IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 007009

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Meeram Bano
Date of birth:	11 April 2019
Date of death:	30 December 2021
Cause of death:	1(a) Hypoxic ischaemic encephalopathy in the setting of immersion
Place of death:	The Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria, 3052
Keywords:	Drowning; pond; public park; Footscray Park; Maribyrnong City Council

INTRODUCTION

1. On 30 December 2021, Meeram Bano was 2 years old when died at the Royal Children's Hospital three days after being located unconscious in a pond at Footscray Park. At the time of her death, Meeram lived in Braybrook with her parents, Rais Ahmed and Shanela Rais, and older siblings Ashaan and Maheem.

2. Meeram's parents remember her as a playful, happy and healthy child, who was walking and talking by the age of ten months. Meeram was reportedly afraid of water.

THE CORONIAL INVESTIGATION

3. Meeram'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 an officer to be the Coroner's Investigator for the investigation of Meeram'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.

7. This finding draws on the totality of the coronial investigation into the death of Meeram Bano including evidence contained in the coronial brief. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Circumstances in which the death occurred

8. On 27 December 2021, Meeram's parents invited seven other families to a gathering at Footscray Park ("the Park") to celebrate the arrival of extended family visiting from Pakistan. Approximately 14 adults and 15 children between the ages of 1-14 were in attendance.[2]

9. At around 3:40pm, Meeram's family arrived at the park to set up before guests arrived at 4:00pm. The women in the group set up picnic blankets in the grassed area between the fenced in playground ("Playspace") and the ponds, while the men tended to the barbeque. While the men prepared the food, the children played in the Playspace under the supervision of the women.[3]

10. At around 7:00pm, the group had dinner together on the picnic blankets. After dinner, the men returned to the barbeque area to prepare tea while the women and children remained on the picnic blankets. [4]

11. At around 7:50pm, Shanela took a phone call from her brother-in-law, who told her they would bring tea to the women. Shanela then realised she could not see Meeram, and had last seen her playing with a duck a few metres from where they were sitting. Shanela entered the Playspace to search for Meeram, to no avail.[5]

12. Shanela then ran to the ponds and sighted Meeram floating face down in one of the ponds. She yelled to another child to alert Rais, before jumping in the pond to retrieve Meeram.[6] Shanela's cousin Asma assisted Shanela and Meeram out of the pond as Shanela was struggling to stand due to the slippery surface on the bottom of the pond.[7] Shanela observed

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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.

[2] Coronial Brief (**CB**), Statement of Shanela Rais, dated 11 April 2022.

[3] Ibid.

[4] Ibid.

[5] Ibid.

[6] Ibid.

[7] Statement of Asma Amjad, dated 27 December 2021.

that due to the pond water being level with the grass and being covered in algae, 'you can't tell when the water starts, and the grass stops'.[8]

13. Meeram was unconscious, her lips were blue and she was covered in algae. Asma lay Meeram on the ground on her stomach and hit her back to encourage her to cough up any water.[9] Rais then carried Meeram to the carpark.

14. Rais' cousin Babar immediately called emergency services and he and Rais commenced cardiopulmonary resuscitation (**CPR**) under the instruction of the Ambulance Victoria call taker.[10]

15. At 8:07pm, Ambulance Victoria paramedics arrived at the scene and took over CPR. Meeram was intubated at the scene before being conveyed to the Royal Children's Hospital, arriving at 8:55pm.[11]

16. Meeram was transferred to the paediatric intensive care unit, where she showed some respiratory effort, including coughing. She soon developed severe seizures, and magnetic resonance imaging scans (**MRI**) undertaken showed severe hypoxic ischaemic injury.[12]

17. On 29 December 2021, clinicians spoke with Rais and Shanela and advised that Meeram was unlikely to survive, and if she did she would require assistance for all aspects of living.[13]

18. On 30 December 2021, Rais and Shanela made the decision to remove Meeram's ventilator. She peacefully passed away at 4:33pm.[14]

Identity of the deceased

19. On 30 December 2020, Meeram Bano, born 11 April 2019, was visually identified by her father, Rais Ahmed, who completed a Statement of Identification.

