IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 006798

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	NJ
Date of birth:	11 January 2020
Date of death:	14 December 2020
Cause of death:	1(a) Drowning
Place of death:	Monash Health, Monash Children's Hospital, 246 Clayton Road, Clayton, Victoria, 3168
Keywords:	Baby death, drowning, pond

INTRODUCTION

1. On 14 December 2020, NJ[1] was 11 months old when she drowned in a fishpond. At the time of her death, NJ lived at her home in Springvale with her parents, NL and NT, and her three older siblings.

2. NL described NJ as very healthy baby, who was very strong and active. NJ loved to dance whenever she heard music. NJ was talkative and happy.

THE CORONIAL INVESTIGATION

3. NJ'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.

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

7. This finding draws on the totality of the coronial investigation into the death of NJ including evidence contained in the coronial brief. Whilst I have reviewed all the material, I

[1] This is a pseudonym.

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.[2]

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

Circumstances in which the death occurred

8. NJ lived at her home in Springvale with her parents, NL and NT, and her three older siblings. NJ's family lived in the front house on the property. At the rear of the property, there was another house, occupied by VN, his wife TT and their son.

9. Behind the front house on the property, there is a large rectangle-shaped koi fishpond. There are flashing lights around the pond, and multiple pot plants border the pond's edge. The fishpond was 327cm long, 60cm wide and 60cm high, with a water depth of approximately 32cm. The pond contained a water pump at the rear of the pond that pumped out a continuous stream of water. The base of the pond contained a thin lawyer of green algae, and within the pond there were approximately five medium to large koi fish.

10. NJ was very active and learned to walk when she was ten months old. NJ was able to climb onto the bed unassisted, and was very persistent, often trying something more than once if she was at first unsuccessful.

11. On Sunday 13 December 2020, NL arrived home from work at approximately 6.30pm. NJ walked over to her and gave her a cuddle. NT was in the kitchen with her brother. NL sat on the couch playing with her children.

12. NT left for work at approximately 7.30pm. NL continued playing with her children until approximately 7.50pm, at which point everyone went upstairs to get NJ ready for bed. NL then fed her.

13. At approximately 8.10pm, TT came over. She often visited the front house to play with the children. She called out and asked to play with NJ, so NJ's older sister carried NJ downstairs, accompanied by their other siblings. The children began watching television.

[2] 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.

14. At approximately 8.40pm, VN took the bins out after dinner. On his way back to the house, he observed something in the koi fishpond. At first, he could not discern what it was, however as he got closer, he observed that NJ was face-down in the pond. It was unclear how long she had been there. NL deduced that NJ had likely pulled herself up onto the edge of the koi fishpond. NJ had always loved looking at the fish in the pond, and NL later reflected that NJ was likely trying to look at them. It seems that she then tragically fell in.

15. VN immediately called for help, grabbing NJ out of the pond. He called out to NL upstairs, and shortly after, neighbours who had heard the calls for help came to assist.

16. Police attended shortly thereafter. Police observed that NL had commenced cardiopulmonary resuscitation (**CPR**) immediately took over, performing CPR. Police officers could tell that NJ had water in her mouth, and flipped her onto her side, clearing her mouth of any other obstructions. Chest compressions continued.

17. Paramedics arrived shortly thereafter, and assessed the situation, determining that NJ needed to be transported to hospital. NJ was conveyed to Monash Hospital in Clayton.

18. On Monday 14 December, NJ underwent a computed tomography (**CT**) scan, which showed that there was transtentorial and tonsillar hemiation as well as cerebral oedema. There was no skull fracture or spinal injury.

19. At approximately 3.00pm, NJ underwent a nuclear perfusion scan which confirmed brain death. NJ was declared deceased at 4.15pm on 14 December 2020.

Identity of the deceased

20. On 14 December 2020, NJ, born 11 January 2020, was visually identified by her father, NT.

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

Medical cause of death

22. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 21 December 2020 and provided a written report of her findings dated 20 July 2021. Dr Baber also reviewed the Victoria Police Report of Death for the Coroner (**Form 83**), scene photographs, radiology report from the Royal Children's Hospital, Medical Deposition from Monash Medical Centre and the post-mortem CT scan.

23. The post-mortem examination revealed findings consistent with drowning. An autopsy diagnosis of drowning can be difficult to make as there are no specific signs. Some signs seen in 'classical' drowning include a foam plume around the mouth (which can quickly disappear), heavy and overdistended lungs (emphysema aquosum), blood-stained fluid within the airways and in some cases pleural effusion may be present. In this case, there were small pleural effusions. Due to the extensive resuscitation efforts and the time lapsed between the time of death and autopsy, some of the signs described above may have been present upon discovery but were no longer identifiable at autopsy.

24. Neuropathology showed features of hypoxic ischaemic encephalopathy, tonsillar hemiation necrosis, focal subarachnoid haemorrhage and intrafalcine haemorrhage. These would all be in keeping with a prolonged downtime without circulation.

25. Histology showed acute inflammation in the lungs. This may have been present prior to drowning or may be as a consequence of inhalation of water with subsequent ventilation.

26. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

27. Dr Baber provided an opinion that the medical cause of death was 1 (a) drowning.

28. I accept and adopt Dr Baber's opinion.

CPU REVIEW

29. NJ's death was referred to the Coroners Prevention Unit for review to determine whether there were any prevention opportunities available.[3]

30. Fishponds in Victoria are not required to have any permanent barriers surrounding them.[4] This was supported by the Council Inspection report completed at the property on 14 December 2020, which confirmed the body of water was a fishpond, not a spa, and was

[3] 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.

[4] Victorian Building Authority, 'Building Practice Note SP-01: Swimming Pool Standards and Safety Requirements, <https://www.vba.vic.gov.au/__data/assets/pdf_file/0007/135727/Building-Practice-Note-SP-01-Swimming-pool-standards-and-safety-requirements-Final-Approved.pdf>, accessed 9 August 2022.

therefore exempt from having a safety barrier installed around it.[5] CPU did not identify any regulations requiring wire mesh to be installed above or below the waterline in fishponds.

31. Life Saving Victoria (**LSV**) were also consulted about whether wire mesh should be a requirement of fishponds. LSV noted that, although they did not oppose the idea, children could potentially get stuck under mesh (as sometimes happens in pools with pool covers) and this would inhibit their ability to escape the fishpond. LSV further noted that due to the specific circumstances of NJ's death, including her nappy filling with water and the pressure of the water pump, a wire mesh may not have prevented her death.

32. CPU identified that there have been four drowning deaths of children in ponds since 2000.[6]

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was NJ, born 11 January 2020;

    b) the death occurred on 14 December 2020 at Monash Health, Monash Children's Hospital, 246 Clayton Road, Clayton, Victoria, 3168, from drowning; and

    c) the death occurred in the circumstances described above.

34. Having considered all of the circumstances, I am satisfied that NJ's death was the unintended consequence of drowning.

35. There is nobody to blame for NJ's tragic death, however the circumstances of her death highlight the potential danger of fishponds. Children around fishponds, much like children around other bodies of water such as pools or spas, require vigilant and constant supervision.

36. The importance of ensuring the safety of children around water cannot be overstated.

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

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.

[5] Coronial Brief, City of Greater Dandenong General Inspection Report, page 148.
[6] 20013378; 20023480; 20043092; 20163296

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

NT & NL, Senior Next of Kin

Senior Constable Emily Stephens, Coroner's Investigator

Signature:

John Olle
Coroner

Date: 31 August 2022

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.