechanisms and grades of material in self-closing hinges.

RECOMMENDATION PURSUANT TO SECTION 72(2) OF THE ACT

71. I recommend that Committee CS-034, Safety of Private Swimming Pools, of Standards Australia consider whether amendments should be made to Australian Standard 1926.1 to ensure that pool gate hinges are resistant to degradation over time, particularly in conditions of disuse, by requiring either:

    (a) that certain grades of materials be used in spring-based self-closing hinges; or

(b) that self-closing gate hinges employ a prescribed class of mechanisms.

FINDINGS AND CONCLUSION

72. I express my sincere condolences to Baby M's family for their loss.

73. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Baby M, born April 2015;

    (b) The death occurred on 30 October 2018 at the Royal Children's Hospital, 50 Flemington Road, Parkville, from hypoxic ischaemic encephalopathy complicating drowning; and

    (c) The death occurred in the circumstances described above.

74. I commend the Coroner's Investigator, DSC Treloar, for providing an exceptionally thorough coronial brief with a focus on ensuring public safety.

75. Pursuant to section 73(1B) of the Act, I direct that this redacted version of my findings be published on the Internet.

76. I direct that a copy of this finding be provided to Brimbank City Council so that they ensure that the pool at 1 Z Street is registered and inspected.

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

(a) Ms K, senior next of kin;

(b) Mr K, senior next of kin;

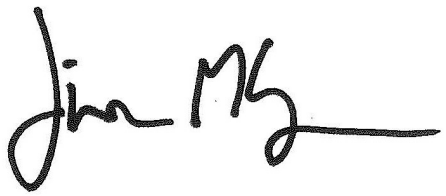
(c) The Royal Children's Hospital;

(d) Life Saving Victoria;

(e) Committee CS-034, Safety of Private Swimming Pools, of Standards Australia; and

(f) Detective Senior Constable Kane Treloar, Coroner's Investigator

Signature:



SIMON McGREGOR

CORONER

Date: 1 July 2020