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

[8] CB, Statement of Shanela Rais, dated 11 April 2022.
[9] Ibid.
[10] CB, Statement of Babar Zaman, dated 27 December 2021.
[11] CB, Statement of Adriano Scrofani, dated 10 January 2022.
[12] Court File (**CF**), E-Medical Deposition Form of the Royal Children's Hospital.
[13] CB, Statement of Rais Ahmed, dated 11 April 2022.
[14] Ibid.

Medical cause of death

21. Forensic Pathologist Dr Joanna Moira Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of Meeram Bano on 31 December 2021. Dr Glengarry reviewed the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, e-Medical Deposition Form of the Royal Children's Hospital, Ambulance Victoria records and further information provided by Victoria Police and provided a written report of her findings dated 11 January 2022.

22. The post mortem examination showed features in keeping with the clinical history. Dr Glengarry noted that a full autopsy was recommended to define the cause of death, however Meeram's parents expressed a strong preference that an autopsy not be performed.

23. The post mortem CT scan showed brain findings in keeping with hypoxic ischaemic encephalopathy.

24. Toxicological analysis of post-mortem samples identified the presence of midazolam (~ 0.9ng/mg), phenobarbitone and ketamine (~ 9.04ng/mg).[15] There is no suggestion that these medications were administered anywhere other than by paramedics or at the Royal Children's Hospital as part of their treatment of Meeram.

25. Dr Glengarry provided an opinion that the medical cause of death was 1 (a) HYPOXIC ISCHAEMIC ENCEPHALOPATHY IN THE SETTING OF IMMERSION.

FURTHER INVESTIGATION

26. In investigating this matter, I noted that I had carriage of the investigation into the death of Refan Abdulrhman M Al Moarfeg[16] who died at the age of 3 years old on 5 July 2021, from hypoxic ischaemic brain injury following her drowning in a pond at Footscray Park.

27. I determined that there were sufficient similarities in manner and place between the deaths, and what appeared to be an ongoing and significant safety risk to the public.

28. Accordingly, I determined to investigate these deaths concurrently.

[15] CF, Toxicology Report of Melissa Peka, Forensic Toxicologist, dated 7 March 2022.
[16] Case number COR 2021 003519 refers.

CONTEXT

29. Celia Haddock, Chief Executive Officer of Maribyrnong City Council ("the Council"), provided a statement which formed part of the coronial brief. Ms Haddock's statement provided a description of the Park and Playspace.

30. Ms Haddock noted that Footscray Park is Crown Land with the Maribyrnong City Council appointed as Committee of Management. The Park contains several defined activity areas, including a dog park, playing fields, walks along the Maribyrnong River, ponds[17] and the Playspace.[18]

31. The Playspace is located to the northeast of the ponds and is fenced, with two entry points secured with dual latches, which according to Ms Haddock are standard pool gate safety latches and not locked. The distance between the Playspace and the Maribyrnong River is approximately 43 metres from the eastern gate, 54 metres from the western gate and 25 metres from the closest point of the Playspace fence line.[19]

32. Ms Haddock stated that ponds and vegetation within the park had been in place for many decades. The ponds comprise of two main ponds connected by culverts, with the larger pond covering approximately 1515 metres^2 with a perimeter of approximately 242 metres, and the smaller pond covering approximately 1290 metres^2 with a perimeter of approximately 194 metres.[20]

33. The ponds vary in depth from 50 centimetres at the edges to 70 centimetres in the centre. They are located approximately 41 metres from the western gate of the Playspace, with the fenceline coming within 8 metres of the ponds on the south-western side.[21]

POLICE INVESTIGATION

Initial investigation

34. At around 8:30pm on 27 December 2021, detectives from the Wyndham Crime Investigation unit arrived at the scene along with uniformed police officers, established a crime scene around the pond and obtained statements from witnesses.[22] Detectives noted that the pond was

[17] The ponds within the Park are covered by a Heritage Overlay and noted on the Victorian Heritage Register.
[18] CB, Statement of Celia Haddock, dated 3 May 2022.
[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] CB, Statement of Sergeant Michael Haysom, dated 2 March 2021.

unfenced, and 'the majority of it was covered by thick green algae'.[23] The area was photographed.

