IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 2773

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Choon Jie Chai
Date of birth:	14 December 2000
Date of death:	30 May 2019
Cause of death:	1(a) Drowning
Place of death:	Mantra on the Park Hotel, 333 Exhibition Street, Melbourne, 3000

INTRODUCTION

1. On 31 May 2019, Mr Choon Jie Chai was 18 years old when he died in the Intensive Care Unit (ICU) at St Vincent's Hospital, Fitzroy.

2. At the time of his death, Mr Chai lived in Malaysia at C-28 Sedenak, 81010 Kulai, Johor, with his parents and had no history of ill health. He arrived in Melbourne on an all-expenses-paid holiday on 25 May 2019 with a group of fellow employees, accompanied by their employer who arranged the holiday for his employees as an employee benefit.

3. On arrival in Melbourne, the group checked in at the Mantra on Park Hotel, Exhibition Street, Melbourne. After settling in, at approximately 6 pm, Mr Chai and his colleague, Xiao Keng Tee, decided to go for a swim in the hotel's swimming pool located on the sixth floor. Although Mr Chai could not swim and Mr Tee only had basic swimming skills, neither Mr Chai nor Mr Tee informed the other members of the group of their intention to go for a swim.

THE CORONIAL INVESTIGATION

4. Mr Chai'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, violent or result from accident or injury.

5. 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.

6. 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.

7. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Chai'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.

8. This finding draws on the totality of the coronial investigation into the death of Choon Jie Chai, 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 BE MADE[2]

Circumstances in which the death occurred

9. When Mr Chai and Mr Tee arrived at the swimming pool on the sixth floor, they found the pool precinct unattended. The evidence indicates that the area was devoid of guests or hotel patrons and hotel staff alike.

10. Mr Tee noticed a signpost, affixed to the wall, which indicated that the maximum depth of the pool was 1.9m. He entered the pool first and waded from the shallow end towards the deeper end, followed by Mr Chai.

11. When he reached the middle of the pool, Mr Tee suddenly realised that his feet could not reach the bottom of the pool. He panicked and tried to swim back to the shallow end but could not do so. Mr Chai went to his rescue and assisted Mr Tee to the side of the pool where Mr Tee managed to haul himself to safety, out of the pool. He spent a short period catching his breath.

12. After regaining his composure, Mr Tee realised that Mr Chai was in trouble in the pool but he was too afraid to re-enter the water.

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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 If possible.

13. Mr Tee then threw the lifebuoy into the pool but Mr Chai could not reach it. He then attempted to extend a skimming pole to pull Mr Chai out of the water, but the pole was too short.

14. To raise the alarm, Mr Tee used the telephone in the pool area to call the reception. When the call was not answered, he tried to alert other guests by knocking and calling for help at every door in the portal outside the pool area. No one responded to his cries for help.

15. Mr Tee then made his way to the hotel reception area where he successfully raised the alarm. However, when he returned to the pool with Jullian Keighley, a hotel employee, Mr Chai had already sunk to the bottom of the pool.

16. Mr Keighley jumped into the pool, brought Mr Chai to the surface and managed to get him out of the pool. At this stage Mr Chai was already unconscious.

17. Mr Keighley administered cardio-pulmonary resuscitation until the paramedics arrived.

18. Initially, paramedics from the Central Advanced Life Support Ambulance Service attended to Mr Chai and initiated their assessment of the situation and administered treatment.

19. Mr Matthew Graeme Riddle, a member of the Mobile Intensive Care Paramedic Unit (MICA), a unit of Ambulance Victoria arrived shortly thereafter and took over the resuscitation attempts.

20. Mr Riddle confirmed that Mr Chai had suffered cardiac arrest, administered treatment and conveyed Mr Chai to St Vincent's Hospital, Fitzroy.

21. Mr Chai was admitted to the Intensive Care Unit (ICU) where clinical tests revealed that he suffered hypoxic brain injury with the prognosis that brainstem death would ensue.

22. After Mr Chai's parents were informed about the incident they travelled to Melbourne from Malaysia to be with their son, accompanied by another family member said to be Mr Chai's uncle.

23. Mr Chai died six days later, having never regained consciousness, surrounded by his family.

Identity of the deceased

24. On 13 March 2019, the body of Choon Jie Chai, born on 14 December 2000, was visually identified by his father, Mr Chuan Ping Chai.

