IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 005428

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Master H[1]
Date of birth:	[redacted] 2020
Date of death:	[redacted] 2022
Cause of death:	*Drowning*
Place of death:	[redacted] Victoria

At the direction of Coroner Sarah Gebert, the names of the deceased, his family members, and neighbours, have been replaced with pseudonyms, or redacted, to protect their identity.

INTRODUCTION

1. On [redacted] 2022, [redacted] (**Master H**) was 1 year and 9 months old when he drowned in a dam located at the property where he lived with his parents, Mrs H and Mr H, and two older siblings, [redacted]-year-old [redacted] and [redacted]-year-old [redacted].

2. At the time of Master H's passing, the family lived on a private property in [redacted], Victoria.

THE CORONIAL INVESTIGATION

3. Master H'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 Jarrod Pye (**SC Pye**) to be the Coroner's Investigator for the investigation of Master H's death. SC Pye 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 Master H 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]

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

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

Circumstances in which the death occurred

8. At approximately 9.40am on [redacted] 2022, Master H wanted to go outside to play in the yard. Mrs H dressed him in gumboots and put on a yellow waterproof jumpsuit to keep his clothes from getting muddy. At the same time, his brother [redacted] also went outside to play.

9. Approximately one month prior, Master H's parents had installed temporary fencing around the side of the house between the sheds and the house. The temporary fencing consisted of panels and gates which were linked together. The rest of the fencing was constructed from wooden posts and chicken wire or wooden pickets. There were also some panels in places where there were gaps, including the southwestern side of the yard closest to the train line and deck. This is where the two children were playing.

10. At approximately 10.00am, Mrs H made a cup of tea in the kitchen. While she was in the kitchen, she could see Master H out of the window in the back corner of the yard pulling leaves off the bushes, poking the temporary fence, and pushing his miniature wheelbarrow around. Mrs H sat at the breakfast bar in the kitchen while she had a cup of tea, checked emails and scrolled through Facebook.

11. Sometime later, [redacted] came inside and asked if he could go and see his dad, who was working in the shed. Mrs H could hear Master H riding around on the deck at this time.

12. At approximately 10.15am, Mrs H finished her cup of tea and went outside to check on Master H. She looked around the yard but couldn't locate him. Mrs H then raised the alarm with her husband that Master H was missing. Mr H, his workers, and Mrs H began searching the property.

13. At 10.42am, emergency services were called to report Master H missing and Victoria Police officers arrived at the property soon after. State Emergency Services were subsequently requested to attend, and Victoria Police Airwing and Search and Rescue divisions were dispatched to search the area. Neighbours and other civilians also participated in a search of the property and surrounding area.

14. At about 1.00pm, neighbours [redacted], [redacted] and [redacted] were searching a small dam in a neighbouring paddock approximately 120 metres from the residence. [redacted] entered the dam to conduct a sweep of the dam floor and located Master H underwater on the southwest edge.

15. Ambulance Victoria paramedics attempted cardiopulmonary resuscitation (**CPR**) at the scene before Master H was transported by ambulance to hospital. Treatment continued in hospital for approximately half an hour but was sadly unsuccessful, and Master H was pronounced deceased.

16. Victoria Police conducted an investigation and concluded that there were no suspicious circumstances surrounding the death.

Identity of the deceased

17. On [redacted] 2022, Master H born [redacted] 2020, was visually identified by his mother, Mrs H.

18. Identity was not in dispute and required no further investigation.

Medical cause of death

19. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine conducted an examination on [redacted] 2022 and provided a written report of her findings dated [redacted] 2022.

20. The post-mortem examination showed findings in keeping with the reported history. A post-mortem CT scan and skeletal survey was performed by a Consultant Radiologist at the Royal Children's Hospital and showed findings *consistent with the clinical diagnosis of drowning*, and no other injuries.

21. Dr Baber provided an opinion that the medical cause of death was *drowning*.

22. I accept Dr Baber's opinion as to medical cause of death.

CORONER'S PREVENTION UNIT REVIEW

23. During the coronial investigation, I referred this case to the Coroner's Prevention Unit (**CPU**) to consider whether there were any opportunities arising from the circumstances of Master H's death, in order to prevent similar deaths from occurring in the future.[2]

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

24. The CPU reviewed the Coroners Court of Victoria surveillance database to identify all unintentional deaths reported to a Victorian coroner between 1 January 2013 and 30 April 2023, where the deceased was a child aged 0-4 years and drowning in a dam on a private property. The CPU identified four deaths in this category.

25. Further, the CPU advised that in the 2021/22 financial year, there were 17 drowning deaths among children aged 0-4 years in Australia. This is a 29% decrease on the previous year and a 23% decrease on the 10-year average. Specifically in Victoria, drowning deaths among children aged 0-4 years decreased by 15% compared with the preceding year; noting that 2020/21 was the highest number of drowning deaths on record.

26. The CPU advised that, while a decrease in the 10-year average for this age group is a step in the right direction, children continue to experience high rates of drowning, despite there being clear and effective prevention measures.

27. Farm safety fact sheets for children recommend fencing off a safe play area close to the house.[3] The CPU also noted that Master H's death highlights the importance of active parental supervision, even when there is fencing to contain children to a particular area.

FINDINGS

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

    a. the identity of the deceased was Master H, born [redacted] 2020;
    b. the death occurred on [redacted] 2022 at [redacted], Victoria, from *drowning*; and
    c. the death occurred in the circumstances described above.

29. Having considered all of the circumstances, I am satisfied that Master H's death was the result of a tragic accident, and that there were no suspicious circumstances surrounding the death.

COMMENTS

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

    30.1. During the period 1 January 2013 and 30 April 2023, the CPU identified four deaths of children aged 0-4 years who drowned in a dam on a private property. In all four deaths,

[3] Better Health, Farm Safety – Children, https://www.betterhealth.vic.gov.au/health/healthyliving/farm-safety-children.

each of the children were male, and the constant feature highlighted was the importance of active adult supervision. Toddlers are curious and increasingly mobile but lack an understanding of water-related hazards, making them vulnerable to drowning in and around the home, particularly in private swimming pools and dams on rural properties.

30.2. Whilst noting that the parents in this case were satisfied that they had made adequate changes to fencing arrangements to prevent a young child from escaping, for broader prevention purposes and following a CPU review of other cases, this case highlights the importance of active parental supervision, even when there is fencing to contain children to a particular area.

CONCLUSION AND ORDERS

31. The loss of a young child is an unimaginably devastating event, and I convey my deepest sympathies to Master H's family for the pain this tragedy has caused them. I also acknowledge the efforts of their friends and neighbours in assisting the search for Master H as well as emergency services who responded, and extend my sincere condolences to all those who have been impacted.

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

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

Mr and Mrs H, Senior Next of Kin

Senior Constable Jarrod Pye, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date : 31 August 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.