35. Detectives also inspected the Playspace, including the locking mechanisms on each gate. While the locks were found to be in working order, officers noted a crawl space under the fence at the eastern end of the Playspace that would allow for a child to pass through.[24]

36. Detectives determined that there were no suspicious circumstances surrounding the drowning, and the scene was then handed back to uniformed officers.

Further investigation

37. On 6 January 2022, the Major Crime Investigation Unit attended and filmed Footscray Park in its entirety.

38. On the same day, Victoria Police Forensic Scientist Kylie Slattery attended at the Park to inspect the ponds. She observed the presence of a substantial amount of common duckweed[25] covering the surface of the water, making it difficult to see the water. She further observed the presence of yellow waterlily and pickerel weed, the latter of which can form a thick pad of fibrous roots within the water. A large willow tree grew on an island in the centre of the pond, which again can form strong fibrous roots within a body of water.[26]

39. Ms Slattery concluded that the four plants observed within the pond area were likely to mask the presence of the water and grow in such a way that would create underwater snags that could entangle a child.[27]

40. On 7 January 2022, officers from the Victoria Police Search and Rescue Squad attended the Park to inspect the ponds. Senior Constable Michael Littleford ("SC Littleford") observed that the ponds were surrounded by temporary fencing.

41. SC Littleford noted that the ponds appeared to be 'fairly shallow'. However, upon attempting to enter the water, SC Littleford immediately realised he had misjudged the depth and fell into the pond.[28]

[23] CB (Refan Al Moarfeg), Statement of Detective Senior Constable Colin Raj, dated 3 January 2022.
[24] CB (Refan Al Moarfeg),, Statement of Detective Sergeant Julian Frazer, dated 3 January 2022..
[25] Common duckweed (scientific name *Lemma disperma Hegelm*) is a small plant that consists of a single leaf that floats on the surface of the water. It forms colonies which appear as a 'mat' on the surface of the water.
[26] CB, Statement of Victoria Police Forensic Officer Kylie Slattery, dated 10 October 2022.
[27] Ibid.
[28] CB, Statement of Senior Constable Michael Littleford, dated 11 January 2022

42. SC Littleford noted that there was a straight drop from the edge of the pond to the bottom, with a depth of approximately 90cm. The pond had an edge of raised rocks approximately 20-30cm in height, resulting in an approximately 120cm climb from the water. He entered and exited the ponds at several different points and was 'surprised' at how steep and deep the drop into the water was at each point.[29]

43. Although SC Littleford's initial assessment was that the water was clear, it became cloudy and impossible to see through as soon as it was disturbed. Further, he observed that the algae covering the ponds varied in coverage, with some parts covered such that it was 'very hard' to see through.[30]

44. Following the tragic death of Meeram Bano in similar circumstances, a former New South Wales Police member Amy Buttsworth contacted Footscray Police to report a near drowning on 24 August 2021, in the same pond. In her statement, Ms Buttsworth recounted thinking that the proximity of an ungated pond to the Playspace was 'odd, if not dangerous'.[31]

45. Shortly thereafter, she witnessed a boy of approximately two years old slide down the pond embankment into the water, though he was able to exit the pond with the assistance of the bushes and another adult. On the same date, her seven year old daughter pointed out a hole in the Playspace fence, which she and her friends had been using to exit the Playspace without supervision.[32]

MENTION HEARING

46. On Tuesday 28 June 2022, I convened a Mention Hearing into the deaths of Refan Al Moarfeg and Meeram Bano.

47. Leading Senior Constable Fiona Nation ("LSC Nation") of the Police Coronial Support Unit (**PCSU**) appeared to assist me. Mr Dale McQualter of Maddocks appeared on behalf of Maribyrnong City Council.

[29] Ibid.
[30] Ibid.
[31] CB (Refan Al Moarfeg), Statement of Amy Buttsworth, dated 3 January 2022.
[32] Ibid.