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

Medical cause of death

26. Forensic Pathologist, Dr Michael Phillip Burke, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 3 June 2019, reviewed a post- mortem computed tomography (CT) scan, considered the contents of the relevant medical records and referred to the Victoria Police Report of Death, Form 83. Dr Burke provided a written report of his findings dated 5 June 2019.

27. The post-mortem examination findings were consistent with the history given and medical records and as such the external examination was unremarkable.

28. Toxicological analysis of ante-mortem samples identified the presence of Midozolam in the blood sample, concentrated at ~ 0.1mg/L.[3]

29. Dr Burke provided an opinion that the medical cause of death was '1(a) Drowning'.

INVESTIGATIONS

30. On 4 November 2019, my coroner's investigator, First Constable (FC) Daniel Staffieri, delivered the Coronial Brief of Evidence for my consideration. Having review the evidence contained in the Coronial Brief, I determined that further investigation was required to interrogate the following issues:

    i. Whether the reception area to which the emergency number which Mr Tee dialled to raise the alarm was directed, was left unattended at any time;

3 Midozolam is indicated as a pre-operative medication for its sedative and anaesthetic properties. The concentration identified is consistent with therapeutic use of the drug.

ii. Whether there were any safety measures in place at the time of the incident with regard to warning signs or information pamphlets available to guests in the hotel rooms; and

iii. If such measures were in place, to what extent did they address the linguistic needs of visitors who are not conversant with the English language; and further

iv. Whether any such measures highlighted the risks of entering a 1.9-metre-deep swimming pool in circumstances where the user was either a novice swimmer or could not swim at all.

31. Mr Robert Perry on behalf of the Mantra Hotel responded to my request for further information.[4] Mr Perry submitted further statements from the Mantra Hotel's management and other staff of appropriate rank and function.[5]

32. According to Colin Stevenson, the current Cluster General Manager, Victoria at Accor Apartments and Leases, and former General Manager of the Mantra on the Park Hotel since 2018, at the time of the incident, there were three employees stationed at the front reception desk who were instructed 'never to leave the reception unattended'. As such, there 'is always someone present at reception'.[6]

33. At the time of the incident, the following safety measures were in place:[7]

i. Signage which stipulated the pool rules was both in English and Mandarin which advised the patrons that the swimming pool is heated;

ii. Running, diving and bombing was prohibited;

iii. The use of glass utensils was prohibited in and around the pool area;

iv. Patrons were prohibited from using the pool facility whilst under the influence of drugs or alcohol;

4 Mr Robert Perry is a partner at Perry Maddocks Trollope Lawyers, South Yarra, Vic.

5 Coronial Brief of Evidence [CB], statements of Colin Stevenson and Joyce Tan.

6 CB, statements of Colin Stevenson, Joyce Tan and Emma Pocklington

7 CB, statement of Colin Stevenson

v. Patrons were advised to exercise caution because the surfaces around the pool were ‘slippery when wet’;

vi. The pool depth was clearly marked at delineated points along its length—1.1 metres, 1.7 metres and 1.9 metres;

vii. At the shallowest end of the pool, at the 1.1 metre depth mark, were steps and a handrail to aid access into and out of the pool;

viii. At the deepest end of the pool, at the 1.9 metre mark, a fixed metal ladder with handrails was installed. The ladder extended to a depth of approximately 780 millimetres;

ix. A safety flotation ring, a ‘reaching pole’ and hook were affixed to the wall at the 1.9 metre end of the pool;

x. A notice communicating ‘CPR/ Resuscitation’ instruction was affixed to the wall’; and

xi. A ‘wall mounted telephone’ was provided with a sign in English and Mandarin stating that ‘to contact reception please dial 550’.

34. Mr Stevenson stated further that each hotel room had an ‘information card’ available, advising guests of the services available at the hotel. However, he conceded that the ‘information card’ had no specific reference to risks associated with the use of the pool.

35. After the incident, the Mantra on Park Hotel took additional steps to improve the safety features in and around the pool area by upgrading the CCTV system and installing a ‘pushbutton alarm’ to complement the existing telephone connection to the hotel’s reception.

36. Satisfied with the adjusted safety measures brought about by the hotel after the incident, the Victorian WorkCover Authority (WorkSafe) did not issue any Improvement Notices.