48. During the proceedings, I indicated that I had not yet determined whether I needed to take the matters to Inquest, though wished to avoid this if I could, given the extremely distressing nature of the matters particularly as they related to young children.[33]

49. I sought submissions from Maribyrnong City Council as to the restorative and preventative measures implemented following the incidents, noting that I needed to be satisfied that the Council had done everything possible to ensure public health and safety.[34]

50. I also indicated my intention to attend the park to view the scene of the incidents and the restorative measures already implemented by the Council, and a date was set down for this to occur.[35]

VIEW OF INCIDENT SITE

51. At 2:15pm on 5 July 2022, I attended Footscray Park to view the scene of the incidents. Also in attendance were Coroner's Solicitor Ms Ann Kho, LSC Nation and Sergeant Tracey Weir of PCSU, Senior Constable Jessie Cook[36] and Sergeant Ann Marie Baird of Victoria Police, Mr McQualter and Mr Patrick Jess[37] and Mr Paul Jane[38] of Maribyrnong City Council.

52. I observed the following restorative works:

    a) The ponds were drained, cleared of debris and in parts pressure washed;

    b) Temporary fencing was in place surrounding the ponds with warning signage attached;

    c) Timber had been added to the base of the playground fencing to mitigate any means of egress;

    d) Access gates to the playground had been replaced with an airlock system with warning signs attached;

    e) Vegetation had been cut back to enable a direct and unobstructed line of sight from the playground to the ponds.

[33] Transcript of proceedings (**T**), p 15.
[34] T, p 14.
[35] T, p 15.
[36] Coroner's Investigator for COR 2021 007009 Meeram Bano.
[37] Director of Infrastructure, Maribyrnong City Counsil.
[38] Manager of Sport and Recreation, Maribyrnong City Council.

53. I did not see any signage around the perimeter of the park regarding the presence of ponds or the Maribyrnong River within the park. I enquired as to whether the Council was considering signage around the perimeter of the park once the temporary fencing had been removed. The Council advised me that they had engaged Life Saving Victoria (**LSV**) to provide guidance with respect to signage around the park, among other safety issues.

54. The Council further advised that a report from LSV would be complete within the month and provided to the Court upon receipt.

MARIBYRNONG CITY COUNCIL SUBMISSIONS

55. On 30 September 2022, via email from Ms Amber Davis of Maddocks, the Council provided a copy of LSV's 'Inland Waterway Risk Assessment' report, as well as the Council's action plan in response to the report.

56. On 21 October 2022, via email from Mr McQualter, the Council provided their written submissions to the Court.

Submissions on whether an Inquest should be held

57. The Council submitted that the deaths were not matters that must proceed to Inquest. In support of this proposition, the Council outlined, *inter alia*[39]*:*

    a) There would be no utility to holding an inquest, in that the purposes and objectives of the Act could be satisfied by means of an "in chambers" finding;

    b) Holding an Inquest would be unnecessarily traumatic for family members and others involved, who had already provided detailed statements as part of the investigation;

    c) The Council had provided significant evidence of actions taken to enable me to be satisfied that appropriate action had been taken to reduce the risk of similar incidents occurring.

58. I accepted the submissions of the Council and determined to finalise both investigations "in chambers" by way of Form 38 – Finding into Death without Inquest.

[39] CF, Submissions of Maribyrnong City Council, dated 21 October 2022.

Actions taken by the Council in response to the deaths

59. The Council undertook a number of internal and external reviews following the deaths of Refan and Meeram, resulting in a number of restorative and preventative measures being recommended and implemented.

Risk assessment of the Playspace by SafeT Now Pty Ltd[40]

60. Immediately following the death of Refan, the Council conducted a preliminary review of the Playspace. In July 2021, following their internal review, the Council commissioned SafeT Now Consulting Pty Ltd ("SafeT Now") to undertake a Playspace Health and Safety Risk Assessment. SafeT Now provided its findings in a report dated 13 August 2021 ("SafeT Now Report").

61. SafeT Now made the following findings and recommendations:

    Finding 1: The perimeter fence of the Playspace was obscured in several locations due to vegetation. This obstructed a clear line of sight from the internal area of the Playspace to the external environment at several locations and therefore it would be difficult to sight a child who had exited the Playspace. Given the nearby waterways, the risk was assessed as high.

    Recommendation: Maribyrnong City Council trim back all existing vegetation obstructing the line of sight from the Playspace and further, to establish an item in the Footscray Park Ponds Playspace iAuditor checklist to include an examination of the size of the vegetation and whether it obscured the line of sight.

    Finding 2: The pedestrian gates at the western and eastern ends of the Playspace were functioning normally. However, the risk associated with a child exiting the Playspace at the same time as another person entering or exiting was assessed as high.