37. According to Mr Stevenson, the Mantra on Park Hotel ceased to function as a hotel after the incident and has been converted to a residential apartment block.

Further investigation

38. Noting the commendable effort undertaken by the hotel in addressing the preventative and restorative needs of the facility, and the subsequent change in the hotel's business model, I focused my further investigation on the available guidance on pool safety for operators and managers of hotel and similar swimming pools.

39. I engaged the Coroners Prevention Unit (CPU)[8] to support this aspect of my investigation. The CPU collated background information on Victorian and national pool safety guidelines and conducted searches of coronial databases to identify previous similar deaths, advising me that there have been six unintentional drowning deaths (in addition to the death of Mr Chai) in pools at Victorian hotels, motels, camping and caravan grounds since 1 January 2012.

40. The CPU also drew my attention to the Royal Life Saving Society Australia (RLSSA) report, *A 10 year analysis of drowning in Aquatic Facilities: Exploring risk at Communal, Public and Commercial swimming pools*, which was published in 2018. According to this report, there were 42 drowning deaths in hotel pools and other communal pools[9] nationally between July 2005 and June 2015, with the key risk factors including lack of swimming ability and water safety knowledge. RLSSA's key safety messages for operators of communal pools included:

    - *Promote safe aquatic behaviour through clear safety signage, including the need for adults to actively supervise children and non-swimmers*
    - *Consider ways to improve safety through use of the Guidelines for Safe Pool Operations, trained personnel, alarms, CPR charts and defibrillators*

8 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.

9 The term "communal pool" was used in this report to designate any pool located in a Residential Class 3 Building as defined under the RLSSA's National Aquatic Facilities Classifications. For more detailed information on the classification system see Emergency Management Victoria, *Safer Public Pools Code of Practice*, version 1.0, October 2018, p.38.

- *Ensure there are ways for patrons to call for assistance in the event of an emergency, such as an emergency telephone*[10]

41. These key safety messages resonated with my concerns as to the circumstances in which Mr Chai drowned and confirmed for me the broader potential prevention benefit of undertaking this further investigation.

42. Finally, I received invaluable assistance from Life Saving Victoria (LSV) to understand the contexts underpinning safe operations of hotel swimming pools. I thank the following LSV staff for their time and effort in this regard: Dr Hannah Calverley, Manager Research and Evaluation; Mr Andy Dennis, General Manager Training and Aquatic Industry; and Dr Bernadette Matthews, Principal Research Associate and General Manager.

Guidelines for safe hotel pool operation

43. In January 2007 the Royal Life Saving Society Australia (RLSSA) published its *Guidelines for Water Safety in Hotels, Motels, Camping and Caravan Grounds*. These were detailed and comprehensive and contained material addressing many areas relevant to the circumstances in which Mr Chai drowned, including supervision of bathers, development of emergency action plans, safety equipment availability, and appropriate signage.

44. The *Guidelines for Water Safety in Hotels, Motels, Camping and Caravan Grounds* were written in a clear and direct style, and gave unambiguous advice on water safety best practice, even when acknowledging the advice was not legally binding. The following passage regarding supervision illustrates this quality:

> *It cannot be stressed enough that supervision should be applied to the aquatic setting at all times, and all users of the Hotel, Motel, Camping or Caravan aquatic setting are recommended to have a supervisor with them at all times, however this is at the discretion of the user.*[11]

10 Mahony A, et al, A 10 year analysis of drowning in Aquatic Facilities: Exploring risk at Communal, Public and Commercial swimming pools, Sydney: Royal Life Saving Society Australia, 2018, p.4.

11 Royal Life Saving Society Australia, *Guidelines for Water Safety in Hotels, Motels, Camping and Caravan Grounds*, Issue no 1, January 2007, p.6.

45. Furthermore, the *Guidelines for Water Safety in Hotels, Motels, Camping and Caravan Grounds* were developed in consultation with a reference committee that included representatives from water safety bodies; the hotel, camping, caravan and tourism sectors; and the building sector.

46. In 2015, as part of a revised approach to water safety, the RLSSA developed a *National Aquatic Industry Safety Framework*[12] supported by a strategy, policy, and industry best practice *Guidelines for Safe Pool Operations* addressing various aspects of aquatic facility operation: for example, emergency planning, signage, incident management, asset management, facility design, risk management, water safety and aquatic programs. The Framework and its associated Guidelines (which superseded previous guidelines including the 2007 *Guidelines for Water Safety in Hotels, Motels, Camping and Caravan Grounds*) covered a broad range of 'aquatic facilities', as explained in this excerpt from the *Guidelines for Safe Pool Operations - Aquatic Supervision*:

> *This National Industry Guideline applies to all Hotels, Motels, Camping and Caravan Grounds, Commercial and Public Aquatic Facilities, Learn to Swim Schools, and Body Corporate who own or manage an aquatic facility for the purpose of swimming or recreation such as a pool or waterslide. It may be used for Public Waterways such as Rivers, Creeks, and Streams.*[13]

47. Development of specific *Guidelines for Safe Pool Operations* is based on advice provided by the National Aquatic Industry Safety Committee, which draws its membership from the RLSSA, national swimming organisations, the aquatic facility industry, the building industry and local government, among other areas.

Possible need for additional guidance

48. Having reviewed the RLSSA's *Guidelines for Safe Pool Operations - National Policy* and *Guidelines for Safe Pool Operations - Aquatic Supervision*, I have a deep appreciation for the RLSSA's expert and comprehensive approach to pool safety. However, considering the material from a practical death prevention perspective, I have a lingering concern that nonetheless something important might have been lost when

12 Royal Life Saving Society Australia, *Guidelines for Safe Pool Operations: National Policy*, December 2015.

13 Royal Life Saving Society Australia, *Guidelines for Safe Pool Operations: Aquatic Supervision*, 2016, p.6.

the *Guidelines for Water Safety in Hotels, Motels, Camping and Caravan Grounds* were discontinued.

49. Major strengths of the *Guidelines for Water Safety in Hotels, Motels, Camping and Caravan Grounds* included that they were presented in a single document, had a very specific focus on hotel and related pools, and were prepared in consultation with relevant industry representatives. By contrast, the current suite of *Guidelines for Safe Pool Operations* are spread across multiple documents, they are designed to apply to a broader range of contexts, and the National Aquatic Industry Safety Committee overseeing the Guideline development has very limited representation from the hotel, motel, camping ground and caravan park industries.[14]

50. On a related point, the *Guidelines for Water Safety in Hotels, Motels, Camping and Caravan Grounds* were an easily accessible document, whereas access to the current *Guidelines for Safe Pool Operations* is via fee-based subscription, which may be a potential hurdle to dissemination and adoption.

51. I do not raise the above to criticise the RLSSA, its *National Aquatic Industry Safety Framework* and associated *Guidelines for Safe Pool Operations*. The complexity of the RLSSA material reflects the complexity of the subject matter it addresses. Rather, I wish to propose that some supplementary tailored guidance might assist the Victorian hotel, camping, caravan and tourism sectors to navigate pool safety and thus contribute to mitigating the risk factors in Mr Chai's death.

52. The approach I have in mind was developed in response to my recommendations in the death of Paul Daniel Rayudu, a matter with a similar factual matrix to Mr Chai's death, though it occurred in a public swimming pool rather than a hotel swimming pool. Briefly, in the matter of Rayudu I made pertinent recommendations to the relevant stakeholders with regard to warning signs addressing linguistic challenges of international visitors as well as recommendations regarding inexperienced swimmers visiting public swimming pool facilities. I additionally recommended:

14 For the current membership of the National Aquatic Industry Safety Committee, see Royal Life Saving Society Australia, "National Aquatic Industry Committee", undated, <https://www.royallifesaving.com.au/Aquatic-Risk-and-Guidelines/aquatic-industry/national-aquatic-industry-committee>, accessed 28 April 2022.

> *[…] that Chris Eccles, Secretary of the Department of Premier and Cabinet, work with the appropriate area of Victorian government to establish a central oversight and regulation body for public swimming pool operation in Victoria, to ensure safety standards are applied and upheld consistently across the industry.*[15]

53. While this last recommendation was not implemented, the State of Victoria adopted an alternative by charging Emergency Management Victoria to develop a *Safer Public Pools Code of Practice* in collaboration with LSV and public pool industry representatives: Belgravia Leisure, YMCA and Aligned Leisure. The *Safer Public Pools Code of Practice* set out practical guidance for people involved in operation and management of public pools, ranging across occupational health and safety responsibilities, the RLSSA *Guidelines for Safe Pool Operations*, Australian Standards, and relevant legislation. The *Safer Public Pools Code of Practice* did not seek to replace any of these resources, but instead introduced and summarised them, explained their relevance for the public pool industry, and directed interested readers to relevant resources for further information.