    Recommendation: Remove or trim back vegetation located adjacent to each pedestrian gate in order to provide a clear line of sight, and review the child safe latching mechanism installed

[40] CB (Refan Al Moarfeg), Exhibit 7: Health and Safety Risk Assessment – Footscray Park Playspace, SafeT Now Consulting, dated 13 August 2021.

on both gates, noting previous incidents where the latching mechanism had been tampered with resulting in the mechanism not self-latching.

Finding 3: The current signage at the Playspace was insufficient to warn of the dangers associated with the nearby waterways.

Recommendation: Install signage at both pedestrian gates warning of dangers of the nearby waterways, and detailing the supervision requirements associated with entry into the Playspace. Further warning signage should be installed around the ponds. SafeT Now noted that careful consideration should be given to how the signage is presented, given the diverse and multi-cultural backgrounds of Park users.

62. In response to the SafeT Now Report, the Council undertook the following remedial works:[41]

    a) The bottom of the Playspace fencing was secured and a timber plinch was installed along the base of the fencing;

    b) A twice-daily auditing system was implemented to identify any safety or maintenance issues at the Playspace and surrounding areas;

    c) Safety signage was installed in both English and other languages common to users of the Park; and

    d) The entry and exit gates to the Playspace were modified to include an airlock entry.

63. It is unclear when these remedial works were undertaken. However, a table titled 'Actions from Risk Audit – August 2021', provided by Ms Haddock, noted that the trimming of vegetation should occur within two weeks of the report and the installation of signage should occur prior to 31 December 2021. There was no date provided for reviewing the latch mechanisms at the Playspace gates.[42]

Immediate risk-mitigation measures following the death of Meeram Bano

64. Immediately after being notified of the death of Meeram Bano, the Council erected temporary fencing surrounding the two ponds, preventing access.[43]

[41] CF, Submissions of Maribyrnong City Council, dated 21 October 2022.
[42] CB (Meeram Bano), Statement of Celia Haddock, dated 3 May 2022, Appendix 2: Actions from Risk Audit – August 2021.
[43] CB, Statement of Celia Haddock, dated 3 May 2022.

65. Beginning 28 December 2021, daily inspections of the Playspace and surrounds began occurring on weekdays. Updated signage warning of the dangers posed by water was installed in late December 2021.

66. In the first week of January 2022, the perimeter fencing of the Playspace was modified so that the gap between the fencing and the ground located on the eastern side of the Playspace could not be used as a means of egress by small children. Further, both Playspace access gates were modified to incorporate an 'airlock' system, or two gate entry.

Footscray Park Playspace Review by NTT Australia[44]

67. In January 2022, the Council requested NTT Australia ("NTT") conduct an independent review of the processes and systems in response to the deaths of Refan and Meeram.

68. The objectives of NTT's review were:

    a) To review processes and systems in connection with the Playspace and identify any improvement opportunities to enhance these processes with respect to Playspace safety and mitigating safety risks;

    b) Assess the implementation of recommendations made by SafeT Now in their report of August 2021 and review any further actions undertaken by the Council; and

    c) Determine if any outcomes of the review of the two drowning incidents identify potential enhancements to the broader park Playspace safety framework, and Council risk mitigation systems.

69. The NTT review specifically noted the potential heritage impacts of any risk mitigation strategies that may be implemented, noting *Council has not formally ascertained what this heritage listing means for available actions in respect of the ponds and Playspace surrounds. For example, can the ponds be fenced or drained in the area proximate to the Playspace?*

70. Fourteen recommendations arose from the NTT's review, falling within the following categories. Each recommendation was accompanied by a 'Management Action Plan', an action owner and a target date for completion.

    a) Implementation of the Playspace Risk Assessment recommendations;

[44] CB, Final Report – Footscray Park Playspace Review, NTT Australia, dated 7 April 2022.

b) Critical incident response process and monitoring;

c) Define risk appetite;

d) Footscray Park Playspace actions;

e) Footscray Park Heritage status;

f) Council Park and Playspace safety risk management approach;

g) Strategic and Operational Risk Registers;

h) Knowledge sharing and collaboration; and

i) Potential issues in communication, coordination and clarity of role responsibilities.

71. The Council advised that 13 of the 14 recommendations had either been implemented or were on track, with the implementation of one recommendation subject to minor delays.

Internal Maribyrnong City Council review[45]

72. In March 2022, Patrick Jess, Director of Infrastructure Services at the Council undertook an internal review of the actions taken following both incidents.

73. The resulting Incident Update provided a summary of the reviews and remedial works undertaken to date. The key issue identified by the internal review was that fencing the ponds was not a suitable long-term solution to managing drowning risk.

The ponds are a key part of the history of Footscray Park. The community while broadly understanding the current need for the fencing are expecting that they will at some point be able to access the ponds and arbors again.

74. Instead, Mr Jess recommended that the ponds' surfaces be covered with mesh to prevent immersion should children fall in. This would be an interim measure whilst the Council considered longer term options, as part of the Council's review of its Footscray Park Master Plan.

[45] CB, Appendix 6: Footscray Park Incident Update and Recommended Actions, dated 23 March 2022.

Inland Waterway Risk Assessment by Life Saving Victoria[46]

75. The Council engaged Life Saving Victoria to conduct an assessment of the health and safety risks related to the waterways and immediate surrounding areas within Footscray Park, specifically the 'Thomson Water Garden' (TWG) which encompasses the ponds. LSV finalised the Inland Waterway Risk Assessment report ("LSV Report") on 6 September 2022.

76. The LSV Report is a comprehensive document with over 60 potential risks within the Park assessed and given a Risk Factor Score of either extreme risk, problem area, catastrophic or routine.

77. The Council also provided a copy of its Action Table in response to the LSV Report, which outlines the treatment action suggested by the LSV, the practicality of that treatment action and the treatment actions agreed by the Council.

78. The Council has committed to a number of actions following the LSV's risk assessment, including but not limited to:[47]

    a) Continuing to work with local schools on water safety programs;

    b) Installing additional signage (subject to Heritage Victoria approval);

    c) Installation of non-intrusive barriers around water (subject to Heritage Victoria approval);

    d) Consideration of 'smart pole' technology to enhance access to emergency communication.

FURTHER SUBMISSIONS

79. Noting that submissions were received from the Council in October 2022, I directed my Solicitor contact the Council to ascertain whether they wished to provide an update on any restorative and preventative works that may have occurred since that date.

80. On 21 April 2023, via email, Mr Dale McQualter advised the following:

[46] Life Saving Victoria, Inland Waterway Risk Assessment, Footscray Park, final report fated 6 September 2020.
[47] CF, Submissions of Maribyrnong City Council, dated 21 October 2022.

a) The Council has completed the implementation of all recommendations arising out of earlier reviews provided in their October submissions.

b) Footscray Park sustained significant damage due to flooding on 14 October 2022. The entirety of the Park was inundated by water and much of the equipment and assets within the Park were destroyed, including the fencing and Playspace equipment.

c) The Playspace has been closed to the public since the floods and the Council has no current plans to reopen the Playspace in its existing location, though the Council notes that many groups love the playground and there will be ongoing consultation regarding its relocation. Further, the Park was contaminated by silt flows during the floods and any new location for the Playspace will be informed by the results of soil decontamination within the Park.

d) Work to remove debris and plant material from in and around the ponds was continuing.

e) Any final decisions regarding future work necessary would not be finalised until my Findings were received and considered by the Council. The Council intended to undertake these actions via a review of the park masterplan, which has commenced but was paused at the time of the floods.

CPU REVIEW

81. As part of the coronial investigation, I sought advice from the Coroners Prevention Unit[48] (**CPU**), for the purposes of identifying any like incidents and examining possible prevention opportunities in this matter with a view to making recommendations if appropriate.

82. As part of its review, the CPU interrogated the Court's surveillance database[49] to identity drowning deaths similar to that of Refan and Meeram, in that the death was an unintentional drowning, the deceased was aged under 10 years and the drowning occurred in a body of water adjacent to a playground.

[48] 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.

[49] The surveillance database contains information on all Victorian deaths reported to the coroner since 1 January 2000.