54. When the first edition of the *Safer Public Pools Code of Practice* was launched in October 2018, it adopted a definition of "public pool" that explicitly excluded pools in hotels, motels, caravan parks, camping grounds and similar; but I note that nonetheless it recognised these as relevant settings:

> *Two Community Issues Based Working Groups (CIBWG) will be established and maintained to contribute to and provide ongoing feedback into the practical application and implications of the Code. These CIBWGs will have the aim of contributing to the objectives of the current 'Victorian Water Safety Strategy'.*
>
> *One CIBWG will consist of i) Council owned pool, ii) industry peak body and iii) Government agency representatives. This group will represent Victoria's Council owned pools which are generally exposed to a higher level of risk resulting from the high number of patron visitations each year.*
>
> *The second CIBWG will consist of i) learn to swim pools, ii) early childhood care, tertiary education and higher education owned pools,*

15 Coroner Audrey Jamieson, Finding into the Death with Inquest of Paul Daniel Rayudu, COR 2014 0761, Coroners Court of Victoria, delivered 18 August 2016, p.34.

> *iii) hotel, motel, camping and caravan ground pools and iv) sports, resort and club pool representatives. These pool types are often exposed to a high risk through traditionally failing to provide qualified lifeguard supervision to patrons.*
>
> *The two groups will address the safety challenges associated with the operation of their given pool classification types to inform the ongoing development of the Code and future support requirements of the industry.*[16]

55. When the second version of the *Safer Public Pools Code of Practice* was released in October 2021, all reference to hotel, motel, camping and caravan park swimming pools had been removed from scope of the Community Issues Based Working Groups,[17] and these pools were not elsewhere mentioned.

56. Guidance similar to that found in the *Safer Public Pools Code of Practice* would be highly beneficial for managers and operators of swimming pools in hotel, motel, camping ground and caravan park settings.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death.

57. On the available evidence warning signs at the hotel were depicted in English and Mandarin.

58. The evidence suggests that the hospital staff communicated with Mr Chai's parents and uncle using the services of an interpreter. However, it is not apparent what language his parents and uncle used to communicate which, by implication, would be the language that Mr Chai would have spoken and understood.

59. Geographically, Australia falls within Oceania, the greater Asia-Pacific region, and I would expect that greater attention would have been paid to conveying the inherent dangers of swimming pools and/or natural waterways to non-English speaking users from this region.

16 Emergency Management Victoria, *Safer Public Pools Code of Practice*, version 1.0, October 2018, p.10.

17 Emergency Management Victoria, *Safer Public Pools Code of Practice*, version 2.0, October 2021, p.25.

60. It is especially important that warning signs are clear to individuals for whom English is not their first language; and that these warning signs are clear with regard to the danger posed to people who either cannot swim or who are novice swimmers. I acknowledge that the Mantra on Park Hotel has taken proactive steps to secure public safety after the incident and I commend their effort taken in this regard. However, the evidence indicates that there was no sign conveying information to inexperienced bathers.

61. The evidence indicates that the warning signs displayed at the Mantra on the Park Hotel did not include the details of these inherent dangers. Although the business of running a hotel has ceased at the premises and its use has been commuted to one where individual apartments are let, members of the public still have access to the facility and therefore, there is a need for warning signs to unambiguously identify inherent dangers in multiple languages.

62. I acknowledge that the depth of the swimming pool is indicated at intervals and that those signs are clearly visible to the patrons. However, the evidence does not indicate that the patrons are forewarned that the depth at which they choose to use the facility should be commensurate to their skill or expertise.

63. Although warning signs advised patrons to contact the reception desk in case of an emergency, and although the facility was appropriately equipped with a phone and a pushbutton alarm, the evidence indicates that the staff generally left the swimming pool area unattended. I am not convinced that leaving hotel guests to use the swimming pool entirely unsupervised is a safe practice, though I acknowledge there is no requirement in law for such supervision.