83. For the period of 1 January 2000 to 30 November 2022, the CPU identified three other deaths which fit the above criteria – a three year old male who drowned at Dandenong Rotary Park in 2014, a three year old male who drowned at Kevin Flint Reserve in 2017 and a four year old female who drowned at Lysterfield Lake in 2021.

COMMENTS

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

1. The death of any child is an indescribably tragic event with lifelong ramifications for not only their family and loved ones, but the entire community. This tragedy is only compounded when a child dies in such circumstances as both Refan and Meeram.

2. The impetus for the Maribyrnong City Council to act and implement preventative measures should have come from internal risk assessments, reviews and an understanding of how the local community used the Footscray Park space. At the very least, action should have been taken in response to the eleven reports of malfunctioning locks and fencing within the Playspace.[50]

3. Action should also have been taken immediately following the death of Refan. Sadly, though the Council commissioned and received the report of SafeT now, it appears that the only action undertaken with any urgency was to trim back a number of shrubs in the vicinity of the ponds and Playspace, and to establish an internal checklist item for rangers to assess the shrubbery.

4. Whilst I appreciate and acknowledge the restorative and preventative measures taken by Maribyrnong City Council to date, I note that these were largely implemented following the death of Meeram.

5. This is not at all to suggest that the Maribyrnong City Council or anyone else valued one child's life over another. It does however suggest that the Council thought that perhaps the death of Refan was a one off, tragic accident. It further suggests that the Council did not turn their mind to the inherent risks that existed within Footscray Park in its state at the time of the deaths.

6. It is manifestly disappointing that it took the avoidable deaths of two children in a period of six months in order for the Council to act.

[50] See *Form 38 Finding into Death without Inquest* in the matter of Refan Abdulrhman M Al Moarfeg at paragraph 43.

7. Noting that both Refan and Meeram attended at the Park with their families and a number of other adults known to them, it would be remiss of me to not touch on the topic of supervision. Of course, all young children should be appropriately and adequately supervised in public. However, the lack of signage alerting the public to the ponds, and the vegetation obscuring them meant that their parents were unaware of the potential deadly hazard in close proximity which may have influenced their level of supervision.

8. Whilst I am satisfied that the measures taken by the Maribyrnong City Council are sufficient and appropriate such to prevent a like-event from occurring in the future, I note that similar waterways, carrying similar risks, are a feature in many public parks across Victoria, enjoyed by countless young children and other community members each year. As such, I intend to make a recommendation in this matter.

RECOMMENDATIONS

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

(i) In the interests of promoting public health and safety and preventing like deaths, I recommend that the Maribyrnong City Council implement the recommendations of SafeT Now, NTT Australia and Life Saving Victoria into any ongoing and future works within Footscray Park.

(ii) In the interests of promoting public health and safety and preventing like deaths, I recommend that the Municipal Association of Victoria share with other Victorian local councils the actions taken by Maribyrnong City Council in response to the tragic deaths of Refan Al Moarfeg and Meeram Bano, and encourage other councils to implement similar actions where appropriate, with a view to preventing like deaths in waterways within public parks.

FINDINGS AND CONCLUSION

The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[51] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit

[51] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was Meeram Bano, born 11 April 2019;

    b) the death occurred on 30 December 2021 at The Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria, 3052;

    c) I accept and adopt the medical cause of death as ascribed by Dr Joanna Moira Glengarry and find that Meeram Bano died from hypoxic ischaemic encephalopathy following a drowning incident;

2. AND, having considered all of the evidence before me, I am satisfied that Meeram Bano made her way to the pond, where in all likelihood, she did not realise the presence of the body of water and upon entering the water was unable to get herself to safety. In all the circumstances, I find that her death was preventable, and was the second tragic and preventable death of a young child in Footscray Park within a six month period.

I convey my sincere condolences to Meeram'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.

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

Rais & Shanela Ahmed, Senior Next of Kin

Dale McQualter of Maddocks on behalf of Maribyrnong City Council

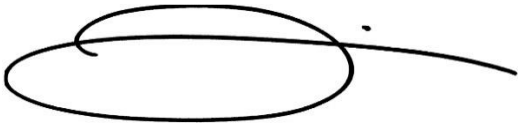
Municipal Association of Victoria

The Royal Children's Hospital

Life Saving Victoria

Senior Constable Jessie Cook, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 18 September 2023

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.