64. I believe the managers and operators of swimming pools in hotels, motels, caravan parks and camping grounds might be greatly assisted by a Code of Practice, similar to the *Safer Public Pools Code of Practice*, which provides an overview of the relevant regulations and advice and guidelines on safe pool operation. If such a Code of Practice could encourage these managers and operators to review their pool safety practices, and to reacquaint themselves with important resources such as the *Guidelines for Safe Pool Operations*, I believe there would be a strong prevention benefit.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:

1. In the interests of public health and safety and with the aim of preventing similar deaths, I recommend that Emergency Management Victoria review and extend the Safer Public Pools Code of Practice to include pools in Residential Class 3 buildings, including specifically hotels, motels, camping grounds and caravan parks.

2. As an alternative to recommendation 1, I recommend that Emergency Management Victoria lead the development of a new *Safer Hotel, Motel, Camping Ground and Caravan Park Pools Code of Practice* to be modelled on the existing *Safer Public Pools Code of Practice*.

3. I recommend that when producing the revised (recommendation 1) or new (recommendation 2) *Code of Practice*, Emergency Management Victoria consider the circumstances in which Choon Jai Chai drowned, and the issues relating to signage and pool supervision and emergency communication. All operators of swimming pools situated within hotels, motels, caravan parks and camping grounds should be encouraged to explore the options and means for best communicating with patrons who have English language challenges and ensuring that these patrons inform a staff member if they are not a confident swimmer before entering the water.

4. In the interests of public health and safety and with the aim of preventing similar deaths, I recommend that Emergency Management Victoria convene an advisory group that includes representatives drawn from the hotel, motel, camping ground and caravan park industries, along with Life Saving Victoria, to assist with developing, launching and disseminating the *Code of Practice* and supporting these industries to implement its advice.

FINDINGS

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

   (a) the identity of the deceased was Choon Jie Chai, born 14 December 2000;

(b) the death occurred on 31 May 2019 at St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Melbourne, 3065;

(c) I accept and adopt the medical cause of death ascribed by Dr Michael Phillip Burke and I find that Choon Jie Chai died by drowning;

2. I find further that at that Choon Jie Chai drowned in a swimming pool at the Mantra on Park Hotel, as it was then known, while no hotel staff member was in attendance at the swimming pool.

3. Whilst I acknowledge the signage around the swimming pool, the evidence supports a finding that the signage was ineffective in conveying to Choon Jie Chai, in any intelligible form, the inherent dangers that the facility posed to novice swimmers, and I find that the warning signs were inadequate in this regard.

4. Ultimately, I am obliged to consider whether, on the balance of probabilities, the death of Choon Jie Chai was preventable. On the weight of the available evidence, I am satisfied that there is clear and cogent evidence to support a finding that the death of Choon Jie Chai could have been prevented. However, I acknowledge that the countermeasures required to prevent his drowning, such as having appropriately trained staff members to supervise pool users and having processes in place to engage people whose first language is other than English in safe pool use, are only recommended rather than compulsory for hotel pool operators.

Pursuant to sections 73(1B) of the *Coroners Act 2008*, I direct that this Finding be published on the internet in accordance with the rules.

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

Chuan Ping Chai

Kate Mellier, Lander & Rogers Lawyers on behalf of Mantra on Park Hotel

Kate Fitzgerald, Chief Executive and Deputy Secretary, Emergency Management Victoria.

Donna Filippich, Legal Counsel on behalf of St. Vincent's Hospital

Derek Blackwell, YDR Chartered Loss Adjusters (Insurers of the Mantra on Park Hotel)

Trechelle Herington, DonateLife Victoria

Victorian WorkCover Authority

Jeremi Moule, Secretary of the Department of the Premier and Cabinet

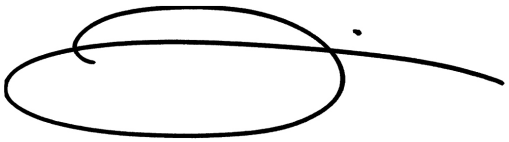
Mazita Marzuki, Consul General, Consulate General of Malaysia, Melbourne

Dr Bernadette Matthews, Principal Research Associate and General Manager, Life Saving Victoria

RJ Houston, National Manager Aquatics, Royal Life Saving Society Australia and Chair, National Aquatic Industry Committee

First Constable Daniel Staffieri, Coroner's Investigator.

Signature:



AUDREY JAMIESON

CORONER

Date: 10 May 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.
